

HRM in Public Private Partnerships: Working in a Health Production System

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Abstract

This study explores the changing nature of employment and employment management within multi-organisational public services 'partnerships'. In line with international trends, a major feature of the 1997-2010 New Labour government's public policy was encouraging partnerships between organisations of all sectors to run public services. Within healthcare, central government has increasingly been seen as taking on a role of market regulator, with organisations from all sectors allowed to plan as well as provide public services (Illife and Munro, 2000). As part of this picture, bringing private companies into partnership arrangements with the National Health Service has been seen as a catalyst for workforce re-configuration and employment change through furthering the reach of private sector type Human Resource Management. However, research has illustrated how inter-organisational contracts can also restrict an organisations choice of employment practice, disrupt the direct relationship between managers and employees, and undermine any aspirations for fair or consistent employment (Marchington et al, 2005). In more recent healthcare partnerships, employment is further complicated as partnerships involve powerful professional groups with their own protected employment systems and established norms of practice. This study seeks to investigate the prospects for HRM within such a professionalised partnership context through comparative case study of two Independent Sector Treatment Centres (ISTCs) operating under differing employment regulations and contractual agreements. In both cases, private sector management sought to impose a more 'rationalised' and standardised approach to work with a greater focus on outputs and productivity, placing ISTCs at the forefront of the Fordist 'scientific-bureaucratic' (Harrison, 2002) approach to medicine. However, the study identifies a number of limits to the degree to which the management of the private health care companies could shape HRM practices in line with these aims. The thesis also examines how being separate from, or integrated with, existing National Health Service organisations can lead to different types of contingencies affecting work and employment, and multiple varieties of inconsistency across the workforce. The findings of the study are explored in terms of the implications for public policy, health service management and HRM theory.

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Chapter 1 Introduction

1.1 Thesis Background

Shrinking the divide between the public and the private sector has been a recurring theme in public policy. Under New Labour, creating a mixed public and private economy in the provision of public services was described as a 'cornerstone of the Government's modernisation programme' (Alan Milburn, 2000, quoted in Edwards & Shaoul, 2003). Early policy announcements from the Conservative-Liberal Democrat coalition government elected in 2010 strongly suggest that the pattern for ever greater levels of private sector involvement in public services looks set to continue (Guardian, 2010; People Management, 2010). This can be seen as part of wider policy debates around forms of public service control, markets, networks and the role of the state in contemporary society (Exworthy et al, 1999; Ferlie and McGlvern, 2003; Thompson et al, 1991; Field and Peck, 2003; Castells, 2000). From this view, increasing private industry involvement in public services indicates a move away from traditional notions of public and private, towards a mixed system of governance (Kirkpatrick, 1999; Broadbent et al 2000; Exworthy, et al 1999). More broadly, the changing relations between the public and private sector can be seen in view of long term neoliberal international economic and political trends (Saint Martin, 2000, Harvey, 2005). Political rhetoric surrounding public services over the past thirty years has continually emphasised market mechanisms, competition, entrepreneurialism, performance measures, decentralisation, increasing efficiency, as well as changing the relationship between the public sector and private industry (Hood, 1991; Hughes, 2003).

In line with these trends and supported by central government policy, numerous form of partnership between the public and private sector have sprung up over the past decade. Within the field of healthcare, all mainstream parties routinely state their commitment to the founding NHS principle of universal health care free at the point of delivery. At the same time, there is a growing sense of central government taking on a role of market regulator, seeking to allow local NHS Trusts to manage their own affairs where possible, including the option for them to bring organisations from all sectors to plan as well as provide public services (Illife and Munro, 2000). The private sector is now heavily involved in many of the current developments in health infrastructure, as well as seeking to become involved in other core services. Profit

making companies are routinely designing, building, and to some extent operating, new hospitals, primary care facilities and treatment centres (Pollock, 2004). Various explanations, rationales and justifications have been given for these developments, ranging from notions of resource efficiency to improved financial management and greater innovation. For example, from a strategic perspective, it is suggested that public-private partnerships (PPPs) bring in resources that would be otherwise unavailable to the public sector, such as finance, knowledge, legislative power or land (McQuaid, 2000). Alternatively they may improve the efficiency and effectiveness of services, or increase the legitimacy of public actions by involving a number of stakeholders within project development (Osborn, 2000). Researchers have also pointed to possible state level financial inducements, such as transferring risks to the private sector and diversifying sources of investment and borrowing (Broadbent et al. 2000). Partnerships have been advocated as allowing the benefits from both markets and hierarchies, such as improvement through competition and state leadership, while avoiding some of the negatives such as market failure and constrictive top down control (Entwistle and Martin, 2005; Francis et al, 1991; IPPR, 2001). The increase in private business in running public services has also been linked to more covert motivations, such as pressure from global financial institutions (Price et al 1999), the widespread use of management consultants (Saint-Martin, 2000) and the declining power of the nation state (Castells, 2000).

Intimately tied to these changes is the management of labour and the nature of work and employment in the public sector. 'Modernising' employment practice has been identified as an underlying premise of many New Labour public administration reforms since their election in 1997 (Harrison, 2002). The past decade has witnessed a sustained top-down push for transformation in public sector employment and workforce re-configuration (Buchan, 2000; Boyne et al, 1999; Nutley 1999; Arrowsmith and Sisson 2002). This is generally presented as a push away from collective industrial labour action, historical segmentation of professional work and paternalistic welfare-focused Personnel Administration, toward the individualistic, 'strategic' approach of Human Resource Management (Lucio and Stuart, 2002; Arrowsmith and Sisson, 2002). At the broadest level, mainstream HRM has sought to identify how the adoption of certain employment practices can lead to improvements in organisational performance, for example through matching employment practices with the overall objectives of the organisation, the demands

of the industry sector and the requirements wider operating environment. The introduction of private providers into public service provision been advocated as supporting the introduction of HRM into the public services and the rationalisation of employment management (CBI, 2008). Indeed, changing work and employment management is often cited as the decisive rationale for private sector involvement (DoH, 2002b). Most basically stated, this logic runs that devolving responsibility for employment to a much greater number of smaller more independent units will drive the system to more locally appropriate forms of employment (Bosanquet et al 2006). For example, local managers will be able to tailor practices such as the design of work, staff roles and pay structures to meet specific organisational demands and the operating environment and therefore improve performance.

However, entering into inter-organisational partnership also presents significant challenges to employment and employment management. Recent research examining work within inter-organisational networks and partnerships has identified how aspects of the employment relationship are affected when organisational boundaries become blurred and existing hierarchies and lines of authority are disturbed (Marchington et al 2005a), for instance when the responsibility for employment is outsourced to external agencies (Grimshaw et al 2005b) or when the activities of smaller suppliers are closely controlled by dominant contractors (Scarborough, 2000). This work highlights the challenges of employment within such 'network organisations', including on one hand the inability of managers to shape employment in the face of contract specifications and client demands and on the other the vulnerability of employees to the actions of those which they have no direct contract or recourse for having their voice heard (Marchington et al 2005b). In this way, public private partnerships introduce new inter-organisational and sectoral relationships, which may bring additional complexities and sources of tension to already fraught attempts to rationalise HRM within in the public sector.

Recent case studies of employment in PPPs have so far focused on instances in which non-clinical services have been supplied by the private sector (Grimshaw et al, 2002; Fischbacher and Beaumont, 2003; Hebson et al, 2003). This has been commonly done through the Private Finance initiative in which the private sector have provide property and equipment, such as hospitals and primary care centres, and in some cases facilities management services such as cleaning, property maintenance and catering (Broadbent et. al. 2000). These studies have brought to light a number of

important issues, including the pressures on work from contract managers, the mix of different values on the public service ethos and the additional tensions of the 'multi-employer' workplace. In general these have illustrated how support staff may lose out, with the increase in private contractors leading to occasions of a 'two tier workforce' (Morgan and Allington, 2002). However, more recent forms of public private partnership in healthcare go further in the transfer of services, for example moving 'core' NHS surgical and diagnostic activities to private providers. This is being done through the establishments of Independent Sector Treatment Centres (ISTCs), mobile treatment clinics and privately sponsored primary care walk in centres, outsourcing professional functions, and bringing in private sector companies to manage NHS organisations. These instance involve different dynamics within the employment relationship, as they cover traditionally more powerful professional and occupational groups who have strong national associations, deeply embedded norms and cultures and already potentially conflicting allegiances to their profession and their employer (Hutton and Masey, 2006; Harrison, 2002). Therefore this thesis asks 'what are the implications of these recent public-private partnerships for human resource management as a means of managing the employment relationship and for the nature of work in public services?'

To explore these issues, this thesis takes a comparative case study approach, focusing on two Independent Sector Treatment Centres (ISTCs). ISTCs are healthcare organisations operated mainly by for-profit companies that offer elective care services to NHS patients, but outside or in partnership with established NHS (public) providers. These were introduced to increase the capacity for elective care and diagnostic procedures, offering greater choice to patients and stimulating innovation in the provision of healthcare. ISTC were chosen as an appropriate site for the research as they were slated by the government as embodying new forms of collaboration between the public and private sector, rather than merely being an additional example of contracted out services (DoH 2005a). This claim holds particular significance within healthcare, as the NHS is often described as the paradigmatic public service, as well as being the most resistant to change. In addition the proliferation of ISTCs has been somewhat ad hoc and experimental, with organisations demonstrating different types of partnership, structure and regulatory framework. This allowed the research to focus on two sites which differed significantly in their approach to employment, offering opportunities for comparison

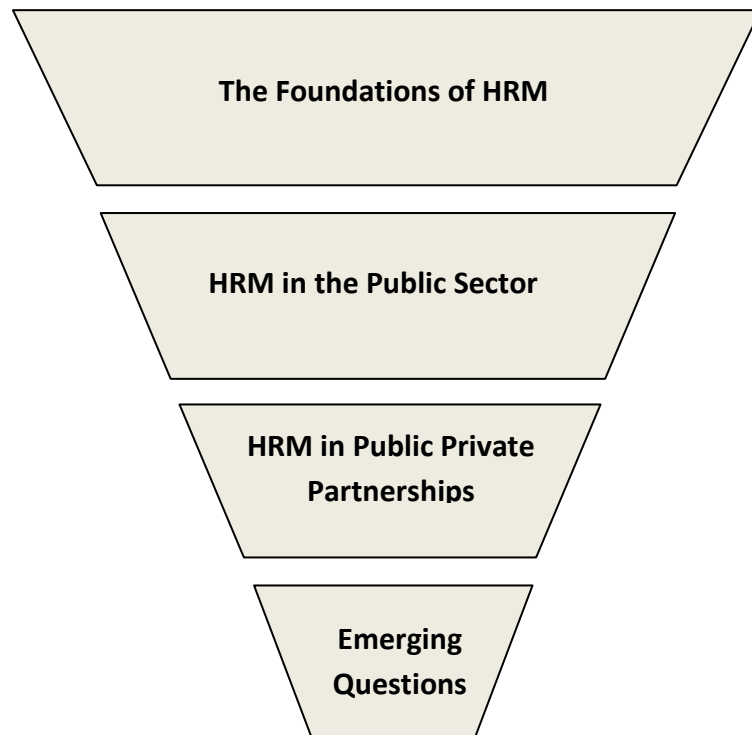
along important dimensions. The first ISTC largely replaced existing services in an adjacent general hospital, and involved the transfer of a large proportion of its staff from the local NHS trust. The second ISTC on the other hand was forced by regulation to employ people only from outside the NHS, and so was brought together clinical and administrative staff from a wide variety of cultural and organisational backgrounds, in many ways building the new hospital service from scratch.

Data is presented from approximately 72 semi-structured qualitative interviews with a cross section of employees and managers, 8 months observational research in clinical and administrative settings, and supporting documentary evidence. Findings from the two sites illustrate two very different organisations, with HRM emerging along divergent trajectories. In the ISTC involving a transfer of staff from the NHS, many HRM practices were inherited and translated from the parent organisation, but into a context of new employment tensions, including directly employed and transferred staff working side by side, people working in the same role under different contracts, as well as people working day to day across the public and private sector. Accordingly there were large constraints on the choices of HRM, which was forced to contend with existing inter-professional relations, managing non-employees and the challenges of the multi-employer workplace. On the other hand, the ISTC that was developed separately from NHS facilities had far fewer pre-existing templates for employment and HRM practices, with management allowed greater scope to shape employment to the terms of the service contract. However, being prevented from recruiting from within the NHS led to ongoing labour market shortages and contributed to a relatively transient workforce with low levels of commitment. This in turn created difficulties stemming from the transactional approach to employment, high turnover, and large uncertainties over the fit between the emerging practices and employment relations and requirements for maintaining quality in health care services. The production of health services within two sites are described in detail in relation to identified themes in the literature, focusing on the foundations of the organisations, the character of employment and the nature of work roles. These findings are discussed in terms of their implications for theories of HRM, the changing nature of public service employment, and how the issues raised relate to public policy in health care.

1.2 Thesis Structure

The thesis is presented in three parts. The first part (Chapter 2) covers the relevant literature and is divided into three sections which examine overlapping areas of literature (see figure 1 overleaf). These locate the current study against the extant literature and lead to a number of questions to be answered about HRM in the context of PPPs. The sections are as follows: 1) the foundations for the concept of HRM and its application in current practice. This includes intra-paradigm debates on the link between HRM and overall organisational strategy and performance, and inter-paradigm debates that have challenged the foundations of HRM as an academic discipline as well as a legitimate area of social activity. This section concludes with a portrayal of how the label of 'HRM' is used within the present study. 2) The basis for HRM in the public sector including the policy background and its translation to the public services. This includes consideration of the influence of professional groups, the distinctive employment and industrial relations culture and the dominant norms and values within healthcare. 3) The nature of the employment relationship within 'networked' organisations such as PPPs. This includes discussion of the challenges posed to integrated employment within the multi-employer or permeable workplace. These areas of literature highlight three categories of relationships of potential importance in shaping HRM within PPPs: namely those between employees and managers, between occupational and professional groups, and between the organisations in constellations of supply and service delivery. These are considered in the final section of literature which identifies a series of questions related to the prospects for HRM within PPPs.

Figure 1: Literature review structure



The second section presents the research context and methodology. Chapter 3 presents the policy background to ISTCs, and how ISTCs relate to the research questions. Chapter 4 presents the research methodology. The emphasis here is on describing personal experience of conducting the research, and relating this process to relevant methodological literature. This includes discussion of qualitative research and the comparative case study approach.

The third section presents the results, discussion and conclusion. Chapters 5 and 6 present descriptions of the employment environment within each of the case study sites. Each chapter covers the foundations of the ISTC with respect to employment, the dominant employment culture, and the work roles of doctors, nurses and other staff groups. Chapter 7 compares the two case sites, focusing on the relationships between organisations, between occupational/professional groups and between employees and managers. Chapter 8 then discusses the comparative findings with respect to the reviewed literature. Chapter 9 draws a number of conclusions from this discussion and comments on the practical implications, limitations and suggestions for future research.

Chapter 2 Human Resource Issues in Public Private Partnerships: Three Levels of Literature

2.1 Introduction

Literature on Human Resource Management is vast and comes from a wide range of theoretical perspectives. Accordingly there are a great number of contrasting definitions to convey the 'rhetoric and reality' (Watson, 1995b) of HRM. Descriptively, 'human resources' and 'human resource management' are now commonly used in settings of management theory and practice to refer to 'anything and everything associated with the management of employment relations in the firm' (Boxell and Purcell, 2000). The emergence of HRM as a concept for managing the employment relationship is usually traced back to the early 1980's, tied to wider changes in society, the industrial environment and academic theorising, including the growth of neo-liberal economics, changes in the global market, increased competition and the new 'enterprise culture'. Within this context, and the corresponding focus on performance and competitive advantage, 'personnel' has generally been replaced throughout both the public and private sector with more managerially powerful ideas of HRM (Legge, 2004). There is however no consensus on the meaning or affect of this change.

Projecting ideas of Human Resource management on to Public-Private Partnerships brings to light a large number of challenges, contradictions and conflicts both in terms of theory and practical application. These can be seen on three overlapping levels. At the broadest level are the issues associated with HRM as a generic concept and how useful, comprehensive and ethical it is as a guide to contemporary employment relations management. These include intra-paradigm debates regarding the advantages of different models of HRM and their applicability to particular contexts, as well as cross-paradigm critiques that challenge more fundamentally the assumptions of the approach. On the second level are the challenges of transferring ideas of HRM from the private sector in which they were originally envisaged to the somewhat contrasting environment of the public sector. Research has identified a number of contextual issues including the high prevalence of professionalism, as well as different norms, values and industrial relations history that pose problems for directly transferring managerial practices to the public sector. On the third level are the additional issues opened up by considering HRM in non-conventional

organisational environments such as public private partnerships. These often alter the nature of the relationship between management and employees, especially in the case of PPPs which introduce both cross-organisational as well as cross-sectoral divisions into the workplace. This chapter examines these three levels, and derives a number of questions for the research based on the application of HRM theory to PPPs.

2.2 1st Level: The Foundations of HRM

2.2.1 Intra-Paradigm Debates: Style, Strategy and Organisational Performance

This section focuses on the literature that broadly supports HRM as an approach to employee relations management and forms the basis of the 'mainstream' HRM perspective. This area of literature has tended to focus on the classification of general strategic models, associated 'styles of management' and specific features of organisational practice. Moreover, it has sought to relate these to organisational level outcomes such as financial performance, productivity or staff turnover. From this perspective, definitions of HRM state that it is a distinctive approach to employment management, usually emphasise valuing people and their skills as the most important organisational resource and often suggest how these can be made to contribute to the organisation's strategic approach. Also within this mainstream HRM work a link is commonly assumed between different patterns of purposeful management action, such as selection, job design, rewards, involvement in decision making and levels of training, and particular desired behaviours in employees, such as commitment, flexibility, initiative or indeed compliance. In this way, HRM is seen as contributing to the overall success of the organisation (Huselid, 1995; Philpott, 2002; Guest and Conway, 1999; Wall and Wood, 2005). Based on this, claims are made to the importance of including the HRM function in strategic decision making alongside other functions that have otherwise taken precedent such as accounting and finance. This picture of HRM is painted largely in contrast with previous approaches to managing employee relations, and views of personnel management as a bureaucratic administrative 'handmaiden' function (Guest, 1987; Storey, 1992).

While the range of HRM activities may differ greatly from one organisation to the next, two contrasting styles are frequently called upon to characterise employment practice. The first of these is commonly referred to as the 'hard' or 'control' view and focuses on close managerial direction of employees, coercively enforcing work around tightly prescribed tasks (Storey, 1992; Legge, 2004). This version has been linked to instrumentalist–utilitarian philosophical views of organisations (Hendry and Pettigrew, 1990) and assumptions of human nature roughly resembling McGregor's theory X (Truss, et al, 1997) stressing the need for tight controls over the workforce and closely monitored performance management (Walton, 1985). This approach also stresses a managerial approach of tight strategic planning and quantitative allocation of human resources; through head count and skill mix in order to meet pre-specified organisational outputs (Truss, et al 1997). Secondly the 'soft' or 'commitment', view emphasises employees' intrinsic motivation, trust, commitment and participation. This is said to rest on more developmental-humanist views roughly equated with McGregor's theory Y, stressing organisations are better served by building employee commitment and high trust relationships (Walton, 1985; Truss, et al, 1997). This language of hard and soft has come to be seen as intrinsic to the concept of HRM; however many aspects and characteristics of the two styles echo debates from previous eras of thinking on employment relations management styles (Purcell and Sisson, 1983; Legge, 2004). The language of HRM can be seen as in many ways continuing dualisms long identified within 'personal management', such as care and control, (Watson 1977), of investment and efficiency, of (feminine) welfare and (masculine) industrial union relations bargaining (Legge, 2004), of individualism and collectivism (Torrington, 1989) (See Niven, 1967 for more detailed history).

More uniquely central to HRM however are attempts to identify how different approaches to employment relations management can contribute to the overall performance of the firm (Guest, 1997). This field of 'strategic human resource management' (SHRM) emphasises the integration of employment practices; with each other to form a consistent system, and with desired outcomes of the organisation. Two versions of SHM are generally considered as illustrative of the approach (Boxell and Purcell, 2000). The first of these is commonly referred to as 'the best practice' approach which suggests that all organisations would benefit from adopting a specific overriding identifiable HRM strategy, usually emphasising those associated with 'soft' or 'high commitment' styles of HRM. Pfeffer, (1994; 1998) has

provided perhaps the most well known version of best practice approach, arguing for the universal adoption of the following practices; employment security, selective hiring, self managed teams/'team working', high compensation contingent on organisational performance, extensive training, reduction in status differences, employee involvement and information sharing. Supporters of this view maintain that by investing in such high commitment management practices, organisations will gain the maximum possible contribution from employees who are committed and involved, giving the organisation the best possible chance for success (Blyton and Turnbull, 1992; Pfeffer, 1998; Guest, et al 2000). A more complete list of advocated best practice activities, along with complimentary lists from other researchers are presented in table 1 (overleaf).

Perhaps unsurprisingly the best practice view has been attractive for academics and practitioners. On the face of it this presents a win-win situation for employers and employees, changing the employment relationship from one of conflict and tension towards one of harmonious working towards shared goals. It would in many ways appear a virtuous choice, appealing to managers' best intentions to invest in and support employees' growth, and warning against coercion, ill treatment or exploitation, not merely for the employees' sake but also for that of the business (Marchington and Grugulis, 2000; Guest, 1990). Accordingly this approach has received much attention and support (e.g. Wood, 1995; Huselid, 1995; Wood and Albansese, 1995; Guest 1997; Gould-Williams, 2004; West et al 2002), to the extent that many commentators have announced that the link between the adoption of high commitment HRM and increased business performance has been categorically proven (Pfeffer, 1998; Appelbaum et al 2000; CIPD, 2001).

Table 1 Summary of Best Practises in Human Resources

Summary of Best Practices in Human Resources			
Friend & Epstein (1984)	Arthur (1992)	Pfeffer (1994)	Delaney, Lewin, & Ichniowski (1989), Huselid (1995) MacDuffie (1995)
Job enlargement	Broadly defined jobs	Employment security	Work teams
Job rotation	Employee participation	Selective recruiting	Problem-solving groups
Job design	Formal dispute resolution	High wages	Employee suggestions
Formal training	Information sharing	Incentive pay	Job rotation
Personalized work hours	Highly skilled workers	Employee ownership	Decentralization
Suggestion systems	Self-managed teams	Information sharing	Recruitment and hiring
Quality circles	Extensive skills training	Participation	Contingent compensation
Salary for blue-collar workers	Extensive benefits	Empowerment	Status differentiation
Attitude surveys	High wages	Job redesign/teams	Training of new employees
Production teams	Salaried workers	Training and skill development	Training of experienced employees
Labor/management committees	Stock ownership	Cross-utilization	
Group productivity incentives		Cross-training	
Profit sharing		Symbolic egalitarianism	
Stock purchase plan		Wage compression	
		Promotion from within	
			Personnel selection
			Performance appraisal
			Incentive compensation
			Job design
			Grievance procedures
			Information sharing
			Attitude assessment
			Labor/management participation
			Recruiting intensity
			Training hours
			Promotion criteria (seniority vs. merit)

Source Youndt et al (1996)

However, despite the attractiveness of the approach there are numerous deep-seated problems with attempts to concretely prove a link between combinations of 'good practice' HRM and positive organisational performance. First, this approach suggests that a single style of employment management both should and could be applied across all organisations, as well as all divisions and functions within organisations, regardless of the context, business, sector or cultural context. In stark contrast to this, studies of individual managerial practices and general styles almost inevitably find a high degree of variation within and between different organisations. Large variations in the nature of employment management are usually found between types of industry, cultural context, size and ownership of the organisation and its operating environment (Guest, 1997; Marginson et al 1988; Purcell, 1999). Underlining these discrepancies, it has been pointed out that the 'best practice' model is insufficient to explain the success of organisations which adopt employment practices which are contradictory to the advocated approach (Purcell, 1999). In addition there have been serious methodological limitations identified in many studies held up in support of this approach, including the difficulties of using correlation studies to establish a causal link between overall HRM strategy and outcome measures. In summary, despite numerous reviews and meta-analysis of the area, a consistent causal relationship is yet to be definitively established between best practice HRM and organisational performance (Wall and Wood, 2005).

Partially responding to some of these problems of treating HRM practice in such universal terms, a large amount of research is now directed at the alternative model of 'best' or 'contingent' fit, that considers a greater degree of variety in HRM practices and contexts. Broadly this argues that HR practice becomes more effective when it is designed to match certain features of the firm's specific market context or its strategic approach. Generic contingencies are usually identified along the lines of product life cycle, market positioning or chosen strategy (Marchington and

Wilkinson, 2005). At the broadest level this suggests that business strategies which seek to capitalise on increased quality and innovation are best served by the 'soft', 'high commitment' HRM styles that require investing in employees through training, development, internal career planning, more equitable pay scales and additional benefits. It is hoped that these encourage employees to 'buy in' to the activities of the organisation and in return for their energy, creativity, and resourcefulness receive a share of the rewards of their work and long term job security. On the other hand, low cost business strategies are served by 'hard', 'low commitment' HRM which minimise costs in order to achieve immediate efficiencies. This is said to be more suitable for routine production apparently requiring little development or initiative. Employees are more interchangeable and are expected to meet only minimum standard of output quality for lower levels of reward.

Table 2 Table 2 Model of Employee Role Behaviour Associated with Generic Business Strategy

Strategy	Employee Role Behaviour	HRM Policies
Innovation	A high degree of creative behaviour	Jobs that require close interaction and coordination among groups of individuals
	A high Tolerance of ambiguity and unpredictability	Performance appraisals that are more likely to reflect longer-term and group-based achievements
	A moderate degree of concern for quality	Jobs that allow employees to develop skills that can be used in other positions in the firm
	A relatively high level of cooperative, interdependent behaviour	Compensation systems that emphasise internal equity rather than external or market-based equity
	A Moderate concern for quality	Broad career paths to reinforce the development of a broad range of skills
	An equal degree of concern for process and results	Pay rates that tend to be low, but that allow employees to be stockholders and have more freedom to choose the mix of components that make up their pay package
	A greater degree of risk taking Longer-term focus	

	A more long-term or intermediate focus	Relatively fixed and explicit job descriptions
Quality Enhancement	<p>Relatively repetitive and predictable behaviours</p> <p>A moderate amount of cooperative, interdependent behaviour</p> <p>A modest concern for quantity of output</p> <p>A high concern for quality</p> <p>High concern for process</p> <p>Low risk-taking activity</p> <p>Commitment to the goals of the organisation</p>	<p>High levels of employee participation in decisions relevant to immediate work conditions and the job itself</p> <p>A mix of individual and group criteria for performance appraisal that is mostly short-term and results orientated</p> <p>A relatively egalitarian treatment of employees and some guarantees of employment security</p> <p>Extensive and continuous training and development of employees</p>
Cost Reduction	<p>Relatively repetitive and predictable behaviour</p> <p>A rather short-term focus</p> <p>Primarily autonomous or individual activity</p> <p>Moderate concern for quality</p> <p>High concern for quantity of output</p> <p>Primary Concern for results</p> <p>Low risk taking activity</p> <p>Relatively high degree of comfort with stability</p>	<p>Relatively fixed and explicit job descriptions that allow little room for ambiguity</p> <p>Narrowly designed jobs and narrowly defined career paths that encourage specialisation, expertise and efficiency</p> <p>Short-term results orientated performance appraisals</p> <p>Careful monitoring of market pay levels for use in making compensation decisions</p> <p>Minimal levels of employee training and development</p>

Source: Storey and Sisson (1993: 6) adapted from Schuler and Jackson (1987: 13)

This approach addresses some of the apparent failings of the best practice approach and dealing with HRM in such universal terms. However, critiques relating to the definition, measurement and multiplicity of management practice remain a key problem in this area of research. Also, the best-fit view suggests that organisations act consistently in response to certain external circumstances such as market opportunities or customer demands. However, external pressures are likely to act differently across various departments at various times (Purcell, 1999), creating a difficulty for the concept of a single, integrated approach to HRM (Purcell and Ahlstrand, 1994). In light of this, researchers have often reigned in the scope of study, to look for a link between mixes of various 'bundles' of HRM practice and performance, taking into account the wider environment, the nature of work and type of organisation (Bach, 2005). As an example of this, ideas of 'flexible' organisations have sought to differentiate between groups of employees, with different groups subject to different regimes of HRM practice. In particular the possibility has been explored of distinguishing between the 'core' workers who are central to developing the strategic activities of the business, as against 'peripheral' workers who are either outside the central focus of the organisation or are otherwise deemed more easily replaceable in the eyes of the management (Atkinson, 1984; Ackroyd and Procter, 1998). The core workforce are likely to be permanent and offered a higher degree of security and a share in rewards with HR practices intended to develop their capabilities in return for higher level of commitment, energy, inventiveness and openness to change. These attributes are less required of the periphery workforce who may be dealt with more instrumentally on a unit cost basis, or even externalised by subcontracting work out to suppliers or other agencies when this is deemed economically advantageous.

Ideas of such flexible firms bring to light the prospect of a link between HRM practices and the decision to outsource particular areas of organisational activity. It may then be possible to consider public sector contracting, networks, and PPPs in relation to such 'flexible' approaches to HRM. Groups of staff central to the provision of a service remain within the public sector, with suitable HRM practices supporting their work, while non-core work areas are outsourced to other organisations specialising in appropriate forms of management for these groups. However, this also introduces an additional set of problems and complications. While 'flexibility' in

normative best practice approaches to HRM is felt to be indicative of employees commitment and willingness to learn and take on new roles in the face of changing market environments and changing operations for competitive advantage (Guest, 1999), here 'flexibility' represents a threat to the security of non-core staff. Also, in many cases no clear line may exist between the 'core and the 'periphery' activities of a company (Purcell and Purcell, 1998), and externalising activities has been seen on some occasions to increase the pressure or destabilising remaining 'core' staff, creating more precarious work environments rather than protective or supportive ones (Ackroyd and Proctor, 1998; Rubery, et al 2004a). Moreover, new organisational forms encourage increasingly close relationships between contracting and contractor parties. This poses a problem for the vast majority of literature on HRM, which is predicated on the assumption of single employing organisation, capable of determining its own employment practice to their advantage (Marchington and Wilkinson, 2005; Rubery, 2004b). The blurring of boundaries between different organisations is of central importance to the current study and is explored in much greater detail in the section 2.4.

In summary, mainstream literature of HRM has attempted to identify the most appropriate approaches to employment relations management, often in fairly universal terms. The focus is on the individual employee and how to gain the maximum contribution from them, with respect to identified organisational goals. Crudely put this often involves some calculation of the costs and benefits of treating employees as human beings or as an expendable resource. Given this, it is perhaps unsurprising that researchers have sought to emphasise the benefits of the former and warned against the latter, despite the fact that elements of both approaches have been widely identified in contemporary organisational practice. A key area of research is the ongoing attempts to establish a link between particular employment management practices and organisational performance. However difficulties in establishing a causal link bring to light complexities in employment relations often set aside by mainstream HRM. These are outlined below.

2.2.2 Cross Paradigm Debates: the Use of HRM

The literature on HRM extends further than that which seeks to improve on existing models, create new ones, or render them more applicable to practice. More fundamental criticisms of HRM have also been well explored and come from a number of diverse theoretical perspectives. With reference to Burrell and Morgans

(1979) classification of perspectives within organisational studies Legge (2004) describes four categories of analysis on HRM, each with different worldviews, assumptions, research methods and implications. The normative perspective introduced above focuses on what HRM ideally should do, and can be generally seen as seeking to advance the case for HRM as an organisational function and as a subject of academic interest. Critiques of this perspective often point to the foundations on which normative models of HRM are based. For example, the focus on 'mutuality' (Walton, 1985) has generally been seen to imply a unitary understanding of employment relations, in which similar goals are shared by all stakeholders, employers, managers and employees alike. Further, it also invokes particular conceptions of human nature as a whole, for example the view of the enterprising, self-motivated, opportunity seeking individual conveyed in the 'best practice' and 'soft' variants.

In various ways these assumptions have been questioned by work fitting into Legge's three other categories of writing on HRM. These are the descriptive-functional, descriptive-behavioural, and critical evaluative approaches. The descriptive-functional approach focuses on what HRM 'is' rather than what it 'should be', and conveys a greater pluralism in the understanding of employment relations. In other words, it does not assume shared goals between employees and managers. Instead it looks at the role of the HRM function in balancing wishes on both sides of the relationship; although still tend to view HRM as integral to all management activity (Torrington, Hall and Taylor, 2008). The critical evaluative approach takes a more radical stand against the normative view, focusing on HRM in relation to asymmetries of power between organisations and individual employees, often in view of more general questions on the role of organisations in contemporary capitalist societies. This commonly pays close attention to the rhetoric of HRM, what it conveys and what it conceals in its vision of the organisation and its 'objectives'. These often posit alternative accounts of employment (and unemployment) that include the full range of experiences of work in modern societies, including negative emotional responses such as powerlessness, boredom, loss of esteem, loss of identity and insecurity, as well as the more insidious motives and actions of businesses and managers, including, discrimination, oppression, redundancy, coercion and pursuit of profit regardless of human consequences. Legge's final category of HRM writing, the descriptive-behavioural approach, focuses on what HRM actually does within

organisations without an explicit agenda to support or undermine it, but with a more full appreciation of the various constraints, limitations and criticisms than functional writing on the subject.

As described by Legge (2004), underpinning much critique is the large distance between the expectations created by the normative models of HRM and accounts of work and organisational life in the 'real world'. Research findings commonly identify the numerous ways in which peoples experiences within organisations differ dramatically from the idealised representations of employment relations in HRM and SHRM theory. Models of HRM envisage organisations as applying a certain pre-planned, explicit approach to employment management with some degree of consistency either across the whole organisation, or to particular parts of it. They also envisage employees and managers working in harmony towards explicit and accepted goals, so long as certain conditions are met. In depth examination of day to day organisational life typically finds this vision lacking as description of employment. Employment practices within organisations are often highly fragmented and inconsistent in their application (Truss, et al 1997; Marchington and Grugulis 2000; Legge, 2004). Practices are usually applied variously across departments or different groups of staff, with policy from the central HRM function interpreted and enacted differently by managers with respect to their own local circumstances and pressures. Within the UK, wide scale survey evidence has suggested that even within large organisations there is often very little common understanding of HRM policy amongst managers beyond vague platitudes on 'caring' and 'fairness' (Marginson, et al, 1988; 1993). Instead, it is suggested the overarching guiding principle for employee relations in most areas of industry is that of pragmatism and opportunism with regards to their internal and external environment, including the state of industrial relations, market and economic conditions, political and regulatory limitations, and socio-cultural norms and values (Marginson, et al, 1988; 1993; Legge, 2004). Related to this are difficulties in meaningfully defining and comparing HRM practices across organisational, sectoral and cultural contexts (Dyer and Reeves, 1995) that involve different norms and expectations in the workplace, where managerial actions are likely to be interpreted in different ways. Within this picture, the role of the HRM department and function has not necessarily achieved the transformation presented in theory. Instead, like personnel before it, HRM has often been seen as struggling with perceptions of status and legitimacy. Although there

may have been some changes to the activities and perceptions of HRM departments, they are still often marginal to decision making, lack a consistent role and identity amongst other managers and employees (Calwell, 2003).

These general themes of HRM 'in reality' are explored in far greater detail with respect to the context of this study in the sections on the HRM in PPPs below. However, literature critical of HRM amounts to more than just outlining a problem of incomplete implementation. It has been suggested that the limitations with generic HRM models are inevitable as they rest on flawed representations of the nature of organisations. Generic models of HRM tend to assume a rationally defined strategy, and the possibility of purposefully selecting a uniform HR practices at the will of management. This is particularly apparent in work which advocates organisations may in some way 'fit' HRM style to the wider strategic objectives. This treats organisations as instrumental social structures which act according to objective natural laws and rational choices cascaded by those at the top down 'making the decisions' to those 'doing the work' at the bottom (Dobbin, 1994), a view perhaps best summed up as the 'rational-bureaucratic' model of organisations. Watson (2004) characterises mainstream HRMs view of the work organisations as 'as a black-box system which functions more-or-less well in performance or 'output' terms according to the structural arrangements that are made to convert human resource 'inputs' into these outputs' (Watson, 2004: 453). This notion has frequently been invalidated, not only in work on HRM, but across a wide range of research and theory on organisations in general. To give some indication of this, dramatically departing from the view of organisations as a 'black box' are various perspectives of analysis; for example those that view the organisation as a subjective social construction (Chia, 1995), as a negotiated order (Strauss, 1979), as shaped in the face of intense institutional pressures for conformity (DeMaggio and Powell, 1983), or as the site for capital's extraction of profit from labour (Braverman, 1974).

Perhaps the most well known rebuttal of the rational design of organisations from a strategic perspective is that provided by Mintzberg's (1987; 1994) view of emergent strategy. This rejects the notion of top down, centralised strategic planning as unrepresentative of reality. Instead, Mintzberg saw strategy as formed through an incremental process, as actors distributed throughout the organisation interact with the existing internal and external environment. From a public policy perspective, Lipsky (1980) made comparable statements regarding employees of state

organisations who in part create public policy through exercising their discretion whilst carrying out their work on the front line. Others areas of research have extended the emphasis on the socio-cultural constitution of the organisation further. Research in the social constructionist tradition has explored more thoroughly the social contexts and processes in which managerial actions such as strategy formation are conceived of and embedded. This has presented numerous challenges to instrumental-rationalist notions of managerial decision making, including the situated nature of knowledge, the construction of social identities, the importance of language to meaning, and multiple subjective interpretations of the nature of the organisation (Downing, 2005; Nicolini and Meznar, 1995; Dobbin, 1995; Whittington, 1993). This work also often includes consideration of common features of social life often left out of management academic thinking about management, including social class, gender, and ethnic and national cultural norms and values. Rather than separate from the 'rational' actions by managements, these play an ongoing role in how the organisation is understood and enacted, and prevent uniform replications of the managerial visions which emanate from the centre. Also relevant here is research which examines individual managers own situated identities, self interests and individual strategies in terms of career progression and political manoeuvring (Watson, 2004). Empirical illustrations of the social processes that partially constitute everyday organisation life have often come from detailed qualitative case studies. For example these have shown organisational change can be a slow, complex and highly fragmented process, such as the longitudinal study of strategic change in the NHS (Pettigrew et al, 1992) that examine how variations in circumstances can lead to essentially different interpretations and realisations of strategy.

Leading on from this, it has also been said that mainstream HRM presents only a very limited account of the employment relationship. Not only does it view the organisation as populated by essentially similar individuals interested in growth and development, but also that these can be unified around common purpose in working towards organisational goals. This, it has been suggested, tends to obfuscate tensions within employment management such as the conflict created by multiple and divergent employer and employee interests (Knights and Willmott, 1990), whether these are profit, income, security, job satisfaction or meaning through work (Blyton and Turnbull, 2004). It plays down employee resistance to managerial control (Flemming and Spicer, 2003) as well as the contradictory requirement of employers

to gain the active input of employees while maintaining control over them (Watson, 1986). Highlighting this, 'soft' and 'best practice' HRM appears to suggest that managers should do all they can to ensure employee wellbeing, leaving out any indication that this may only be done so as long it serves the controlling interests of the employer such as profit or growth (Watson, 1986). Further, HRM focuses on managerial solutions to labour problems, rather than the input of the workforce or wider society through for example, government policy and legal regulation (Blyton and Turnbull, 2004).

Recognition of such tensions and conflicting interests in employment were of far greater central focus in previously dominant approaches to employment management, namely industrial relations based around union representations of the workforce and collective bargaining. This gave primacy to notions of redressing power imbalances inherent within the employment relationship, including employees' agreement to submit to managerial control at work, the often large differences in resources between employers and employees, as well as the uneven negative consequences of the relationship ending. For employees this could mean the loss of their livelihood and sense of purpose, whereas for organisation individual workers leaving may be less detrimental and may often be more easily replaced (Blyton and Turnbull, 2004). By focusing on 'mutual benefits', any recognition in tensions over the purpose of work are largely absent from HRM. For some, this represents a deliberate attempt by management to hide the real conflict and resistance that is fundamental to the work organisation by extending control through ideological means (Thompson, and Ackroyd, 1993). Under HRM employees are expected to see work quality as their individual responsibility, monitor their own behaviour or that of their peers, 'buy in' to the mission of the organisation and wilfully accept managerial control (Gabriel, 1999). For others drawing on post-structuralist theories, managerialist discourses such as HRM are not merely a tool for those in power, but a constitutive part of existing power relations, in which subjective knowledge of the organisation and individual identities are formed (Knights, 1990). 'HRM' in part produces the way the content and value of work is understood, ordered, and divided and the way the employee understands their (subordinate) position in relation to the employer (Townley, 1993). In light of this interpretation, understandably some have cast HRM as a fundamentally or 'totalitarian' feature of contemporary organisations (Willmott, 1993).

Based on these far reaching critiques of normative HRM and the problematic way in which it represents the organisation, employees and the employment relationship, there have been a number of suggestions as to how study of HRM should proceed. Legge (2004) advocates greater prominence of the descriptive behavioural approach to investigation of HRM, which compares normative models to the 'proclaimed implementation of HRM in organisations', while paying close attention to the problems and complexities identified above. Bach (2005) suggests that the meaning of HRM today has lost some of its most aspirational and prescriptive connotations and is now usually used to refer to all aspects of personnel and employment practice rather than specific high commitment styles. This move he suggests has dampened down some of the ideological concerns, with analysis now more fully taking into account the evolving political and economic context inside and outside the workplace. Down (1999), in an essay generally negative about the use of the term HRM states 'There is a reality about the employment relationship, and HRM does reflect a general but less than consistent shift to unitarist and individualised employment control practices, and it is that reality we should be interested in, not banal unanswerable discussions about what names they have' (p546). Similarly, Watson (2004) advocates using some of the labels presented by normative HRM only in terms of the provision of a framework and language with which to view and describe different employment activities within contemporary business; so long it is kept in mind that the models represent an ideal (in the Weberian sense) rather than directly represent organisational reality. Taking this view, certain forms of description and labels can be argued to be more appropriate, fair and instructive than others. As an example of this, in talking about HRM strategies 'high/low commitment' is preferred to 'hard/soft', as it does not conceal employers' ultimate objectives to use peoples efforts to further organisational goals.

Bearing this in mind, this study seeks to investigate HRM from a descriptive behavioural perspective, with particular attention to the socio-cultural environment in which HRM practices are formed. This includes recognition that the meaning of HRM can encompass a set of ideas, a management function, a department and specific activities. Therefore 'HRM' is not something done solely or even mainly by those in a HRM department, but is used as a term to cover all activities associated with managing work and employment dispersed throughout the organisation. The study seeks to describe the character of employment and of particular work

practices, and the consequences of these, particularly in terms of how they relate to perceptions of work and commitment, compliance and resistance to employer and managerial wishes, and particularly given the focus of the current study in relation to the objectives of public policy. This also points to the need for thorough examination of the constraints, conflicts and contingencies within the workplace. It is also acknowledged here that understanding and experience of HRM is not formed solely within the narrow confines of the individual organisation, but shaped within the wider organisational, societal and historical context. It is in view of this approach that the next two sections focus on relating HRM to the specific context of the study and identifying salient issues that are likely to have a bearing on the nature of HRM within Public-Private Partnerships.

2.3 2nd Level: HRM in the Public Sector

Following the proliferation of HRM throughout industry, in recent years there has been an ongoing push to reform labour relations in the public sector. However, the rise of HRM in this context has been far from straightforward. Alongside the generic tensions in employment management introduced above, the public sector has a number of additional characteristics which further problematise the realisation of particular models of HRM. Underpinning all discussions of public sector reform is recognition of the strong influence of various professional groups. Professions have played a key role in shaping the nature of many public services; particularly in healthcare where the powerful medical profession often continues to provide the dominant voice (Kitchener, 2002). In view of the influence of such professional groups as well as different structures and objectives, labour relations in the public sector have taken a historically divergent course, with a more enduring role of union representation and national employment agreements. This relates to the complex nature of many public services, the endemic challenges of the social problems they seek to address, and the political basis for resource allocation and decision making (Stewart and Ranson, 1994). Focusing on healthcare, this section presents an overview of attempts to implant HRM into the public sector, relating this to characteristics of the employment relationship within the public sector and the prospects for management.

2.3.1 NPM and the Push for HRM

Related to many of the same themes of public sector change that gave rise to PPPs, the past decade has witnessed a sustained top-down push for transformation in public sector employment and change in the employment relationship (Buchan, 2000; Boyne et al, 1999; Nutley 1999; Arrowsmith and Sisson 2002). Given the nature of the 'third-way' project to which claims a balance between neo-liberalism of the Conservative government and the corporatism of 'Old Labour' (Giddens, 1998), the government's approach to labour relations has been a central area of policy reform and also the focus of much debate. In terms of union negotiation and participation of state employees, the government have stressed 'stakeholding' and 'partnership' which emphasise constructive ongoing relationships (Legge, 2004). At the same time reform to employment management has been at the forefront of NPM attempts to increase efficiency, performance and value for money. Within public sector organisations, employment often represents by far the largest area of spending (Bailey, 1994), and the government has been under pressure to emulate private sector models to reduce costs and increase productivity (Horton, 2003). For some, the re-ordering of labour relations has been the central tenant of public sector change, with successive governments seeking to replace the traditional professional appeasement with decentralised corporate management (Arrowsmith and Sisson, 2002). With respect to these trends, there has been a continued push from the top away from paternalistic welfare-focused Personnel Administration, toward the more individualistic, managerially led approach of Human Resource Management (Lucio and Stuart, 2002; Arrowsmith and Sisson, 2002).

As with the generic approaches to HRM identified above, within the public sector a new emphasis has been placed on the strategic alignment between employment practices and policy aspirations (Lucio and Stuart, 2002; Arrowsmith and Sisson, 2002). Rather than a focus on employee welfare within a context of national agreements, in principle the nature of employment management now promoted by the government is based around local decision making at the organisational level 'driven by the demands of those leading public organisations for effective job performance, high quality of output, service to customers and value for money' (Farnham and Horton, 1996: 331). As identified above, strategic HRM theories have made a general assumption that managers have the discretion to shape the employment practices of their own organisation based on their own choices and

particular internal or external circumstances. In line with this, it has been argued that public sector restructuring that devolves responsibility to smaller, more independent units will be more capable of responding effectively and efficiently to local needs and circumstances. Encapsulating this view is the idea that breaking up existing state bureaucracies through handing power to independent trusts and introducing new providers and practice based commissioning 'will drive the system towards much more local and flexible systems of staff roles and pay structures', (Bosanquet et al 2006: 21), as well as encouraging well developed, supportive HR practices 'which will create greater job satisfaction and professional pride.' (Bosanquet et al 2006: 21).

Translating this logic into practice, New Labour have consistently promoted new employment policies and strategies for public sector organisations that have emphasised rational decision-making, formalising the workforce needs in accordance with organisational performance requirements, and designing employment practices accordingly (Gould-Williams, 2003). In general there has been a move away from uniformity and standardisation, towards flexibility and differentiation based on local needs and circumstance (Boyne et al, 1999). Key aspects of HRM imported from the private sector have been performance-based rewards, reducing employment costs, and an emphasis on HRM departments taking a 'strategic role' (Truss, 2008). In addition there has been a push for breaking down traditional boundaries between organisations and professional groups, reconfiguring the historical segregation of professional work towards more consumer-oriented practices that align with contemporary demands for service re-organisation, quality improvement, value for money and customer service (Farnham and Horton, 1996). In line with these general aspirations, programmes of 'workforce modernisation' have been introduced in a number of public sector organisations, designed to link pay and terms and conditions to specific tasks and markers of performance, rather than seniority and hierarchy (DoH, 2002; Loveday, 2006, Hyde et al, 2005).

In many ways, healthcare has been at the forefront of these debates. Healthcare is one of the largest areas of budgetary expenditure, and the focus of much political attention (Pettigrew et al, 1992). Changes to employment have been a central component of New Labour's reform policies for the NHS. Following up from the 2000 healthcare reform document, in 2002 the DoH published 'HR in the NHS Plan: more staff working differently'. This outlined the government's strategy for HRM, putting forward a number of objectives and actions plans, including redesigning jobs,

changing career structures, improving staff moral, and promoting the HRM function. In particular, this outlined the plans for changing the composition of the NHS workforce, involving the creation of new roles, altering the 'skill mix' and filling areas of previous staff shortages. During this period, the NHS underwent a significant expansion in the size of the workforce, with staff numbers increasing on average 38,000 a year between 1997 and 2005, reaching a total of approximately 1.3 million in 2005 (IC, 2006). The HRM plan can be seen as attempting to consolidate these increases, matching the new resources with improvements in efficiency, through for example improving recruitment, retention and the output of the growing workforce. As well as outlining plans for reform, this document also reiterated aspirations from the previous era for the NHS to remain a 'model employer', outlining targets for improved working conditions and work-life balance, lifelong learning, supportive leadership, and the involvement of staff in decision making.

In putting these aspirations into practice, comprehensive new frameworks for employment were introduced. Perhaps the most high profile of all recent public sector employment system changes has been the introduction of the NHS 'Agenda for Change' which began to be implemented in 2004. Described as the most radical change to health employment since the NHS was founded in 1948, (DoH, 2002) this involved the analysis and re-grading of 650 professional and non-professional posts covering all NHS staff other than doctors, dentists and senior managers into nine pay bands based on job content rather than title or professional membership (DoH, 2004a, 2005d). This intended to link pay structures to training programs such as the Skills Escalator and continuing efforts at role redesign (DoH, 2002a), in a way that made the link between work done and rewards more explicit, fair and manageable. Groups not covered have also undergone revisions in pay arrangements, such as the new consultant contracts (DoH, 2003b). These new frameworks have reported as leading to increases in the basic pay of most groups affected and harmonising pay levels, at least in the short term (Staines, 2009), while in theory giving management more control over workforce planning, providing them with tools for monitoring staff levels and skill mix, and allowing them to plan and enact organisationally appropriate personnel policies.

Importantly, throughout the policy documents associated with these reforms it can be seen that the government is largely drawing upon ideals of 'high commitment', 'soft' or 'best practice' normative approaches to HRM. The common principle

underpinning these texts is the mutuality of employees' job satisfaction, their personal growth and organisational performance. The rhetoric of policy stresses the mutual benefits of supportive employment environments which encourage individuals to progress and fulfil their potential, while also contributing to the wider organisational goals. For example, in the area of training and development, 'lifelong learning' is about 'growth and opportunity, about making sure that our staff, the teams and organisations they relate to, and work in, can acquire new knowledge and skills, both to realise their potential and to help shape and change things for the better.' (DoH, 2001: i). Constant reference has been made to the need to integrate the efforts of recruitment and retention, training and development, career progression and job design along generic best practice lines. Echoing aspects of Pfeffer's best practice HRM, the DoH advises they are:

'Modernising workforce development, education and training; increasing training places and widening access to training; developing substantial recruitment and retention and return to practice programmes; continuing action to improve the working lives of staff and helping NHS organisations to re-design jobs, career pathways and work roles so that staff can use their skills more flexibly' (DoH, 2001)

Frequent links are made between rational HRM planning, quantitative monitoring of performance and capacity, individual achievement and improvements in overall performance. New training and development systems are said to 'renew and extend [employees] skills and knowledge so they can move up the escalator. At the same time roles and workload pass down where appropriate, giving greater job satisfaction and generating efficiency gains' (DoH 2002: 19). In other words, training and development systems create win-win scenarios as staff continue to progress upwards with roles that are increasingly enriching and productive for themselves and the organisation. This 'best practice' rhetoric is continued across the various aspects of the HRM model including flexible working practices, inclusive management styles, job design and appraisal systems.

This approach promoted by the government has received some support in theory and in practice. In view of strategic models of HRM, many of the employment practices advocated would appear to fit with goals of 'quality enhancement' (Schuler and Jackson, 1987). Traditionally employment in the public sector is often

represented as already involving some aspects of best practice found in the private sector (Hughes, 2003) and public sector managers have been found to place more emphasis on training, involvement in decision-making and equal opportunities (Boyne et al 1999). Many public services, especially healthcare, involve 'emotional labour' and 'relational work' (Barley and Kunda, 2001) in that the content of the service is to some extent created within the interpersonal interaction between the employees and consumers (or patients), requiring empathy, emotional involvement and the application of tacit knowledge particular to each case. Accordingly, outcome quality has been commonly seen as dependent on the cooperative involvement and commitment of employees throughout the organisation (Morgan and Allington 2002; Lucio and Stewart, 2002; Siddiqui and Kleiner, 1998). High commitment practices have been linked with both improvements in public sector organisational performance and employee satisfaction and motivation (Gould-Williams, 2004). Within healthcare, examples of 'high commitment' employment practices have been linked empirically with various positive clinical outcomes, for example increases in overall quality of care (Aiken et al, 2002), lower infection rates and patient satisfaction (Needleman et al, 2002) and reduced mortality (West et al, 2002).

Therefore, public services would appear to benefit from some forms of 'high commitment' HRM practice and have more leeway to take a long-term approach to staff investment than some other areas of industry. However, the multiplicity of their aims and complexity of operations mean that linking specific models of HRM to outcomes is perhaps more, not less, difficult. Further, while often not subject to immediate market competition, they do not operate outside the common pressures on employment. Within the NHS a recent major review of current evidence has pointed out the complications in linking particular employment practices with organisational outcomes and concludes that despite some interesting study results, there is currently insufficient evidence to link any single element of HRM 'good practice' to increases performance (Hyde et al, 2006). A host of research implies that even if definite links could be found between the HRM approach and positive organisational outcomes, extending these practices through policy reform has been far from straightforward. As already identified, even within a single organisation, there may be a number of constraints on choice between HRM practices (Purcell and Ahlstrad, 1994) as 'political imperatives, policy prescriptions and well established institutions, procedures, values and expectations may serve to influence the exercise

of choice on management style, the deployment of corporate personnel resources and bargaining level' (Kessler and Purcell, 1996: 226). The following sections explore some of these particular constraints to HRM within the public sector, focusing in on professional autonomy, labour relations, and the multiplicity of values.

2.3.2 Professional Organisation of Work

A major feature of public sector life with significant implications for how work is organised is the pervasive influence of multiple professional groups. Analysis of the professions represents a rich stream of sociological research, and extensive literature from has covered the definitions, histories, influence, characteristics and structures of professions and professional organisations. Relevant to the current study, influential texts have identified how protection and control over domains of work and expertise are key elements of professional occupations (Freidson, 1970, Abbott, 1988). Rather than merely specialists in particular skills or knowledge, professions are also signifiers of social stratification, with professional groups indicative of claims to authority over a particular subject matter, work area or collection of tasks. The status of such professional groups affords rewards such as legitimacy and autonomy in decision making and control over the content and terms of their work, and in broad terms 'the license to determine what should be done, how it should be done and whether it is being done properly' (Bucher, 1970). Recently there has been questions as to whether professions have retained this license, with some associating the wide scale adoption of discourses of 'professionalism' as indicative of additional pressures to display competence, certainty and self-motivation in more insecure or competitive environments (Fourneir, 2002). Within traditional professional occupations however, professional autonomy has continued to be seen as tending to limit the degree to which others, including managers and policy makers, are able to dictate the way work is divided and carried out (Currie et al, 2009b).

To this end, some professions have over time become strongly embedded, and are widely accepted as having almost exclusive authority or 'knowledge mandates' (Halliday, 1985) over a particular area of expertise or service. A paradigmatic example of professional control is that of the standing of medicine in relation to diagnosing and treating illness (Freidson, 1970). In western societies, medicines dominance over this domain is largely unchallenged with the status of doctors as practitioners of medicine protected in numerous ways including mandatory training and qualification, national associations, standard career paths, formal and informal

networks, accepted hierarchies of command and intricate segmentation, as well as legal rights and responsibilities. Through their long history, professions in health care and medicine have gained a broadly recognised and legitimate cultural status (Hafferty and Light, 1995). These institutional practices are passed on to individual members, reinforced by long period of socialisation through extended generalist training followed by increasing specialisation (Becker et al, 1961). Professional groups are therefore usually seen as a primary source of workplace identity, support and shared organisational meaning. Professionals in organisations are far more likely to be the recipients of new information within their fields, and have the legitimacy to promote innovations. Further, the intensity of professional membership entails the development of technical language, 'epistemic cultures' (Ferlie et al, 2005) and ongoing interactions with people practicing similar day to day work, with similar values and aspirations. For such reasons, professions within health have been usually observed as the fundamental peer reference group for sharing norms, values, knowledge and advice (Waring, 2009; Swan and Newell, 1995).

In addition, this dominance of the medical profession has played a large role in shaping national health systems throughout the world, with many of the norms, cultures and regulations within healthcare strongly influenced by those of the medical profession (Kitchener, 2002). At its inception, and to some extent continuing to the present day, the organisation and structure of the NHS reflects and maintains the authority and internal social structure of pre-existing medical groups (Klein, 2006). There is some indication that this is changing, with doctors increasingly vocal about being left out of managerial and policy decisions and processes, and constrained by regulation and accountability (Rosenthal, 2002), or adopting new professional identities in light of public sector reforms and cultural changes (Jones and Green, 2006). However, there is also little doubt that various professions play a key role in shaping healthcare practice at the local level (Waring, 2007), and also maintain a unique relationship with the state.

In this respect, not all professions or branches within each profession are equal. Rather professional and occupational groups are located within structures of relationships, in terms of status, hierarchy, division of tasks and acceptable modes of interaction and collaboration. A prime example of this is the relationship between doctors and nurses. Although nurses have taken on different roles throughout their history, with recent moves towards professionalisation (Dingwall and Allen 2000;

While 2005), they are still today usually viewed as subordinate to doctors, acting as handmaidens or assistants, providing care and 'waiting for patients to get better' (Radcliffe 2000: 1085), while doctors apply expert medical knowledge to provide diagnosis and treatment to cure them (Fagin and Garelick, 2004). While doctors' professional status is largely uncontested, nursing as a profession is seen as more problematic (Liaschenko and Peter, 2004; Crawford et al, 2008; Kirpal, 2004). Within medicine itself, numerous sources of stratification can be seen that have all played at different times and in different ways a significant part in shaping how health services are organised. These include divisions between surgeons and physicians; between primary and hospital care; between medical divisions and specialties; between those involved in different collegial activities such as research, teaching, and the spread of innovations; between ranks and across locations.

Further, structured relations between professional groups are not stable or fixed, but liable to change in response to social, technological and market change and inter-professional competition. Through historical and contemporary comparative analysis, Abbott (1988) portrayed how each profession does not practice independently, but exists within an interdependent system, with shifting jurisdictional boundaries dividing the contested terrain of professional practice. This analysis proposes that professionals provide expert services for human problems which can contain both objective and subjective elements that are in part culturally defined. As societies and technologies change, new problems emerge and existing problems are understood in different ways, the tasks involved in the practice of a service are also modified. This opens space for various challenges to existing jurisdictions, for example as new occupations are established or existing professions claim control over the new tasks. Further, ongoing ambiguities in the routines of practice and division of tasks open space for negotiations over the precise role of each professional group (Svensson, 1996). In the contest or negotiations for control, numerous factors come into play, including the degree of a group's organisation including formalised associations, legal or political mandates, integration into national infrastructure, perceptions of legitimacy, and the type of concrete or abstract knowledge professed. Based on these attributes, professional practice is formed in a dynamic system of negotiated power and control.

In light of these processes, the professionalised environment of public organisations has widespread implications for healthcare employment reform. A wide range of

recent studies have considered the relationship between organisational change and public sector professional/occupational groups, focusing on the challenges posed on both sides by the incompatibility of professional autonomy and the rationalising tendencies of management (Alford, 1975; Harrison, 1999; Hunter, 1996; Light, 1995). Two recent and relevant examples illustrate how the dynamics of professions relate to government policy in the re-organisation of healthcare work. First, Currie et al (2009a) investigate the introduction of a new professional role, the modern matron, and their ability to tackle healthcare acquired infections. Although modern matrons were mandated by policy, they find limited scope for them to enact their envisaged role in the face of existing professional hierarchies. In the drive for professional status, nursing has established new structures of nursing management, and norms of practice based on expert technical tasks, with certain technical tasks inherited from medics, and certain care tasks handed down to health care assistants. These were observed as preventing matrons from returning to the 'hands on' direct departmental authority based on holistic patient care they had held in the past. Second, Hyde et al (2005) looks at attempts at role redesign in the Changing Workforce Programme. They found that redesign initiatives were most successful when matched by changes in remuneration, accountability and training. However, when role redesign led to the alteration of professional boundaries, imposing change was more difficult, as for example they clashed with existing pay scales, management structures, or threatened territories of professional practice.

In summary, while reforms have sought to reduce ability of professional groups to dictate their own term and conditions of employment, as well as the character and design of work, the above literature suggests that professional groups continue to play an important role. This has important implications for HRM within PPPs, as the degree to which management can design systems of employment is then likely to be strongly influenced by the professional groups that constitute the workforce.

2.3.3 Industrial Relations and Employment Culture

Aside from the widespread professionalisation, public sector organisations can be said to be distinct from those of private enterprise in a number of ways (Boyne, 2002; McDonough, 2006; Pratchet and Wingfield, 1996; Supiot, 1996; Stackman, 2006). Differences in ownership, funding, organisational structures, legal and social responsibilities can all be seen as having an impact on the nature of employment and the relations between employees and managers. Two related characteristics that

have a large bearing on the degree to which the organisation of work is subject to managerial control are the continuing role of collective industrial relations, as well as the prevailing norms and values, identified as the public sector 'ethos'.

According to Farnham and Horton (1996), employment management in the public sector has been traditionally distinguishable by four key factors; a more paternalistic style, greater standardisation of employment practices across organisations, more collectivised industrial relations and a general aspiration to the role of 'model employer' with regard to such things as equal opportunities and fair terms and conditions (Farnham and Horton, 1996). From the viewpoint of industrial relations, current public sector reforms can be seen as attempting to shift the basis of fair employment away from collective standardised agreements, towards an approach that provides a 'fair deal' through linking rewards with specific work tasks and employee skills and performance (Boyne et al 1999). In an extension of third way rhetoric, there has been an emphasis on a 'partnership' approach that 'attempts to locate new management-union relations within the context of a broader set of interests such as those of the individual and, in particular, those of the employer and the customer' (Lucio and Stuart, 2002: 253). A greater stress is placed on joint decision making in order to find ways in which organisational activities can lead to mutual gains for both the individual employee and the wider organisation; 'Partnership assumes a shift to 'soft', involvement-driven HRM strategies that are seen as beneficial to all sides' (Lucio and Stuart, 2002: 414).

Recent research has suggested that in the public sector there remains a much greater focus on standardised and collective employment relations (Boyne, et al, 1999) with pay agreements continuing to be set at the national level and greater union membership and staff participation (Farnham et al, 2003; Buchan, 2000). Within UK industry as a whole, the last thirty years has seen the proportion of employees covered by collective agreements drop from around four fifths to currently around two fifths (Brown et al, 2000). However, within the public sector there remains a much stronger role for unions and national agreements, with currently 60% of employees covered (Millward et al, 2000). Accordingly, 'activities associated with the conventional state role as a model employer, such as staff training and the promotion of equal opportunities, are still more likely to be found in public organisations' (Boyne et al, 1999: 417). Healthcare in particular has been found to be highly resistant to changes to national agreements. Attempts to introduce more

flexible, locally determined approaches to pay have been seen as difficult in light of ongoing employee expectations of pay in line with occupational skills, professional status and the perpetuation of the national industrial relations framework (Grimshaw 2000). Similarly, Arrowsmith and Sissons (2002) conclude in a study of the impact of HRM reforms in the NHS that local pay deals or performance based pay have failed to materialise. However, they do suggest that HRM departments have been more instrumental in pushing through other areas of local flexibility, particularly in relation to working time arrangements.

Other studies have further explored the role of the HRM function within individual NPM or post NPM era public sector organisations in more detail. As already discussed even within the private sector, the ability of the personnel function to take on a 'strategic' role (Ulrich, 1997; Purcell, 1989) is often limited (e.g. Purcell and Ahlstrand, 1994), and in the public sector unique cultural and political factors come into play. To give illustrative examples, Oswick and Grant (1996) point to centrally imposed financial constraints shaping and restricting the practices of local human resource departments. Harris (2005) and Givan (2005) find the drive for greater performance monitoring of HR activities was problematic due to a number of contextual factors such as a distrust of externally generated guidelines, the inappropriateness of centrally defined targets, and continuing time and resource constraints that hinder full and effective evaluation. Truss (2003) outlines how a number of common public sector considerations can restrict the strategic role of personnel, including the centrally set national policy and targets, the dominance of professional bodies that reinforce established training systems and career pathways, and the embedded administrative role of the HR function. Finally, a collection of associated studies (Proctor and Currie, 1999; Currie and Proctor, 2001) show how multifarious groups play some part in determining the personnel role, with perceptions of what these roles are may vary throughout the organisation. In these studies, while the personnel department itself may portray it has successfully taken on a strategic role, divisional middle managers viewed the personnel department as having merely retreated from day to day activities, both dumping extra work on divisions, as well as policing their output.

Further analysis has argued that the introduction of private sector HRM models and non-standard employment has over the past 20 years created a number of differences in employment relationships, but these have been most strongly felt on

the periphery of the workforce, for example most strongly affecting non-professional workers, or site services staff such as cleaners, catering or maintenance staff. For example in one study of health care, local government and higher education, Morgan and Allington (2002) conclude that there has been a large increase in flexible workers, casual and agency staff and fixed term contracts and a reduction in the size of the permanent workforce, as well as changes to industrial relations practice. This has already led to much greater differentiation across the workforce:

‘in terms of job restructuring, there appears to be at least a two-tier system of employment operating in the public sector where a minority now have permanent jobs and a majority have a mixture of temporary, part-time, short-and fixed-term contracts. The job insecurity this engenders seems likely to continue, further fractionalising public services and creating divisions within the sector’ (Morgan and Allington, 2002: 40)

However, amongst the more powerful groups there remains a resistance to corporate level HRM. This would appear to indicate a possible link between prevailing norms and values and expectations over the collective and individualised aspects of employment. Distinctive values of the public sector are captured in the common idea of the ‘public sector ethos’. Traditionally, certain social values are understood to underpin the employees’ relationship with the public sector such as political neutrality, loyalty, honesty, trustworthiness, fairness, incorruptibility and serving the public interest, (Farnham and Horton, 1996). Pratchett and Winfield (1996) highlight qualities such as ‘accountability’, ‘public interest’, ‘altruism’ and ‘loyalty’. These can all be seen as affecting perceptions of what constitute fair employment practices, levels of commitment, effort and responsibilities at work and can be related to various features of public employment such as differences in ownership, social orientation and institutional history (Du Gay, 2000). These could also be reflective of the specific demographic characteristics of the public sector, in which older and female workers are overrepresented in comparison to the workforce in general. There is however some suggesting that a distinctive ethos is diminishing in the context of ongoing public service reforms (McDonough 2006), with such fears widely cited in opposition to the introduction of change. In contrast to this, John and Johnson (2008) based on the British Social Attitudes Survey find a continued and significant difference in the values of public and private sector employees, with public sector employees much more likely to emphasis the social value in their work,

autonomy in their job role, and intrinsic rewards outside of pay and direct benefits. Aside from these differences in measurement, the public sector ethos is commonly accepted as conducive to a number of desirable organisational and employee outcomes usually associated with 'high commitment' forms of management in the private sector, such as greater commitment, motivation, loyalty and satisfaction, even in the face of increasing job insecurity and negative assessments of management policies (Guest and Conway, 2001).

In summary, certain aspects of public service make it both conducive to and receptive of certain 'high commitment' type HRM practices. However, professionalisation, national agreements on terms and conditions, and the distinctive ethos of the public sector may all stand in opposition to instrumental managerial control (Kessler and Purcell, 1996; Buchan 2000), and contribute to an environment that is in many ways unsuitable for the direct transplant of normative models of managerially designed HRM practices. Changes to pay and working conditions are commonly resisted (Arrowsmith and Sisson, 2002) and the intentions of centralised, top-down HR policy and strategy are often ignored, re-interpreted or dramatically modified by managers and employees with respect to their local context (Proctor and Currie, 1999; Stewart and Walsh, 1992). In addition, the HRM function often has to deal with the potentially conflicting demands of employers, employees and professional norms (Truss, 2008).

2.4 3rd Level: HRM in Public Private Partnerships

The final level of literature is that which points to new challenges posed for HRM in public-private partnership arrangements. This section first briefly outlines the emergence of recent public private partnership and their common forms. It then goes on to explore non-traditional organisational forms disrupt notions of an integrated employment relationship. This is then applied to the particular case of PPPs and the prospects for the HRM agenda. It looks at how this creates additional limitations over HRM styles and strategies, challenges for the HRM function and their ability to reconfigure working practices, as well as issues of training and learning, consistency in employment and existing forms of commitment. Following this, a number of questions are derived regarding the prospects for HRM in recent healthcare PPPS.

2.4.1 Public Private Partnerships: Emergence and Recent Developments

Although examples of joint ventures between public and private institutions can be found throughout history (Wettenhall, 2005; Grimsey and Lewis, 2004; Saint Martin, 2000), the current era of Public Private Partnerships is most frequently examined alongside similar trends that led to push for HRM. Namely the New Public Management (NPM) arising with the New Right thinking of 1980's (Grimshaw, et. al, 2002). While many services were privatised during this period, others like the NHS were less straightforwardly removed from state ownership and control (Le Grand, 1999; Iliffe and Munro 2000). However, there were efforts to subject the health service 'to the discipline of the market as a way to do 'more with less'' (Saint Martin, 2000:9). Within the subsequent market reforms of the NHS (Klein, 2006), several steps were taken that allowed increasing private capital involvement. GPs were encouraged to manage the budgets provided to them and act as gatekeepers to services. Together with regional health authorities they purchased health services from a number of providers such as hospitals and mental health organisations who themselves were reorganised into NHS Trusts. This decentralisation opened the door for increasing private sector involvement. For example, external contractors were increasingly employed to supply services such as care for the elderly as well as infrastructure building projects (Laing and Buisson, 2004; Curwin, 1999). Compulsory Competitive Tendering (CCT) was introduced for ancillary services such as cleaning and catering. This initiative stated that internal departments within organisation had to compete with other private sector providers for service contracts to demonstrate they were getting the best value for public money (Grimshaw et. al, 2000; Kelliher, 1996).

When New Labour came to power in 1997 they professed a move away from Conservative market control mechanisms and privatisation, towards a vision of 'networks' based on cooperation and 'partnership' (Clarence and Painter, 1998). As the largest, and to some extent archetypal public service (Klein, 2006), the NHS has been a consistent focus of New Labour governance reforms, with ideals of partnership and networks consistently held up within policy (Entwistle and Martin, 2005). Initiatives at all levels have been put forward as embodying the network approach, seeking to link professionals from primary, secondary and tertiary care 'unconstrained by existing professional and organisational boundaries to ensure equitable provisions of high quality, clinically effective services' (DoH, 1999: 5).

However, many aspects of the New Public Management agenda have remained at the centre of health service thinking. Managerial ideals such as efficiency, competition, value for money and entrepreneurialism are unquestioningly accepted (Grimshaw et. al, 2002). What's more, the Conservative policies for introducing private businesses into health care investment and delivery have been fully embraced (Gafney, 1999). Indeed private sector involvement, invariably labelled as Public-Private Partnership, became far more widespread under the New Labour government than the Conservatives (Robinson, 2000). Rather than straight-up privatisation, this was portrayed as being a new approach, capable of creating public services that are distinct from those that existed in the past. For example, an IPPR report advocating partnerships between sectors succinctly captures government rhetoric of the time:

'On the one hand we totally reject the privatisers' vision of public services: their aim is always and everywhere to increase the role of the private sector in the provision and funding of public services [...] On the other, we distance ourselves from a public monopoly perspective which holds that as a matter of principle public services should always and everywhere be provided by the public sector [...] Government has tended to rely on too limited a pool of service providers and too restrictive an approach towards undertaking large capital projects. This has resulted in public services missing out on the skills, creativity, and areas of expertise that reside in a wide range of private and voluntary organisations.' (IPPR, 2001: 1)

Partnerships are often seen as the public sector equivalent of networks, capable of overcoming the problems associated with both the hierarchical and the quasi-market and promoted as capable of delivering increases to the efficiency and effectiveness of state run activities (Ferlie and Pettigrew, 1996; Ferlie, and McGivern 2003: 16). In line with the key characteristics of networks, partnerships are said to involve altruism, trust, cooperation, collaboration, alliances, multi-agency work, inter-agency work, and working together (Exworthy, 1999). Lowndes and Skelcher (1998) describe partnerships as 'collaborative relationships with businesses, voluntary (or non-governmental) organisation and community associations' underpinned by formalised 'agreement between the parties which is given concrete expression through the creation of an organisational structure – a partnership board or forum' (p314).

In seeking to describe current relationships between the public and private sector, Linder (1999) spells out a widely recognised paradox. During the privatisation in 1980s, the underlying rationale was that private providers would provide higher quality goods and services at lower cost due to discipline provided by competitive market pressures. Conversely, the hallmark of partnership is supposedly cooperation rather than competition. Rather than customer exit and profit, partnerships intend to stabilise volatile markets and work to lessen direct competitive pressures. Therefore private firms are advocated as a good thing due to competitive advantages shaped under market pressures, but then expected to continue to develop such advantages when protected from market failure. Proponents of PPPs argue that this paradox is mitigated by a coming together of values that gives rise to trust and understanding between partners and allow additional competencies to develop. The most recent report (March 2006) on the progress of the Private Finance Initiative entitled 'PFI: Strengthening Long Term Partnership' states that PFI schemes embody a 'spirit of partnership' between contractors necessary for performance, and that "Authorities and contractors should always seek to understand each other's businesses and establish a partnership approach [...] based on a common vision of how they will work together to achieve a mutually successful outcome to the project." (Treasury report, 2006 p14)

However, these aspirations of trust and mutual understanding are stated as desirable characteristics, not necessary conditions for a PPP to be founded. Indeed studies have often found the relational characteristics of 'partnership' distinctly lacking (Teisman and Klijn, 2002; Pollock, 2004). In practice, within the context of the NHS the term PPP has been applied loosely, with the Department of Health using 'partnership' 'to describe the relationship between public and private sectors in any instance in which there is some form of contractual obligation, 'however short term or insignificant' (Field and Peck, 2003, 496). It has been pointed out that the definition of PPP is often constructed at a local level, varying greatly depending on the purpose, location, actors involved, timescale, and process by which the partnership is carried out (Atkinson, 1999, cited in McQuaid, 2000: McQuaid, 2000). Similarly Wettenhall (2003: 80) states 'there is often little precision in how "partnership" is used, and belief that what it refers to is "a good thing" seems much more a matter of faith than of science'. Given this, a universal definition of Public Private Partnerships is problematic. However, the term has widely applied to a

number of schemes within healthcare. For example under PFI arrangements first embarked upon under the conservative government in 1992 (Curwin, 1999) but greatly expanded by New Labour, the private sector supply capital investment for public services, usually involving the provision of property and frequently ongoing facilities management services such as cleaning, property maintenance and catering, over a long time span (typically 20-30 years), in return for an annual charge, with varying degrees of flexibilities and contingencies (Broadbent et. al. 2000). In some cases this has seen the work of services staff transferred to the private sector, or in others, work is subcontracted further to other companies. With the introduction of these mechanisms, it has been stated that the “boundary between public and private sector become so blurred as to be virtually unrecognizable” (Iliffe and Munro, 2000:322).

Aside from PFI, the private sector has also become involved in a number of additional services. Many parts of long term care has been in the process of being transferred to the private sector since the Community Care Act in 1990 (OPSI, 1990), in which the cost of care was shifted to local authorities, who then encouraged individuals to fund their own care when possible, particularly the case with nursing care for older people. This was been extended under the New Labour government who encouraged further use of the private sector for intermediate care for patients recovering from hospital treatment but unfit to return home. Under the label of ‘Best Value’, a policy that requires local authorities to demonstrate that their services are ‘cost-effective’ by comparison with those of other providers, most long term care, especially for older people, is now carried out by independent sector organisations (Laing and Buisson, 2004). In primary care, new nurse led walk-in centres and GP practices have opened in commercial spaces (Guardian, 2007). There is currently discussion as to how these types of services can be extended, with private primary care providers opening facilities in connection with private retailers and supermarkets to be paid for on a per visit basis. Furthermore there has been a slight increase in the role for pharmacies that may offer immunisation jabs and routine surgery. In secondary care, various forms private sector diagnostic and treatment services are regularly purchased by NHS providers. This has been done both in the form of ‘spot contracts’ with existing private hospitals and mobile units, as well as joint ventures such as ISTCs.

One way of seeking to understand these partnerships is in the structure of inter-organisational agreements. Helping to categorise emerging partnership, researchers have attempted to identify different features of contractual inter-organisational relationships. Away from of public services research, Child (1987) explores a number of contractual arrangements that offer various points in between full hierarchical integration and pure market based contracting-out, some of which contain features of partnership working in various degrees. Within this framework, four different contractual relationships can be seen. Three of these, 'Co-contacting', 'Coordinated Contracting' and 'Coordinated Links' all contain characteristics of partnerships working, but are structured in different ways. Co-contracting occurs when a small number of firms with different resources and expertise become involved in a joint venture to share the same market. Policy and division of labour is jointly decided, resources are expertise are pooled and risks and benefits of success are shared. Alternatively, the coordinated contracting mode involves a single principle and a number of subcontractors as agents who supply goods or services to an agreed performance specification. The relationship here is ongoing and trust and cooperation may be sufficient to handle contingencies. Finally, coordinated revenue links primarily refer to franchising operation, and are usually underpinned by tight but ongoing contract, with the relationship dependent on the reputation of the agent. A spot network on the other hand more closely resembles more conventional notions of market relationship, with tight contractual controls on the behaviour of both parties, and only minimal need for trust.

Table 3 Modes of Organising Transactions, adapted from Child (1987)

Organising Mode	Control & Coordination	Common Examples
Integrated hierarchy	Direct authority relations	Single product firm
Semi hierarchy	Arms length control & periodic review	Multi-division firm holding company
Co-contracting	Arms-length control but the organisation also mediates between co-contractors	Mutual organisation joint ventures
Coordinated contracting	Use of agreed specifications & deadline long-standing trust relations	Contractors and subcontractors
Spot network	Limited to the terms of the contract	Market transacting between independent traders

Within public services, Bovaird (2006) explores how the different structure of suppliers and purchases may impact on the current scene of public sector contracting. He outlines the possibility that in house (hierarchical) provision and conventional contracting-out (based on market choice of several providers) is being joined by a number new forms of public sector procurement. Collaborations of varying nature affect single commissioners and contractors (relational contracting), multiple commissioning bodies with a unified procurement policy (partnership procurement) and multiple commissioning bodies with diverse procurement policies empowered by a single purchasing body (distributed commissioning).

Table 4 New Contractual Forms in the NHS, Bovaird (2006)

	Single, stand-alone commissioner	Many (coordinated) commissioners
Single (or unitary) provider	<i>Relational contracting</i> Traditional in-house provision	<i>Partnership procurement</i>
Many (uncoordinated) providers	Traditional contracting-out	<i>Distributed commissioning</i> Purchasing consortia

'Relational Contracting', Bovaird (2006) states, has become the 'conventional wisdom' (p82) of public sector contracting, and, like partnership, involves trust and cooperation. The typology of 'Partnership Procurement', may come in many forms including PFI and PPP, but in order to become a genuine partnership, it must involve a number of organisations across sectors, each of which contributes a particular expertise to some part of the commissioning, purchasing or providing process. Finally, 'Distributed Commissioning' involves a public sector purchaser acting on behalf number of smaller public agencies to plan and procure a variety of services from a collective budget. Again implied in this approach is some level of collaboration between the various parties involved.

These types of public service outsourcing relationships have been slated to achieve a large number of objectives; value for money, reducing costs, a greater diversity of service provision, meeting targets around waiting times, increasing resource input, bringing in new technology and organisational innovations, tackling 'wicked' social problems, as well as altering public service control. Some deal of research has now attempted to evaluate the possibility of achieving these aims and the costs and benefits of pursuing these types of outsourcing arrangements. In many instances, these have identified significant barriers to reaching prior financial expectations, and the difficulties in establishing balanced, trusting relationships between sectors with different norms, purpose and socio-cultural environment (Teisman and Klijn, 2002; Price et. al 2004; Edwards and Shaoul 2003; Gaffney & Pollock, 1999; Edwards, 2005; Robinson, 2000). However, what has been less well considered is the impact that these news types of inter-organisational relationships have on the nature of employment and the way in which public service labour is managed. As previously outlined, the move to decentralise public services and bring in additional providers was in part intended to hand greater control to local managers to enact changes in employment. However, a collection of recent studies have investigated how the type

of partnerships created by these policies can break the direct relationship between the employers and employee, and can have a significant impact on the nature of employment (Marchington et al, 2005a; Rubery et al, 2002; 2003; 2004a&b; Grimshaw et al, 2003; Scarbrough, 2000; Beaumont et al, 1996).

2.4.2 Inter-Organisational Contracts and Multi-Employer Workplaces

Traditionally, notions of employment are conceived in both social science literature and in employment law as constituted by a relationship between a single employer and an employee (Simon, 1951; Rubery, et al 2004a). For example, definitions of 'the employee' have described the 'duty to obey lawful and reasonable orders, to act faithfully to the employer and use care and skill in the execution of the performance of their employment' (Gillhams.com, 2009). In turn, notions of both industrial relations and human resource management are based on this assumption 'of a hierarchical and bounded relationship between an individual employer and its employees' (Rubery et al 2005: 88). Ongoing debate has explored changes to the standard employment contract in relation to changing career patterns and the employment market. Regularly cited directions of change include an increase in employment flexibility, lower job security, an increase of short-term contracts, more indirect employment, uncertainty over employment status and the 'marketisation' of the employment relationship (Doogan, 2001; Burchill, et al 1999; Cappelli, 1997; Cappelli, 1995). In the main, this has focused on intra-organisational employer-employee relationships associated with the reshaping of the standard bureaucratic organisational form.

A collection of recent studies on employment across organisational boundaries and 'permeable organisation' has taken up this theme and re-examined employment in light of close and complex inter-organisational relationships (Roper and Grimshaw, 2007; Marchington et al, 2005a; Rubery et al 2003; Rubery et al 2002 & 2004a; Grimshaw et al, 2003; Scarbrough, 2000; Beaumont et al, 1996). Issues of work, employment and HRM have been frequently disconnected in analysis with other aspects of organisational theory, such as strategy, structure and performance (Rubery, et al. 2002). Similarly, analysis of network forms have concentrated on structural features of inter-organisational relations, but with little regard for how this affects or is affected by the relationship between employees and employers (Grimshaw, et al. 2005). Given the interaction between these areas, this has been seen as problematic. As Barley and Kunda (2001) state, 'work and organisation are

bound in dynamic tension because organisational structures are, by definition, descriptions of and templates for ongoing patterns of action' (76). To rectify this, Marchington and colleagues place changing employment relationships within and alongside changing inter-organisational arrangements. They argue that complexities and tensions arise not only from the internal and external conditions surrounding the organisation, but also out of 'inter-organisational relationships which create confusions and ambiguities in the shaping of the employment relationship in both its legal and its social, institutional and psychological form' (Rubery, et al 2002: 648).

Within close working partnerships, lines of control may become unclear as all parties may have an interest in, and potentially try to influence, employment practices across the partnership or network. Outsourcing agreements, agency workers and multi-employer sites all create situations where an organisations performance may be dependent on the action of workers who are not directly employed by them. Therefore, organisations management may seek to monitor performance of external employees or attempt manipulate the employment practices in external organisations (Rubery, et al 2002; Marchington, et al 2005). Particular arrangements highlight this possibility. For example, when a worker or group of workers are constantly employed to fulfil a single long-standing contract, the client may have a greater stake in the day-to-day actions and output of the worker(s) than the employing organisation. Therefore, the 'non-employing' client may seek to influence the workers terms and conditions, which workers are used (and not used), check the standard of the work being done and encourage rewards and discipline to be handled in ways beneficial to them. There may be even greater imperatives for direct control over the work of contractors in situations where the client retains a legal duty to ensure the quality or accuracy of the service provided, as is often the case in public sector contracting (Grimshaw, et al 2002; Grimshaw and Hebson, 2005; Rubery et al 2002). These situations can be yet further complicated when contracting organisations themselves use temporary and agency staff, legally employed elsewhere.

These scenarios create a number of potential areas for tension, increased complexity and conflict for employment management (Rubery, et al 2004a). Much of employment law is based around the principle that those in the same workplace share common terms and conditions. However, inter-organisational relations of the type seen in PPPs can create situations where employees from different

organisations work alongside each other on the same site, with different pay and rewards and subject to different management practices. Alternatively employees may be answerable on an everyday basis to those outside of their organisations with whom they have no employment contract (non-employers) (Rubery et al 2005). Employees may be monitored, disciplined and have their roles and positions decided or influenced by people outside of their organisation. The responsibility for providing employment rights, normally resting with the employer in traditional hierarchical bureaucracies, may, in certain circumstances become unclear. In instances of grievance or health and safety while under the control of a non-employer, workers may be left without the channels of formal procedures normally open to them (Marchington et al, 2005b).

It is also likely that an organisation's ability to favourably influence aspects of employment, or susceptibility to being influenced, may be spread unevenly across a set of inter-organisational relationships. Although all organisations may have to modify employment practices in light of the characteristics of a network, 'some are more powerful than others and are able to buffer themselves against the external environment whereas others are more exposed' (1024). As portrayed in discussion of PPPs (section 2.4.1) it has been claimed that networks can provide a number of benefits when based on strong, equal trusting relationships (e.g. Powell, 1990; Lowndes and Skelcher, 1998; Field and Peck, 2003; Ferlie and Pettigrew, 1996) but empirical evidence has shown that in many instances, this type of ideal is not realised in practice (e.g. Hunter et al, 1996; Teisman & Klijn, 2002; Kirkpatrick, 1999). Contractual arrangements have been frequently made on a short term, ad-hoc basis in response to financial pressures and immediate need, rather than the long term partnership ideal with similarly high levels of commitment from all stakeholders (e.g. Klijn and Teisman, 2003). Collaboration is often restricted to the terms of the contract bound within other competitive pressures, and inter-organisational relationships are frequently unbalanced in terms of distribution of risk, access to resources or influence over outcomes with political and possibly opportunistic or exploitative behaviour likely to result.

While the effects of such unequal relationships have been well observed in their impact on financial and strategic risk, they are also involved in shaping aspects of employment management. In 'networked' organisations HRM practices may also become a site for negotiation and conflict alongside other areas of the contract

agreement (Scarborough, 2000), with dominant parties seeking to play an instrumental role in shaping employment in external organisations and minimising their own commitments and risk. Opportunistic behaviour has been particularly observed where organisations have a deep interest in the work processes of external organisations over who they are in a position of power and influence. For instance, when a supplier is dependent on a single customer for resources, they may be particularly susceptible to influence, changing their employment practices to suit the requirements of the customer (Hunter et al, 1996). In the case of outsourcing production or services, the responsibility and liability associated with the direct employment of workers is shifted to the supplying firm. In doing so, the client potentially increases their own flexibility and limits their risk by replacing their commitment to fulfil the standard employment contract with a purchasing decision or fixed term service contract. At the same time, they may then seek to steer the employment practices, pay structures and staffing of the supplier or contractor in a favourable direction (Rubery and Earnshaw, 2005; Rubery et al, 2004; Grimshaw et al 2005b).

Equally, just as some organisations are more open to manipulation than others, certain employee groups may be more to be marginalised by inter-organisational relations. In light of close interdependence with clients and suppliers, employers may seek to increase their own flexibility by transferring the increased risks onto individual employees, offer less protection for employees, reduce job security, and increasing the use of temporary staff or part time staff. 'The bargain that underpins the employment relationship can be seen to be embedded in a set or inter-capitalist relations that may shift risk and responsibilities both between organisations and between employers and employees' (Rubery and Earnshaw, 2005: 176). Furthermore, the bargaining position of some employee groups such as part time workers, temporary workers, or agency staff employed through a third party may be reduced as communication channels with management are unclear and the workforce is fragmented. In particular 'those employed on precarious contracts across organisational boundaries lack the collective strength to make their voice heard' (Marchington et al 2005b; 260). Rubery et al, (2004) outline how organisations in a weaker position and are particularly susceptible to external influence, are far less likely to develop either strong industrial relations, or a defined human resource management approach:

'Many supplier organisations can be expected to fall into this black hole as their capacity to develop consistent and strong human resource policies is moderated by the need to manage external pressures, particularly those of clients. We need to move towards a more general framework where internal and external influences on the management of human resources are seen as mutually constituted, iterative and interactive. It is the interplay between these factors in a dynamic context that provides the basis for analysing human resource policy in permeable organisations.' (Rubery, 2004: 1220)

In this way the division of work in multi-employer relationships have been observed as creating additional pressures on employment. Even within single organisations there are problems in balancing efforts to control and monitor the workforce with attempts to capture the capacities of employees to contribute to performance (Rubery et al, 2002). Third party interests make this balance more difficult. It has already been stated above that processual issues of management and employment are often considered only after decisions have been made on financial terms whether to open up public services to private sector contractors (Shield et al 2002). The work outlined here takes this argument further by suggesting that increasing inter-organisational relations are often used to intentionally externalise and further obscure problematic employment issues and employment responsibilities which involve a cost to the employer. Grimshaw and Hebson (2005) point to a paradoxical element of this logic, namely the continuing or even greater need for active cooperation of labour to produce goods and services when collaborating with others across organisational boundaries: 'The tension at the heart of the employment relationship that derives from the dual imperatives towards conflict and cooperation is thus exacerbated, and certainly not resolved, by the formation of employment relationships in a multi-agency setting' (176-177). A summary of the ambiguities created by employment across supply chains is presented in table 5 below. The next section considers the research questions to be tackled in this thesis presented by this changing employment relationship and in light of policy aspirations for HRM.

Table 5 Main areas of ambiguity in employment in inter-organisational arrangements

Employment Issue	Ambiguities in the Employment Relationship
Supervision and control	Employer not present at workplace or more than one 'employer' present. Employee on loan on secondment to another 'employer'.
Discipline	Differences in rules between 'employers'; who is responsible for monitoring performance, identifying disciplinary issues, initiating actions, verifying information
Grievance	For example, duties not to harass staff apply to contract staff, not just direct employees; can employees have a grievance against employer if harassed by manager/employee of another organisation?
Terms and conditions – equal pay issues	Outsourcing may result in different pay for work of same or broadly equivalent value for either employees of same organisation or employees of different organisations but working side by side in same workplace.
Health and safety responsibilities and other legal/statutory obligations	Responsibility for health and safety of workers/general public lies with main employer/owner of site, but can managers of main employer instruct employees of other employers not to behave in ways which endanger health and safety? Main employer may have responsibility for overall delivery of service (e.g. hospital); responsibilities indirectly enforced on non-employees through performance-related contracts with other employers
Loyalty and confidentiality	Duties of loyalty and confidentiality to employer may be difficult to interpret where conflicts of interest arise between own employer and those of the employer in the workplace where employee is located
Trade union recognition	Multi-employer relationship may complicate the definition and constitution of appropriate bargaining units for trade union recognition

Source: Adapted from Rubery et al (2004a)

2.5 Research Questions and Emerging Issues on the Prospects for HRM in PPPs

Given the complex and political nature of public services, the changes to employment and tensions created by fragmenting work and blurring organisational boundaries have been seen as occurring nowhere more so than in the changing interface between the public and private organisations (Grimshaw et al 2005c). In light of the

literature so far covered, the overall research questions of the thesis can be stated as follows:

- What are the implications of public-private partnerships for human resource management as a means of managing the employment relationship in public services?
- What are the implications of public-private partnerships for the nature of work in public services?

In particular the focus here is on recent forms of PPP which involve the transfer of what have hitherto been seen as 'core' areas of public services to the private sector. These increasingly involve high status professional groups having their work moved out from public bureaucracies to independent and for profit organisations. Each example of recent PPP is likely to take on a unique form and involve different relationships between the various contractors and suppliers involved. This thesis concentrates primarily on partnerships in healthcare and the contracting out of surgical services in Independent Sector Treatment Centres.

Building on the insights of employment within inter-organisational relationships covered in the previous section along with the issues of HRM in general and HRM and employment in the public sector context, the overall research questions can be further elucidated by considering in turn different aspects of HRM that are likely to be affected by ongoing structural change. The next sub-sections discuss implications for specific areas of HRM, drawing out more detailed consideration points to guide the research.

2.5.1 HRM Strategy and Style

As identified in section 2.3, an important driver of public sector restructuring has been the push to devolve HRM decision making to local organisations, giving corporate managers greater freedom and encourage flexibility in approaches to employment (CBI, 2008). However, the above analysis of employment across organisational boundaries has suggested that close partnerships potentially multiply the external influences on HRM and further limit an organisations input into their own HRM styles and strategies.

When organisations are embedded within network relations HRM strategies are partially 'shaped and constrained by the characteristics of the external environment

within which the firm operates. This includes the network conditions, which generate positive effects for firms as well as the darker side where some members of the network benefit at the expense of others (Kinnie et al, 2005: 1024). Kinnie et al (2005) characterise network relationships as either generally collaborative, allowing advantageous HRM practices to be established across the network, or coercive, in which dominant parties are able to exert influence over particular employment practices of others to their own advantage. Similarly, Hunter et al (1996) speculates that when one partner is highly dominant, there are large imbalances of risk, or lack of trusting relations, the value of HR practices likely to emerge could decrease. They ask 'Are 'hard' or 'soft' HRM models more likely to be adopted in supplier organisations 'assisted' along the HRM route by their customers? Are the gains available to the commercial partners in part paid for by increasing effort and reduced autonomy on the part of the workforce' (255).

Certain features of public sector contracting out may indeed suggest more directly controlling forms of management and 'hard' or low commitment HRM practices may arise. First, when in a dominant position, private organisations may seek to directly influence the HRM practices of partners, customers and suppliers in directions that are commercially beneficial to them. As they are no longer directly responsible for the employees carrying out the work or concerned with employee commitment to them, this is more likely to be in terms of bottom line costs rather than long term HRM planning (Hunter et al, 1996). Second, PPPs may increase the use of tight contractual terms that require employment to be designed to meet the needs of predefined output levels, quality standards and costs. This may encourage employment to be dealt with on a more instrumental and transactional basis, rather than in a long term relationship between employees and employers. Finally, close partnership may expose public sector organisations to a host of new private sector institutions, practices and values that alter the public sector context. These have all been shown as important in studies of recent outsourcing arrangements, which have commonly found an increase in low commitment HRM practices. For example, studies of private sector involvement in the NHS have shown narrowing jobs and work intensification, increasing isolation, irregular shift patterns, less room for initiative or innovation, a reduction in staff levels, downgrading or introducing charges for staff facilities, and management seeking to de-skill jobs and replace trained nurses with untrained staff wherever possible (Pollock, 2004). Similarly,

Hebson et al (2003) and Grimshaw and Hebson (2005) reported for staff transferred from the public to the private, a frequent reduction in job security and an increase in work intensification, and very tight control of work contracted out to external firms or staffed through temporary agency workers.

This does not necessarily mean that particular types of contract will alone dictate a particular approach to HRM. The ability or will of a particular organisation to actively shape their own human resource approach is likely to depend on the specific interaction of several contextual factors, of which the formal structure of inter-organisational relations are just one part. For example, even when public sector contract managers are in an ostensibly more powerful position as service purchaser, they may not be able to unilaterally dictate employment practices, either to drive down costs, or to install 'high commitment' practices to develop or protect the healthcare workforce. Aspects of the public sector environment identified in section 2.3, such as professional autonomy and national agreements may contribute to the bargaining position of management to negotiate changes in internal or external employment, or of a group of employees to limit the power of management to dictate employment terms and working practices. Institutional norms, strength in the market, experience of managing/being managed by contracts and regulatory protection have all been seen to play a part in mediating the types of HRM practice that emerge in a given context. This study therefore aims to investigate how these various factors come together in the formation of HRM approaches within PPP organisations.

- How do the emerging styles and strategies of HRM fit with dominant normative models? For example, can public-private partnership be described in terms of best practice/best fit HRM, or is there no clear strategic approach?
- What are the inconsistencies and tensions in the emerging HRM approach?
- How does the interplay of different organisations impact upon HR strategy? This could be in the form of purposeful interventions of management between organisations, or through more unintentional, undirected or processual influence.
- How is the HR strategy influenced by professional or occupational groups across the public private partnership?
- Do PPPs differentiate their strategy – For example, high involvement for powerful professionals but minimise cost for others?

2.5.2 Innovation and Workforce Reconfiguration

A further primary goal for PPPs has been the introduction of ‘innovations’ from the private sector and new ways of working (DoH, 2002b; 2003a; CBD, 2008). PPPs have been seen not just as a way to introduce new providers into the system, stimulating competition and choice, but also as a way of introducing new and innovative ways of working to the NHS in general. In promoting private sector HRM, the government has laid out a vision of organisations installing HRM practices designed around local operational and market requirements, such as altering pay structures, introducing new job roles, changing the skill mix of employees, designing new workflows and processes, changing divisions of work, or designing unique training, development and career plans (DoH 2002a). A commonly cited example of innovation leading to greater efficiencies is that of rationalising the responsibilities and work tasks of professional groups, with a preference for ‘handing down’ less technical areas of work to less specialist occupational groups. In doing so higher professional groups will benefit by ridding themselves of more routine aspects of their work, while lower groups will benefit from learning new tasks above their current level of expertise

(DoH, 2002a). This creates a win-win of efficiency savings as tasks are carried out by appropriate grades of staff and the opportunity for individual development as staff take on higher grades associated with increasingly complex tasks.

However, already identified as problematic in the public sector, the capacity of organisational management to enact such changes and change working practices may be further restricted by entering into partnership working. Constraints such as professional norms and embedded employment values may be more strongly felt when the personnel department is exerting influence from an external organisation with no formal lines of communication or responsibilities for workers. As Hunter (1996) states changes to working practices 'may be sensitive when introduced in the confines of a single organisation, at the behest of HQ or divisional management, but they may be even more so when pressed for by an external organisation' (p253). In particular, this may involve a greater diversity of agendas, more distrust of performance targets set externally, and greater resistance to being monitored when this does is not matched by formal responsibility for employment. Grimshaw and Hebson (2005) report that for transferred public sector employees, private sector type workplace practices were commonly seen as manipulative and unable to generate positive notions of loyalty and commitment; 'for many workers, although not managers, there was a direct rejection of the strategies that had been developed to generate commitment, either because they conflicted with existing values or were seen as control devices' (Grimshaw and Hebson, 2005: 191).

- Can PPPs introduce new working practices? For example are more autonomous organisations able to further policy objectives for performance orientated pay/skills mix?

2.5.3 Training, Learning and Development

A further element of HRM activity of specific importance in PPPs is that of training, learning and development. This is of particular importance given one of the primary justifications for entering into partnerships with the private sector, as well as network forms of organisation in general, is that of increasing the knowledge and resources available for use in public services. The present government has espoused a focus both on improving the opportunities for training and increasing workers skills

(Marchington and Wilkinson, 2005), as well as increasing organisational learning, the development of new knowledge, and increasing innovative practices; 'Under the mantra of 'joined-up government' there have been major programmes to coral, coordinate and then to manage and share knowledge... [and] share good practice and encourage the diffusion of innovative approaches to service delivery' (Hartley and Bennington, 2006: 101),

Inter-organisational relationships and PPPs have been promoted as advantageous to this agenda, as they potentially allow public services to gain access into previously untapped sources of experience and expertise (IPPR, 2001, Bate and Robert, 2002). In addition network organisational forms have been said to open up new roles and opportunities for skill development (Kunda et al 2002) and provide greater opportunities for sharing knowledge, skills and innovative practice (Wenger, 1998). There has been some focus on the different skills likely to emerge in network organisations, with the break down in bureaucratic hierarchy and closer inter-group collaboration potentially associated with 'soft' and 'feminine' interpersonal styles (Arthur and Rousseau 1996; Hebson and Grugulis, 2005), such as empathy (Trevillion, 1991), 'understanding of people and organisations outside their own circles' (Williams, 2002: 110), communication (Engel, 1994), reciprocity and trust (Hornby, 1993). Also, in the particular context of public private contracting, public sector workers and managers may gain access to competencies primarily associated with the private sector such as entrepreneurship, cost effectiveness (Cooke, 2006), contractual negotiation, and performance management (Hebson et al, 2003).

However, aspects of emerging public-private relationships cause potential problems for this analysis. For instance, it may become unclear how the formal responsibility for training and development is to be organised. There have been some fears that private partners could use advantageous contractual arrangements in order to benefit from public sector training without providing similar opportunities for themselves (Pollock, 2004). Alternatively contracting out individual services, such as the treatment for a single medical specialty, would mean that the employees transferred to the contractor would gain only experience of single, perhaps routine, service, while remaining employees will have no opportunity for training on the areas contracted out, unless this is written into the original contract (HSC, 2006). This was seen as a particular risk surrounding the introduction of ISTCs, discussed in the next chapter. Further, the increased likelihood of a focus on short-term economic

efficiencies may mean they are less conducive to providing long-term training and development (Cappelli, 1995). This may be particularly acute for employees who are already classed as 'low skilled' workers who are already closely supervised and tightly controlled, leaving little room for skill development (Grugulis and Vincent, 2005). The tight contractual arrangements and performance monitoring that has been observed in outsourced organisations 'not only excluded skill enhancement, but also de-skilled the work they controlled' (Grugulis and Vincent, 2005: 148). Empirical evidence has suggested that crossing organisational boundaries may lead to more learning opportunities for isolated individuals in certain 'higher' roles that increasingly emphasise interpersonal skills to work within and between different groups and organisations, but this does not necessarily translate to a general focus on changing skills of workers throughout a partnership (Hebson and Grugulis, 2005).

- How is the agenda for training and learning affected by the move to PPPs?

2.5.4 The role of the HRM function

Alongside the drive for more local control over employment, reform has been intended to promote the HRM function within local public service organisations, giving it more scope to design specific activities and take on a more strategic role at the organisational level. Increasing the range of independent service providers to the health economy is promoted as an opportunity to 'extend HR into wider leadership and management, for example mainstreaming HR across other management functions and integrating HR into the service development and governance elements of the organisation to ensure staff and members realise the benefits and the organisation is effectively skilled to meet the changing demands of service delivery' (DoH, 2006: 13).

In literature on partnerships and inter-organisational relations there has been some suggestion that HRM could play a role in militating against some of the problematic elements of coordination and working across sectors so far discussed. For example HRM could support the diffusion of management 'best practices' across the partnership or assist in organisational change across boundaries. The HRM function has been encouraged to take a proactive part in changing employment practices

across partnerships, and act as a 'boundary spanner' (Williams, 2002). For example, personnel managers in health are advised to 'act as role models for the new cultures and behaviours around leadership and collaborative working' (DoH, 2006: 15). Hunter et al (1996) identifies several specific activities that HR managers may be able to carry out across a network. These include quality and audit visits to suppliers, promoting different management styles through for example training programs and conferences, improving the internal status and rewards for those involved in forming inter-organisational relations and direct assistance to set up compatible processes in suppliers and partners. It is also proposed that managerial practice could help to promote loyalty and commitment across the partnerships. Shield et al (2002) suggests that active HRM may can help reshaping employees orientation to work following the merger of culturally distinct organisations 'it seems likely that the merger [of two hospitals] would have benefited from better HRM activity [...] such activity might have improved the morale of individual employees and so the overall organisational performance' (365). Literature on networks and networking has also suggested that new skills and competencies may aid public sector managers to exert influence across a partnership. For example, Ferlie and Pettigrew (1996) stress that 'participants in polycentric organisations will need to be adept at crossing boundaries and at managing intercultural encounters' (pS97). Similarly, Williams (2002) argues that the ability to 'span boundaries' will depend more on 'relational and interpersonal attributes designed to build social capital. They will build cultures of trust, improve levels of cognitive ability to understand complexity and be able to operate within non-hierarchical environments with dispersed configurations of power relationships' (p106).

However, inter-organisational relationships may also foster new hurdles for the HRM function to overcome. Both public and private organisations involved are likely to have independent human resource departments, operating at different levels within the organisation dependent on their own agendas, institutions and strategies (Ferlie and Pettigrew, 1996), and therefore personnel managers may be required to overcome conflict, or negotiate with counterparts in other networked organisations. It is so far unclear within partnerships how responsibility for HRM will be resolved and the role different departments will play. As previously discussed, public sector reforms are likely to cause an increasing focus of financial performance, in some instances limiting the budget of personnel departments to make decisions based on

short term needs rather than to coherent, long term plans (Siddiqui and Kleiner, 1998). In this way 'practical accounting pressures arising from the outsourcing context may diminish the size and authority of HR within organisations, undermining any capacity for the complex inter-organisational liaison' (Colling, 2005:101). These pressures have indeed been seen to increase during contractual arrangements for PPPs, increasing the propensity to overlook processual issues such as HRM. Fischbacher and Beaumont (2003) report that even when personnel specialists were involved in the process of setting up a PFI, the focus on outcomes meant that they were often not fully utilised or consulted, but paradoxically their involvement took them away from their core function for a substantial time period.

- What role does the HRM function play in PPPs? For example how are responsibilities and powers of employment management shared across partnership organisations?
- Are HRM functions able to take on any additional roles in advancing partnerships or promoting practices across organisations?
- Is the 'strategic role' of HRM further constrained within partnerships?

2.5.5 Consistency in Employment

Consistency in HRM practice has been seen as a key feature not only of academic literature on human resource management (Schuler and Jackson, 1996) but also of industrial relations agreements and employment law (Blyton and Turnbull, 2004). In the past, centrally governed, integrated public sector organisations have been seen as providing a greater level of consistency in employment terms and conditions based around collective agreements and professional groupings than industry in general.

According to government strategy documents there is no discrepancy between 'good value' and providing high quality employment practices and changes to the management of employment signalled by HRM. For example the code of practice for workforce matters in public sector service contracts (built upon the Transfer of

Undertakings (Protection of Employment)- TUPE - Regulations 1981 and 2006) from the Office of Government Commerce states:

'The Code recognises that there is no conflict between good employment practice, value for money and quality of service. On the contrary, quality and good value will not be provided by organisations who do not manage workforce issues well. The intention of the public sector organisation is therefore to select only those providers who offer staff a package of terms and conditions which will secure high quality service delivery throughout the life of the contract. These must be sufficient to recruit and motivate high quality staff to work on the contract and designed to prevent the emergence of a two-tier workforce', dividing transferees and new joiners working beside each other on the same contracts' (OCG, 2006)

However, there are signs that such a two-tier workforce is indeed being encouraged by recent public sector reforms (Morgan and Allington, 2002). There have been widespread fears that breaking up state organisations threatens this aspect of public employment. For example, while pay reforms such as the agenda for change in health may bring full time, permanent staff within the organisation under a common framework, they do not necessarily extend to less standard employment forms, 'non-employees', and temporary and agency staff that play a part in the delivery of a many services (Morgan and Allington, 2002). It is suggested that changing inter-organisational relationships in PPPs are likely to contribute to this further and promote even greater inconsistencies in employment. Clearly demonstrating the disorder that can arise, Rubery et al (2002) discusses the implications for employees transferred from public to private sector companies. This can result in instances in which workers are legally employed by the private sector, but in many respects remain a part of, and answerable to, the public sector organisation from which they were transferred. Union action and legislation may seek to protect workers, such as recent code of practice has had to be passed that urges Agenda for Change wage structures and training and development plans to be applied to contracted-out facilities staff (DoH 2005b). However, legislation may also create additional problems when it applies differently to employee groups working together.

Of particular relevance here are questions surrounding TUPE [Transfer of Undertakings (Protection of Employment)] arrangements frequently applied to public

sector workers transferred to the private sector organisations. While this legally protects the pay and conditions of transferred workers, it often leads to situations in which transferred staff work alongside other employees of the contractor or agencies staff with no such protection/limitations on their employment. When there are differences between the pay, terms and conditions between the transferred staff and the contractors own staff to begin with, this would impose almost unavoidable inconsistencies. In this case, management would be unable to harmonise employment, leading to a number of potential tensions between employee groups or between employees and management (Cooke et al, 2004); 'TUPE potentially leaves employees in a kind of limbo, cut off from their previous employer and the right to maintain terms and conditions in line with that employer, but also separated from and not integrated into the new employers systems and structures' (Rubery, et al 2002: 667).

Aside from these instances where differences are written into the formal terms of the contract, the employment practice may be negotiated differently across the partnership. As already identified, different organisations may seek to influence the working conditions of non-employees in contradictory directions;

'The differences the collaborating organisations...result in potentially conflicting influences on internal employment policies and practices, particularly where there are multiple non-employers involved. Thus some clients may seek to push down prices and wages while others may focus on quality, reliability, and the fostering of commitment' (Grimshaw and Hebson 2005)

Within PPPs, the potential for tensions would appear particularly large given the differences in the public and private sectors organisations and the apparent imbalance of power and risk in emerging partnerships. Further, differences in risks between categories of workers are likely to mean that inconsistencies will emerge variably depending on the nature of the employment contract, institutional norms, regulatory framework and type of work. Those in low skilled, part time and manual occupations have been seen to be particularly vulnerable. With women much more likely to be in these positions (Hebson and Grugulis, 2005) this also may lead to PPPs causing further differentiation and inconsistency across gender lines.

- Do PPPs introduce inconsistencies in the workplace?
- What are the key employment tensions resulting from PPP arrangements?
- Does the multi-employer relationship create uncertainty in the nature of employment, for example problems related to defining who is the employer?
- Is collective IR replaced by managerially led more individualistic bargaining arrangements?

2.5.6 Commitment and Ethos

Multi-organisational relationships pose additional problems for traditional notions of employee commitment and loyalty. Managerial ideals of commitment often involve the assumption that workers will forge a bond with a single employer. But as has been pointed out, this notion is 'especially misplaced in those situations where the employer, as supplier, must respond to the changing demands of the client organisation (Hebson, et al 2003: 483). Even within a single organisation, commitments are often multifaceted; employees potentially identify simultaneously with their work group, their professional body, their employer etc. However, 'taking on board the further dimension of multiple employers renders these concepts even more complex' (Rubery et al, 2004: 9). For example, new forms of commitment have been observed when employees from different organisations work together, cut off from their respective employers or in a multi-employer site, or when workers spend the majority of their time on one particular client contract, interacting with employees, managers and customers of the client over and above others within their own organisation (Marchington, et al 2005).

In addition, during periods of large organisational change or transformation employee commitment and involvement have been seen as even more crucial as staff are required to actively engage with and respond to change. Paradoxically, periods of change may be marked by an increase in conflict and tension, both between employee groups, and employees and management, lack of employee

involvement in managerial decision-making and employee resistance (Shield, et al 2002; Veenswijk and Hakvoort, 2002).

Straightforward notions of commitment have already been seen as overly simplistic, particularly in the public sector where strong professional identities and loyalties may contrast with employers' goals (Hutton and Massey, 2006). Additionally, there have been longstanding views that any introduction of the profit motive will negatively affect employees will or ability to work for the public good (e.g. Sachdev, 2001, Pollock, 2004). Academics and employment groups have frequently expressed concern that in blurring the boundaries between the public and private sector there is 'there is a danger that organisations in the public domain will neglect the values inherent in that domain' (Stewart and Walsh 1992: 516). PPPs may serve to obscure these distinctions further and create additional difficulties for the public sector ethos, as they encourage new forms of relationship between actors from the public and private sector.

Case studies presented by Marchington et al (2005a), Hebson et al (2003), Grimshaw and Hebson (2005) directly investigate the impact on the public ethos in PPPs, finding wide ranging consequences for all employee groups. For managers transferred from the public sector there were some positive connotations of private sector practices that led to identification towards their new employer; 'Managers who had transferred to the private sector felt empowered by their new roles and for some this had led to a direct transfer of commitment, not only for one employer to another, but from one sector to another' (Hebson and Grimshaw, 2005: 190). Other aspects of private practice led to a change in how this commitment was displayed. For example there was 'recognition of the power of shareholders and incentives of a performance-based bones system in shaping the actions of their colleagues (some of them ex-NHS managers) working for the private sector' (p489) and a new self-interested approach was assumed by the public sector managers in order to get the most out of the private companies. They had to hold formalised meetings, constantly monitor work activities and frequently involve solicitors in order to enforce contractual arrangements such as cleaning quality and maintenance. Managers came to realise that the service they received depended on continually questioning the contractual obligation, rather than assuming interests were aligned to a common notion of working for the public service. This was seen as 'reflecting both a shift to

new lines of accountability (private sector shareholders) and a vicious circle of monitoring and distrust between partner organisations' (p481).

For the workers transferred to the private sector in these case studies, loyalties were not straightforwardly redirected to the new employer, with a general reluctance to identify with private sector interests (also reported elsewhere, by Leys (2001) and Pollock (2004)). There has also been the suggestion that managerial practices threaten workers' capability to serve the public good: 'while certain values appear resilient, the cost cutting and work intensification associated with PPPs present a significant threat to the long-term survival of the traditional public sector ethos' (Hebson et al, 2003: 482). However, this rejection of the employing private sector did not mean that workers necessarily continued to identify with the public sector organisations. The public sector 'non-employer' was commonly seen as having broken the promise of providing job security and as enforcing tight contractual terms onto the workers new employer, therefore increasing pressure and monitoring on workers without responsibility for employment.

Instead of commitment to a single organisation, a more generalised notion of commitment to 'the service' was observed, with workers seeing themselves as acting for public interest, co-workers and for their own individual careers. 'The coordination of public services through PPPs must depend on a relatively dysfunctional relationship between public sector client, private sector supplier and public services workers; workers' loyalty to the client, or to their new employer, is not part of the equation' (Hebson et al, 2003; 497). On top of this, there was also an increase in the 'forced commitment' brought about by reduced job security. This ensured that despite increased tensions and lack of loyalty, workers made sure that organisational goals continued to be met and 'relationships between contractors and clients ran more smoothly than the contractual arrangements should in theory allow' (Grimshaw and Hebson, 2005: 191). However, given the uneven distributions of risks noted across partnerships, this is likely to vary greatly between different employee groups and the type of contractual arrangements.

- How is employee commitment spread across the PPP? For example do employees within PPP tend to identify themselves with their workplace or the public partner, or their occupation or profession?
- Do employees/managers/professionals retain a public service ethos? - Or is this replaced by new forms of commitment? This could be either to the organisation, or to practices and ways of working.

2.6 Summary of Literature Review

The previous three sections have reviewed generic models of HRM, HRM in the Public Sector and HRM across organisational boundaries. In summary, it can be said that on a normative level, HRM assumes a unitarist perspective in which all managers, staff and other stakeholders share similar values, purpose and objectives. In public-private partnerships, these assumptions are challenged by three overlapping areas of literature. That is the literature which has questioned the appropriateness of HRM as a lens for analysing the employment relationship in any context, literature which has questioned the suitability and success of transferring private sector models of HRM into the public sector, and literature which has identified the conflicts and tensions of involved in employment within unconventional organisational forms and close inter-organisational relationships. Strongly implicated across much of the literature reviewed are three relationships which simultaneously involve varying degrees of cooperation, trust, tension, competition and conflict. These are the relationships between employees and employers, the relationships within and between professional and occupational groups, and the relationships between organisations across partnerships and supply chains. All of these provide potential challenges to standard models of HRM founded on notions of integrated organisations, workplace harmony, shared values, understanding and mutual interests. In answering the questions relating to prospects for notions of HRM within PPPs, analysis should take account of and be informed by the basis and nature of these relationships. The next chapter presents the specific context for the case studies of this research, namely the introduction of Independent Sector Treatment Centres into the UK health economy, mandated by central government.

Chapter 3 Research Context: Independent Sector Treatment Centres

3.1 ISTC: A Contested Policy

A significant aspect of the NHS modernisation agenda outlined in the NHS Plan (DH, 2000), was the introduction of Diagnostic and Treatment Centres (now Treatment Centres - TCs). These were introduced as specialist “one-stop” centres delivering elective (pre-planned) services, normally on a ‘day-patient’ basis, without the burden of managing unplanned emergency care or hospitalisation. Treatment Centres (TCs) were described as working within and alongside the NHS providing extra capacity, helping to reduce waiting times, offering patients greater diversity in provision and stimulating innovation in the delivery of services (DH, 2006a; 2005a). Six months after the initial announcement for Diagnostic Treatment Centres, it was declared that a number would be developed in partnership with the private sector in the form of Independent Sector Treatment Centres (ISTCs), which would be owned and run by private companies (DoH, 2002b). At the launch of the initiative, the principle aim of the ISTC project was increasing capacity in the NHS (DoH, 2005a). This was seen as important both for reducing waiting times for common procedures including orthopaedic and cataract operations, as well as increasing choice by ‘expanding the plurality of provision’ (DoH, 2005a). Also however policy continually stresses the opportunity to bring in the ‘innovative thinking and solutions’ from the independent sector with promised improvements including (DoH, 2006a):

- Construction of new facilities designed around the clinical flow of patients
- Process design to improve the patient’s experience by increasing throughput
- Taking extraneous administrative processes off-line so that surgery is not delayed and commence at the start of the working day
- Stocking smaller ranges of prostheses allowing theatre staff to become more proficient and productive
- Administering local rather than general anaesthetics

The role of change is played up further in a later CBI report on the introduction of ISTCs which states the governments ‘original aim for ISTCs was to change behaviour

in the NHS by providing a challenge to traditional service delivery methods and in doing so to create a self-improving NHS' (CBI, 2008). Notwithstanding this emphasis on innovation, policies have continually reiterated that patients are still treated in line with the principles of the NHS, with care 'free at the point of use' and with the same high-standards (DoH, 2000; 2004b):

"This enables the NHS to learn from innovative approaches from the independent sector while retaining and transferring the strength of the NHS and protecting the high standards of care that have been developed in NHS hospitals" (DoH, 2005a: 6)

While also fitting with ideals of partnership working:

'the ISTC Programme has been designed to allow the IS to work in partnership with local healthcare economies to provide solutions which reflect and cater to local requirements. The ISTCs are being set up and run by leading international companies which have extensive experience of running elective surgical centres and diagnostic facilities' (DoH, 2005a: 5)

ISTC procurement has taken place in two distinct 'waves'. The first wave commencing in 2003 consisted of 25 fixed-site centres and two chains of mobile units. The second wave initially involved 24 schemes, but was later scaled back to 10, of which nine were operational by 2009. Many of the wave 2 centres were larger in scope and scale, involving a wider range of procedures and covering services provided over multiple sites (Naylor and Gregory, 2009). Within the year 2007/08, ISTCs carried out approximately 6 million elective care procedures, 1.8% of the NHS total (Audit Commission, 2008), including around 7% of hip procedures and 9% of arthroscopies. ISTCs have a varied and often complex contractual structure, which have legally binding contracts with both the Department of Health and a number of sponsoring PCTs, although considerable variation exists between sites. In addition they are regulated by inspection by the Care Quality Commission (previously Healthcare Commission). ISTCs also report to the DoH on 26 key performance indicators including measures clinical procedures, complaints and patient satisfaction.

The ISTC Programme has been a highly controversial reform often resisted and publicly criticised by medical and campaign groups supportive of an integrated NHS (Player and Leys, 2008). Their performance and impact has been under heavy

scrutiny by contract managers, central government regulators, staff groups and the general public. Three particular controversies have most frequently been brought to public attention with discussion in the BMJ as well as local and national press; namely the value for money of ISTC contracts, the safety of new facilities outside of the NHS and run by independent organisations, and the impact on the wider NHS as routine procedures are taken out of the system (Wallace, 2006; Squires, 2007; Kelly et al, 2007; Pollock and Kirkwood, 2009). While investigating these criticisms is not a primary focus of the current study, they do form part of the context for ISTCs and could often be seen to inform the perceptions and discussions of ISTCs by staff and management within the case studies. They are therefore worth briefly exploring here.

In relation to the value for money of ISTCs, Allison Pollock (Pollock, 2004; 2007; Pollock and Kirkwood, 2009) has been highly critical of the nature of current contracts. She argues that to encourage new companies into the market, the price paid is often slightly higher than the amount paid to NHS providers stipulated in the national tariff. The government has responded that this price (on average 11.2% higher than NHS tariff (HSC, 2006) reflects the full economic costs associated with building new facilities, not fully taken into account in the NHS tariff price (HSC, 2006). In addition, and perhaps with more serious consequences, patient numbers have been specified within the contract and specific budget 'ring-fenced' in order to guarantee income to the private providers investing in new centres. This, Pollock states, has led in places to extreme overpayments to the private sector, with the state contracting about £2.7bn worth of services and uncertainty around the value for money. As an example, the Scottish Regional Treatment Centre (SRTC) opened in 2006 with the company Netcare contracted to supply a specific number of procedures over for a period of three years at a cost of £18.7m. However, she calculates the actual take up of the service was in the first year approximately 32% of capacity. Adjusting for types of procedures and payments, she estimates that within the first year, approximately 1.6m of payments had been made for services not used (Pollock and Kirkwood, 2009). Based on these figures and others available, Pollock estimated that this could amount to some £927m unused capacity paid for by the state, although she admits these figures are based on wide extrapolations from little data. Although all of the above figures have been disputed, for example by the Chief Operating Officer of the Trust in which SRTC was based (Marr, 2009), Pollock states

that many of the payments remain unaccounted for and difficult to trace due to missing data returns, with fewer than half providing any of the compulsory data to Hospital Episodes Statistics: 'Lack of data and incomplete and poor quality data returns are hallmarks of the ISTC programme' (Pollock et al, 2009). This view was supported by the Health Select Committee (HSC, 2006) which was established to investigate the first wave of ISTCs as well as the proposals for the second wave. Investigating value for money they concluded in that 'since we do not know the details of the contracts, what figure was used for the NHS Equivalent Cost or how it was arrived at, and since the benefits of ISTCs have not been quantified, it is impossible to assess whether ISTC schemes have in practice proved good value for money' (HSC 2006, 38)

The second major concern has been around the quality and safety of care provided by ISTCs. This was again picked up by the HSC (2006). Following the evidence from a number of different stakeholders, including members of the government, hospital consultants and managers from the NHS and private organisations, they found a number of problems potentially affecting quality and safety. These included concerns over arrangements for patients being transferred between ISTC facilities and NHS sites in case of emergency, regulation and checks over safety procedures, poor quality of staff, lack of training and again lack of data on which to base judgements of quality. Further, the safety concerns over ISTCs gained national attention following the death of a patient caused by haemorrhage during in a routine gall bladder operation in 2007 at the Eccleshill Treatment Centre (West, 2009). Insufficient blood was held at the ISTC to cope with the emergency, and a series of problems led to long delays in emergency treatment including a porter having to fetch blood from a nearby hospital in his own car rather than pre-planned courier service, no telephone in the operating theatre to call for help and a lack of equipment to stem the bleeding or warm the blood when it arrived. The coroner at the time pronounced 'global flaws' and that the evidence suggested 'gross failure' (Baldwin, 2008), and a review into the centre is currently underway. Aside from this, doctors have made frequent complaints in medical, local and national press about the quality of the services provided (Wallace, 2006; O'Dowd, 2006; Kelly et al, 2007).

Two recent academic reviews of quality outcomes of ISTCs provide slightly contradictory findings. First, research by orthopaedic consultants examined the results of patients from Cardiff Vale NHS Trust who had been sent to a single ISTC in

Weston-super-Mare for hip (136 patients) and knee (224 patients) operations. Following up patients later within the Trust with they found dramatically worse outcomes for operations carried out within the ISTC than the NHS average. Revision rates within three years of hip operations stood at 18%, compared to 0.9% average within the NHS, and two thirds showed evidence of poor surgical technique (White et al, 2009). Similarly, significantly higher rates of revision, and significantly lower survival rates after three years, were found amongst patients undergoing knee operations at the ISTC (Kempshall, et al 2009). Second, Brown et al (2009) looked at outcomes for a range of day and orthopaedic surgery procedures in patients treated in either an IS or NHS Treatment Centre. This involved a larger group of patients (2664), and a larger group of Treatment centres (6) and NHS sites (20). They found ISTC patients undergoing cataract surgery or hip replacement achieved a slightly greater improvement in functional status and quality of life than those treated in NHS facilities while the opposite was true for those undergoing hernia repair. No significant difference was found for those undergoing knee replacements or varicose vein surgery. For some conditions patients treated in ISTCs were less likely to report post-operative problems. Although these results were adjusted for 'case mix', for example in terms of the relative health of the patients entering treatment, the authors do warn against over interpretation of the results given the large differences in patients treated. In most cases, patients entering ISTC treatment are risk assessed, with only comparatively 'healthy' patients with lower co-morbidities or risk factors such as diabetes or obesity accepted.

The third area of controversy was the impact that ISTCs are likely to have on existing NHS facilities. Medics suggested that they were being forced to send patients to ISTCs against their preference, as contracts were based on a 'take or pay' basis, that the Primary Care Trusts would have made payments to the ISTC companies regardless of the take up of the scheme (Moore, 2007). In addition, there were a number of reports that ISTCs bought in an oversupply of services in places where waiting lists were already being reduced. As PCT were encouraged to send patients to the new facilities, existing NHS were becoming underused as a result (Ferris, 2005). The negative impact of separate elective surgical facilities on overall efficiency is supported in part by operations management research, which suggests that this may lead to loss of flexibility, as well as difficulty constructing theatre lists consisting only of more complex operation to fit time slots, and therefore counter intuitively actually

decrease utilisation of theatre departments (Bowers and Mould, 2005). As ISTCs only tend to carry out less complicated, high volume and low risk procedures on generally healthy patients, they have been accused of 'cherry picking' or 'creaming off' the most straightforward aspects of healthcare. This is seen as taking away an important income stream from the NHS, without IS providers having to pay for the more costly emergency care and support services (Player and Leys, 2008). The HSC (2006) report suggested that 'there are good reasons for thinking that ISTCs could have a more significant affect on the finances of NHS hospitals. We do not know how big that effect might be or how great the dangers might be.' (p6). In addition, within the initial treatment centres subject to rules of additionally, which stated no NHS staff could be employed (see section 3.2 below) there was no provision for training NHS staff. As it was the more routine procedures being outsourced, this was seen as potentially leading to the loss of opportunities for junior doctors to train and develop. This was again strongly criticised by the HSC, which stated:

'There were concerns that ISTCs were poorly integrated into the NHS and that they were not training doctors. These concerns are well-founded. The additionality [see section 3.2] policy was felt by many to have hindered integration between ISTCs and their local NHS facilities, while the reliance on overseas staff which additionality had necessitated raised concerns about clinical quality and continuity of care. We concluded that there was no hard, quantifiable evidence to prove that standards in ISTCs differed from those in the NHS; however, there are failings in the quality of data collection by both NHS and IS providers.' (p6)

In general, medical and campaign groups have argued the introduction of private providers will lead to fragmentation of the health service. Summing up this position, the President of the British Society for Rheumatology wrote in the *BJM* (Bamji, 2008)

'All of these perverse incentives threaten the pattern of specialist care and the establishment and maintenance of multidisciplinary working. They also help to encourage unnecessary activity, particularly in diagnostics, where it becomes reasonable to send all back pain patients for MRI scans (because patients want them) despite both the expense and lack of clinical utility. So there is more to all of this than simply a lack of evidence of clinical benefit from independent services; some may be more expensive, and some less, but

all of them will threaten the existence of current provision without any overall proof that the exercise are financially prudent' (1187)

In addition to these public debates, the limited academic research on TCs has shown conceptual ambiguity in the principles and interpretation of policy. Bate and Robert (2006) discuss the role of TCs in relation to the government's desire to expand patient choice. Echoing debates around PPPs in general, they identify a number of paradoxes that render policy implementation ambiguous. For example they note that choice is being imposed upon patients, TCs undermine the goal of seamless integrated care, and current contracts privilege the IS to the detriment of NHS service providers. Pope et al (2006) suggest that at the local level the translation of policy has been shaped by various strategic actors with different expectations about the role of the private sector. This has led, for example, to significant variations in TCs, ranging from single ward initiatives in which existing departments were relabelled in response to central government policy leading to limited or incomplete change on the ground, to the construction of large infrastructure builds (Pope, et al. 2006). ISTCs are often presented as falling into the latter category, however again considerable diversity exists in the realisation of the policy. For example, in the DoH's own words, ISTC facilities range from 'mobile solutions', such as portable units for conducting cataract operations, 'new facilities' on both private and NHS sites, 'utilising existing IS capacity' and 'refurbishment of existing NHS facilities' (DoH, 2005a). The latter two of these has created situations in which single corridors and operating theatres are run by the private sector, with their own administrative and management staff, within existing general NHS hospitals. Further, the diversity of centres, as well as the contradictions in the rationale for ISTCs was picked up in the HSC (2006) report, which stated in response to the decision for later services to be part of 'reconfiguration plans' that could see existing hospitals or departments closed down:

'The decision to maintain the commitment to spend £550 million per year despite changing circumstances has not been explained, and seems to sit uncomfortably with the Secretary of State's admission that "in other [areas] it has become clear that the level of capacity required by the local NHS does not justify new ISTC schemes". It is not clear whether this represents simply a failure coherently to articulate the situation or a more profound incoherence in terms of policy as opposed to presentation. There are also real concerns

that the expansion of the ISTC programme will destabilise local NHS Trusts, especially those with financial deficits.’ (p6)

Importantly for the current study, this diversity and conceptual ambiguity is also reflected in the arrangements for employment and staffing of ISTCs, which have changed dramatically over the period of the programmes introduction. ISTCs exemplify the growth of networks or ‘permeable organisations’ in the delivery of public services. Many of the contracts were mandated by central government, and involved introducing new companies to the UK market in an array of structured partnership arrangements with existing healthcare organisations. Therefore rather than a single distinct employment context, ISTCs in fact involve a diverse range of employment arrangements, explored below.

3.2 Employment in ISTCs and ‘Additionality’

Central government procurement of the ISTC program took place in two distinct waves. While similar in many respects, one important difference is in the rules governing employment for the two phases of commissioning. Specifically, blanket ‘additionally’ rules were applied to the early ISTCs, which stated that they were prohibited from employing or engaging any healthcare professionals who were working in the NHS at the time, or had worked in the NHS at any time in the last six months (DoH, 2007). This followed concerns from all parties involved in negotiations that ISTCs should provide genuine additional capacity. In effect, this meant that Wave 1 treatment centres would have to source clinical staff from overseas or from existing private sector providers. This caused a number of difficulties, in particular the challenge faced by early ISTCs in recruiting suitable staff given the dominance of the NHS as an employer. This was joined by pressure from staff groups and unions within the NHS who objected that barring them from employment within ISTC was unfair practice, and that employment within ISTCs was unregulated and could lead to unequal treatment across the workforce. In addition to this, criticism in the Health Select Committee (2006) over the potential impact on training opportunities led to calls for greater integration with existing NHS employment systems including allowing junior doctors and other groups to train within ISTC facilities. As a result, by the second wave of ISTC procurement the additionally rules had been ‘refocused’ to ‘allow NHS employees maximum choice and mobility in their careers and to ensure that IS providers have a viable pool from which to recruit’ (NHS Employers, 2006: 9).

Addressing concerns over lack of training opportunities, Wave 2 ISTCs were contractually obliged to make at least one-third of all activity available for the training of junior clinical staff.

Aside from the external pressures, it also appears likely that the decision to open up employment in ISTCs to NHS staff had already been made by the government, given that a number of the wave 2 ISTCs were partial replacements existing services. For the most part these had already been decided upon when the new employment regulations were formally agreed. Although the DoH stated that there was local choice over where the ISTCs were commissioned, other local health service managers complained that there had been considerable pressure from the DoH to accept plans for ISTCs against their own wishes (HSC, 2006).

The removal of additionality meant that management of local Trusts were, alongside the contracted ISTC providers, expected to begin arrangements for the wholesale transfer of staff from local hospital departments to the ISTCs. Certain specialties under short supply were excluded from complete transfer, but even these were given greater leeway to work uncontracted hours in ISTCs. For certain medics therefore ISTCs would replace private hospitals in supplementing NHS income. Accordingly, many Wave 2 treatment centres were largely made up of staff transferred from local NHS organisations, as well as additional staff employed by the private sector health company themselves.

In looking at HR issues in ISTCs, and public-private partnerships in general, the two waves of centres represent an important site for research, in many ways embodying the permeable workplaces and blurring of organisational boundaries. ISTCs are ostensibly 'partnership' arrangements, with the need for ongoing relationships with NHS facilities. They were promoted not in reference to market competition but on grounds that they would supply 'unique competencies'. However, they are also commercial ventures, with evidence of tension, mistrust and divergent values and interests between actors within the public and private sectors.

Many of the research questions identified in section 2.5 relate to the difficulties of translating a private sector HRM approach to a context in which public sector institutions and professions dominate, even when contained within a private company. Therefore Wave 1 and Wave 2 ISTCs could be seen as providing a useful site for comparative study, in which two ostensibly similar forms of organisation are created,

different in one key aspect. Both operate within similar contexts, carrying out largely similar functions, and with similar policy aims, pressures, paradoxes and constraints. However, while Wave 2 centres are largely composed of actors from within the NHS and in some ways tied to existing NHS facilities, Wave 1 centres are formed by actors drawn from a much wider variety of backgrounds.

The different rules governing employment in the two waves of ISTC therefore provide an opportunity to investigate how different partnership structures relate to different contexts for HRM activity. For example, are ISTCs involving no existing NHS actors more able to promote corporate HRM and instil distinct HRM practices? Alternatively, are they likely to establish low commitment HRM approaches in the face of commercial pressures and greater exposure to private sector practices? These issues are explored in much greater detail within the study findings. The next chapter describes the qualitative case study methodology and the research process.

Chapter 4 Methodology

4.1 Introduction

This chapter describes the research methodology and process of carrying out the study. This includes discussion of the choices made during the design and conduct of the research, the process of data collection and means of analysis. This introduces relevant literature on qualitative and case study research which informed the study. It does not engage in lengthy discussions of the competing research paradigms which would be difficult to do justice to here (Denzin and Lincoln, 2005; Guba and Lincoln, 2005; Benton and Craib, 2001; Burrell and Morgan, 1979). The chapter also includes reflections my own changing personal and employment circumstances, developing interests and the numerous practical challenges as well as opportunities that presented themselves during the course of the study. These had perhaps unavoidable consequences for all aspects of the research, including the topics selected, the course of data collection and the duration of the study. Rather than attempting to erase these elements completely from the work, this section will include personal reflections on how and why the research emerged as it did. In contrast to the rest of the thesis, I do not avoid writing from the first person where this helps to provide a more open account of the choices made during the course of the research. The first two sections describe the foundations of the research, introducing the principles of qualitative and case study research. The later sections describe the process of carrying out the study. This introduces the comparative case design and justifies this as an appropriate respond to the exploratory research questions. It also describes how the study was carried out including detail on the data collected, process of analysis and ethical considerations of the study.

4.2 Qualitative Research

In planning the research it was necessary to consider possible approaches to the study. Organisational study does not relate to a single methodology but stems from a variety of academic roots: economics, political science, psychology, sociology and anthropology (Knights and Willmott, 1997). Because of this, the spectrum of paradigms of interpretation used to examine organisations is as wide as those in use in social science in general. A number of epistemological and ontological positions have been used to justify the truth claims of research, with different approaches

gaining and losing status over time and across research contexts. Contrasting schools of thought point us towards various methodologies and aims of research. Some writers have warned against strict adherence to these paradigms (Willmot, 1993), or making 'either/or choices which are artificial and stultifying' (Watson; 1997:5) based upon them. This study does not claim to exactly replicate any particular stream of 'pure' methodology the realisation of the study. Rather the study sought to pragmatically draw upon various insights and methods to produce plausible and worthwhile research findings (Watson, 1997).

This said, the study can broadly be described as qualitative research. Primarily, this choice was driven by the nature of the research questions and subject of the study. Quantitative research is usually seen as appropriate for testing theories that have been previously constructed, or looking for a suspected relationship between two well defined variables (Johnson and Onwuegbuzie, 2004). Quantitative research could have been employed if the research was concerned with, for example, the covariance of partnership models and financial performance or the relationship between the adoption of certain employment practices and employee turnover. However, due to some of the issues identified in the preceding literature chapters, many of the concepts on which measurement could be based are currently not clear. For example, in the move to 'partnership working' the bounds of the organisation may be difficult to precisely define, depend on how both 'employees' and 'non-employees' carry out their activities, and involve several smaller organisations each with potentially complementary or competing objectives. Qualitative research on the other hand, while preventing straightforward generalisations, allows investigation of issues which are unclear prior to commencing the research. Qualitative research is usually seen as appropriate for tackling open ended questions (Lincoln and Guba, 1985) within instances of 'large-scale social change' and situations that involve 'unique, nonrepeatable, and ex-ante highly improbable complex of events' (Hirschman, 1970: 343). It is also used to explore the phenomenon of interest in detail and within their local context, as they emerge and change over a period of time (Jonson and Onwuegnuzie, 2004).

While there are a large variety of research methods that could be employed in qualitative research, certain common characteristics are features generally characteristic of a qualitative mode of enquiry (Bryman, 2001). Contemporary qualitative research has built on the notion that social scientific study is

fundamentally different from the natural sciences as it is concerned with meaningful human action as opposed to physical properties (Benton and Craib, 2001); 'Human actions are intelligible in ways the behaviour of nonhuman objects is not' (Strike, 1972, quoted in Patton, 2002: 28). It also has roots in interpretive study, in which social science 'attempts the interpretive understanding of social action in order to arrive at a causal explanation of its course and effects' (Weber, 1947: 88). In general, qualitative research places a greater emphasis on subjective meanings above wholly generalisable objective laws. Rather than entering the research environment with predefined measures or binary hypotheses, researchers seek to allow 'one's subject to unfold its nature and characteristics during the process of investigation' (Burrell and Morgan, 1979: 6). A key feature is the need for 'verstehen' or 'empathetic identification' in order to 'get inside the head of an actor to understand what he or she is up to in terms of motives, beliefs, desires, thoughts and so on' (Schwandt, 2000:192). Therefore there is usually felt to be a need to explore a social phenomenon in a naturalistic, 'real world' setting (Patton, 2002), from the emic perspective (Denzin and Lincoln, 2005), capturing the actors own voice, and using language defined by the actors relating to situations with which they are familiar (Schwandt, 2000). Flexibility is also advocated so research can be adapted as understanding of the researched situation deepens and situations change (Patton, 2002). Qualitative researchers tend to take into account the context specific influences or 'situatedness' of behaviour, so that observations are not detached from the social and physical environment in which they occurred. Analysis must usually include detailed 'thick description' of the encountered world (Geertz, 1973). Further, qualitative researchers are advised to take into account the active nature of their personal influence in the outcome of the study (Patton, 2002) and retain a degree of reflexivity. That is 'an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgment of the impossibility of remaining 'outside of' one's subject matter while conducting research' (Nightingale and Cromby, 1999: 228).

Although the precise order of any research project may vary, qualitative researches usually see research as an inductive process, by which they search for meanings and structures in their interpretation of the data (Thorne, 2000). Rather than beginning research with a hypothesis to test, this suggests a 'bottom up approach whereby researcher begins with an area of interest, but then develops ideas through the

process of gathering data' (Cresswell, 2007: 28). Analysis is then based on the data gathered, for example through looking for categories, patterns, hierarchies that suggest theoretical generalisations (Strauss and Corbin, 1990). The process of analysis for this study is discussed in more detail below.

These positions lead to a set of responsibilities for qualitative social researchers that are partially distinct from the role of researchers in the quantitative tradition or the natural sciences. They cannot appeal to universally applicable truths in order to incontrovertibly prove a proffered position or derive laws or theories that transcend the context in which they were formed. Just as our own interpretations will be moulded by our existing world-view, they do not then take on an absolute form that can be directly or neutrally presented to others. The process of mediating interpretations into textual representation requires several further steps of interpretation (Schwandt, 2000). The representations presented by researchers will then always be partial, and is 'crafted' through the active decisions of the researcher (Watson, 1995a; Brown, 1998). Writing 'research findings' is not merely a 'secondary or mop-up activity in our professional pursuits' (van Maanen, 1995: 134), but a motivated process of shaping of an account that we wish to present to an audience; 'The words ones chooses, the tropes one adopts, the terms one utilises significantly influence how that research enters into broader discourses and how, potentially at least, they influence human action. It is almost as if one is choosing a reality when one writes, rather than giving an account of one' (Watson, 1995). The researcher must therefore be reflexive about the version of reality they put forward and acknowledge 'how we as researchers and practitioners constitute meaning through our own taken-for-granted suppositions, actions, and linguistic practices' (Cunliffe, 2003: 989).

Reliability and validity in the quantitative conception of the words are then not usually seen as adequate tests of the value of qualitative research. Instead strengths are usually appealed to such as the persuasiveness of their arguments, the trustworthiness and authenticity of their voice, and the practical value of their research (Guba and Lincoln; 1994). Triangulation of different sources and methods while not a source of validation, can add depth and breadth (Denzin and Lincoln, 2005). Theorising is itself a social process, (Van Maanen, 1995: 134) and is perhaps best seen as a ongoing activity rather than the finalised end product of research; all 'relevant theory' [should remain] 'as a work in progress open to rectification by

empirical research' (Castells, 2000: 6). Qualitative research is usually judged by subjective measures such as the 'plausibility to the reader of the particular texts produced from the research, as something yielding insight of understandings felt to be worthwhile to that reader in light of their own situation or projects-in-life' (Watson, 1997; 5-6). In order to achieve this, the researcher must constantly hold in mind their motivated role in theory construction, the importance of language in their representations and search for 'local, small-scale theories fitted to specific problems and particular situations' (Denzin and Lincoln, 2005: 17).

4.3 Case Study Research

As the previous chapters have argued, the current research is not dealing with variables that could be easily isolated or removed from their context. Rather it is asking exploratory questions about intricate and complex systems of social action, diverse political discourse, contested historical accounts and has ethical implications which resist straightforward theoretical reductionism. Because of this, and taking into account the methodological insights above, it was felt that qualitative case study was the most appropriate and feasible approach for the research. In general, qualitative research has been seen as consistent with the understanding of knowledge of the social world as influenced by processes of social construction. It also enables the researcher to capture knowledge within its wider social context (Miner & Mezias, 1996). The term 'case study' is somewhat ambiguous and could conceivably be applied to all research that includes a unit of analysis that could be termed a 'case'. However, case study as a research design is concerned with in-depth 'holistic' investigation of the case, usually over a number of dimensions, over a certain period of time, and possibly through a number of methods (Hammersley and Gomm, 2000). 'We could study it analytically or holistically, entirely by repeated measures or hermeneutically, organically or culturally, and by mixed methods - but we concentrate at least for the time being on the case' (Stake 2000: 435). The guiding supposition that directed the current research towards the case study approach is that it would be almost inconceivable to study or attempt to purposefully control the complex social phenomenon that is the focus of this study disregarding the 'real world' setting in which they occur. The case study strategy allows us to integrate this setting into the core of the research as they form 'an empirical inquiry that investigates a contemporary phenomenon within its real life context, when the boundaries between the phenomenon and context are not clearly evident' (Yin,

2003: 23). Case study research actively encourages detailed descriptions of the uniqueness and complexity of the particular instance (Stake, 2000; Mitchell, 1983) and seeks to 'understand its activity within important circumstances' (Stake, 1995; xi).

Case studies are extensively used within organisational studies (Grunrow, 1995) as they can help us include a number of aspects of interest that would be difficult for other approaches to capture. These include: exploring different character of intra-organisational relationships (e.g. Fincham, 1999); demonstrate organisational processes, including the decision-making process (Teisman and Klijn, 2002), organisational change (Pettigrew, et al, 1992; Pettigrew, 1985), the process of organisational sensemaking (Weick, 1993), human resource development (Newbrunner et al, 2001), constructing narratives (Brown, 1998: Currie and Brown 2003), constructing organisational practices (Rutherford, 2002), personal identity (Coupland, 2001), organisational culture (Bate, 2000; Schein, 1996), emergent strategy (Mintzberg and McHugh, 1985); and the details of organisational life that bring 'unanticipated and often unacknowledged shortcomings and costs to light' (Grimshaw et al. 2002: 476).

Due to the level of analysis required, researchers usually concentrate on one or a small number of cases, seeking to utilise many sources of qualitative or quantitative and qualitative data as appropriate (Yin 2003). Each case is not merely one of many examples whose sole purpose is to yield data for the wider goal of the study, but must be considered to some extent as 'specific, unique' (Stake 2000: 436), embracing rather than disregarding subjective experience, narrative integrity, uniqueness and individual characteristics (Ragin, 1997). Because of this, the type replicable research and generalisability associated with scientific enquiry is not an option from case study research. However, such generalisation is not seen as essential for research to provide benefit. Indeed, many have pointed to the problems of promoting blanket laws that are supposedly free from time and context, formed by actors with their own subjective views of the world and self-interests, over the experiences of particular cases (Lincoln and Guba 1985), and especially so in applied fields in which there is an interest in the individual and not just the aggregate (Donmoyor, 1990). Frequently though, despite denying the importance of law-like generalisation, case study research usually does proffer some kind of wider relevance of the findings, or at least generalise within the case (Gomm, Hammersly and Foster, 2000). Therefore,

other purposes for case research that do not imply deterministic prediction have been suggested.

4.4 Purpose of Case Study Research

Stake (1978) outlines a process of generalisation through the tacit understanding that is gained through the vicarious experience of reading detailed case study research. The particulars of an individual case add to our existing experiences and memories, and can be assimilated into and build upon what we already know in the process of 'naturalistic generalisation' (Stake, 1978; Stake and Trumbull, 1982). 'Naturalistic, ethnographic case material, to some extent parallel actual experience, feeding into the most fundamental processes of awareness and understanding ... The reader comes to know some things told, as if he or she had experienced it. Enduring meanings come from encounter, and are modified and reinforced by encounter' (Stake, 2000; 442). Similarly, Watson (1997) states that the depiction of the case should be such that 'if the reader goes for the first time into the social setting that they have read about, either as a manager or as an academic observer, they will feel better placed to cope than if they had not read it' (Watson, 1997: 8).

Others have argued that more explicit generalisations can be elucidated from case study. Lincoln and Guba (1985) propose that we can form 'working hypotheses'; propositional type interpretations arising from the case that can be potentially applicable across contexts. Unlike scientific generalisation these are highly tentative and cannot be statistically extrapolated to all other settings but are dependent on an inquirer appreciating how and when the general 'rule' is relevant to a specific context. As all cases are unique and contextualised, strict *ceteris paribus* conditions can never be met to apply in a law like fashion the interpretations of one situation to another. However, through 'intimate knowledge of the relationships in the particular circumstances which connect the events in the case, the analyst might be able to show how the general principles being examined manifest themselves in changed form' (Mitchell, 1983: 207). In order for a hypothesis formed in one setting to be applicable to another, some feature must be recognised familiar enough for the hypotheses to be applied and appropriately qualified.

Lincoln and Guba (1985) suggest that contexts must be overtly similar enough for generalised statements to apply and so selecting potentially representative cases is important for generalisation. Others propose that generalisation is based more on

the internal processes fitting the learning from one context into another and so selecting representative cases is less important (Mitchell, 1983; Donmoyor, 1990). Schofield (1990) argues that as a guiding principle, researchers would do well to look for in some ways 'typical' cases in order to increase the potential for applicability but this should not be taken to extremes 'even if one could achieve typicality in all major dimensions that seem relevant, it is nonetheless clearly true that there would be enough idiosyncrasy in any particular situation studied so that one could not transfer findings in an unthinking way from one typical situation to another' (p78). Others have suggested the opposite approach, suggesting that extreme or atypical cases may more clearly highlight the processes that are the topic of investigation (Hartley, 1994). In either case, for others to fully assess the significance of the ideas proposed, and apply them meaningfully to other instances, the researcher must always include sufficient information and thick description about the context in which they was formed.

This would appear to fit with the form of theory advocated within interpretive research 'local, small-scale theories fitted to specific problems and particular situations' (Denzin and Lincoln, 2005: 17). Others have explicitly linked the process of hypothesis generation to theory building from case studies 'The problem lies in the very notion of generalizing [...] an analyst should try to generalize findings to "theory," analogous to the way a scientist generalises from experimental results to theory' (Yin, 2003: 38). Eisenhard (1989) outlines a rigorous process through which we define constructs, look for patterns, derive hypotheses, and then systematically compare them with the evidence from each case in order to assess how well or poorly it fits with the case data. 'The central idea is that researchers constantly compare theory and data – iterating towards a theory which closely fits the data' (Eisenhard, 1989: 541). However, other have warned against over-formalisation of this process or concentrating on measuring and testing constructs between cases at the expense of providing 'a rich background to each case [...the] story against which researchers can compare their experiences and gain rich theoretical insights' (Dyer & Wilkins, 1991: 613).

As well as the possibility of deriving some sort of generalisable findings, case studies have also been stated as particularly useful for testing existing theories as they provide 'critical' instances that can 'impugn established theories if the theories ought to fit it but do not' (Eckstein, 1992:135). In some instances, 'exploratory', 'descriptive'

and 'theory testing' are seen as distinct forms of case study (Yin, 2003). However, it would also seem possible that in the process of researching the case, a number of preliminary working hypothesis may be formed, and a number of examples that are problematic to existing theories are both found; 'the chain of inquiry [...] runs from comparatively tested theory to case interpretation, and thence, perhaps, via ad hoc additions, newly discovered puzzles and systematised prudence, to new candidate-theories' (Eckstein, 1992: 135). Therefore, it could be said that the dual purpose of the cases presented in this research are to explore the questions posed in section 2.5 and, in addition to propose new propositions for the nature of HRM within the changing public sector.

4.5 Research Design and Case Selection

Textbooks on methodology usually suggest that the research design is the first step in conducting a piece of research, to be completed before data collection is embarked upon (Gunrow, 1995). This is seen as the ideal for many reasons, such as developing a clear picture of what it is that is under investigation, tailoring the research to fit the questions and objectives, and adhering to time and resource constraints. While as clear a picture as possible was developed prior to commencing the research during the first year of study, a number of major changes took place when the study was already underway. Of importance here, the design of the research was closely tied to the process of finding and defining appropriate cases to study. Having previously discussed the theoretical appropriateness of case study for this research, the two elements of design discussed in detail here are the selection and boundaries of the cases.

This study took the form of comparative case study of two ISTCs, one providing exclusively orthopaedic services to both in and outpatients (Orthe-ISTC), and one providing a wider range of day surgery and outpatient services (General-ISTC). One of these, Orthe-ISTC was subject to rules of 'additionality' (see chapter 3) and had to employ from outside the NHS, while the other, General-ISTC, involved the secondment of NHS staff to the ISTC to work under private management and alongside a minority of private sector staff. In practice the selection of the cases was opportunistic. The first was recruited when the Managing Director of private healthcare company responded positively to a letter I sent out about the research to a number of ISTCs. The second was only selected to be part of my PhD research after

I had taken a job as a research associate on a project looking at knowledge sharing within ISTCs. This position led to several changes in the focus of my PhD and the process of carrying out the research. However, certain justifications can be made for the cases that were studied. Although I intended to study 'ISTCs', previous academic work on TCs (Pope et al, 2004) and publically available information suggested that there was a large degree of variation in the realisation of ISTCs. While some ISTCs were small scale mobile units or single ward initiatives both of the study sites in this research were more prominent 'flagship' examples that appeared to fit well with the governments' rhetorical portrayal of ISTCs as a major new initiative. These study sites were both multi-million pound contracts with new build facilities, set to run for an initial five year period. The cases that were selected had caused considerable local political debate and media attention and were among the largest of their type in the country. Therefore, the case selection in this instance could be seen to be both 'extreme' and 'critical' (Yin, 2003). While this does not lead to the cases being 'representative' or 'typical' (Yin 2003) of ISTCs in general, it was thought that this approach did provide other important opportunities for the research. Looking at these prominent examples provided a chance to investigate cases that were likely to be of interest in their own right as at the forefront of private sector involvement in previously 'core' NHS activity. Also it was felt that these cases were particularly likely to provide further insight into the issues raised in chapter 2 and likely to yield data relevant to the research questions.

In addition to this, the changing employment laws surrounding ISTCs opened the possibility of studying cases with different arrangements for employment. It has been suggested that multiple, comparative cases can increase the depth of evidence and can make the case study more compelling and robust (Yin, 2003; Zartman, 2005). Finding similar or comparable results in multiple sites does not necessarily mean a more reliable set of results in the positivist sense, but may shed further light on the processes in question. In this research it was felt that comparing cases that involved the transfer of NHS staff to cases of ISTCs employing their own staff provided a good basis for exploring the ideas presented in the literature. A key question identified in relation to workforce reconfiguration and innovation was the extent to which managers within ISTCs are able to introduce new practices. Comparing Orthe-ISTC with directly employed staff to General-ISTC with seconded NHS staff helped to draw out the relative influence of various factors that may assist or prevent new practices

from being implemented. Where staff were seconded, issues relating to the break in the direct employment relationship between managers and staff were borne out. Looking at a comparable site in which staff were directly employed helped me to separate this effect from other distinctive features of working in an ISTC, such as working under private management and a greater degree of separation from wider NHS institutions. Although these justifications of the comparative cases were not firmly in place before the cases were chosen, they were not only considered after the research was completed. Rather, the emerging comparative issues in part shaped the process of research, data collected and interview schedules at each site.

A second important point in this design was identifying the limits of the case study sites under investigation, with two boundaries guiding the research. First I decided to focus the investigation primarily on the activities taking place within the two ISTC facilities, which were purpose built at both sites. Given the research context including the blurred boundaries, non-standard employment relationships and multi-employer workplaces discussed in section 2.4, defining 'The ISTC' was somewhat problematic, and could be conceptualised in a number of ways. They could be seen as legal entities, in terms of the nature of the contract; they could be seen structurally, in terms of the different organisations involved and the relationship between them; or they could be seen functionally, looking across the supply chain of their service production. Each of these approaches may have certain strengths and weaknesses. If I had concentrated solely on the private company responsible for managing the ISTC, this would have prohibited me from examining the important issues relating to non-employees, and inter-employer relationships. On the other hand, if the study were to have spanned the whole of the 'partnership' including acute and primary care organisations this would have made the study unmanageable and may have led to a lack of depth on the specific issues within the ISTCs themselves. Therefore it was decided to limit the scope of the study to the bounds of the purpose built ISTC building. This also helped in terms of management permission, as it was the private company management that largely had jurisdiction over these spaces. However there were a number of exceptions to this, for example during the early part of the study, the senior HR manager at Orthe-ISTC was based at a corporate head quarters in a separate town from where the ISTC was based¹ and this is where the initial meeting

¹ During the course of the study, the HR department moved into the ISTC building, in part to deal with the myriad HR challenges in the development of the ISTC explored in chapter 5

took place. Perhaps more significantly, some initial contact was made with the staff in General-ISTC while they were still working within the partner NHS hospital, prior to their move to the ISTC and there was some continued contact with actors within this hospital. This is discussed further in the next section.

The second limit on the focus of the study was concentrating on the production of clinical activities, and the staff groups whose work was focused on the production of clinical services. Only limited attention is paid to the staff groups whose work was less directly involved in clinical production, such as IT technicians, cleaners, caterers engineers and security staff. This was only decided during the course of the study after a certain amount of data had been collected on these support services groups, for example with one week spent within Orthe-ISTC conducting interviews and meeting with the service subcontractor staff. The main reason for this decision was the development of a coherent narrative that was comparable between the two sites and narrow enough to allow sufficient detail. This was a difficult decision as it has been well recognised that support service groups are often some of those that are first and most negatively affected when work is contracted out to the private sector. Leaving them out in some ways plays into perceptions that these areas of work are less than essential in the production of public services, which is far from the case. Further, by not including them this study does not fully capture the complexity of the multi-employer workplace. However, contracting out these services has been a feature of the public sector for a number of years and the consequences of contracting-out for these types of roles that have been covered elsewhere (Marchington et al, 2005a). More uniquely, this study had the opportunity to investigate diagnostic and surgical activities usually seen as core part of NHS hospitals being handed to external providers. Therefore here I concentrated on roles that directly contribute to the provision of these clinical services that have hitherto remained predominantly within the NHS: namely the doctors, nurses, healthcare assistants, medical secretaries and the associated administration and management of these groups of staff.

4.6 Research process

Just as the design of the research was strongly influenced by the cases that presented themselves, the research process was shaped by my access and engagement with these study sites. Reflecting back on the research process as a

whole, the overriding personal challenge in the research process was that of 'getting to know' the healthcare environment. At the start of the PhD course I felt myself to be a complete outsider to the healthcare work environment, with only the usual experiences of the NHS in the role of patient and visiting relative to draw upon. Indeed, my initial interest was not in healthcare in particular, but in the rise of Public-Private Partnerships across the UK public sector. My interest was initially spiked by political debate around the notion that PPPs represented a new form of organisation and governance that mitigated some of the failing of purely publicly or privately owned public services, and counter claims that the policy was 'merely' a continuation of trends towards increasing privatisation. Over the subsequent period of study, in which I switched to part time PhD study and a full time research associate role, and spent a significant amount of time in the hospital environment, the research became more specifically focused on healthcare and how PPPs related to a social context characterised by a split between managerial verses professional control. Further, during this time, my feeling of being an outsider changed somewhat. Although there is inevitably far more about healthcare organisational life that I do not know or understand than that which I do, I began to feel comfortable with the limits to my knowledge. One example of this was by the end of the research it was far less common to be concerned before asking a question that I should already know the answer, or that a 'real' healthcare person would not make the same judgments or mistakes. This process occurred gradually over the course of the research, and involved not just the present research, but was helped by the various contacts made and side projects I was involved in during the period.

Prior to entering the first case study site, some level of planning was undertaken in terms of the number of interviews I intended to carry out, with which staff groups, and writing research schedules and questions for each. Reading research manuscripts and talking to supervisors and colleagues experienced in healthcare organisational research helped a great deal in preparing me for my research and provided me with a certain amount of 'insider' information about healthcare, for example the differences in professional groups and the tensions between management and medics. However, without any direct experience of healthcare work, the full significance of these insights was hard to grasp. Although I had conducted numerous qualitative interviews prior to the current study in previous roles, I felt I needed more preparation before entering into the first case study site. Therefore a small 'pilot'

study was carried out, interviewing three people from within the NHS contacted through university links who were involved in setting up an additional ISTC. These initial interviews helped me to understand the weight of the issues at hand for those involved. For example, speaking to an NHS manager involved in identifying how services were being co-ordinated with the ISTC gave me the first indication of some of the emotional as well as technical effort that was being required to re-organise services in addition to her 'day job'. An early alert to the political sensitivity of the initiative was when one of these respondents asked to see my university ID to 'just check you are not from the local newspaper'.

Following this introduction to research in healthcare, over the next five months the majority of the interviews for the first case study, Orthe-ISTC took place. Initial interviews were arranged by the general manager's secretary, but following these respondents were recruited on a snowball basis, with respondents asking if they know of anyone else who may be willing to take part with the numbers of respondents from each group provided below. Appointments with nursing staff were usually made on an ad-hoc basis, depending on who was available on the day when I was present at the ISTC. Managers and medics on the other hand were pre-booked to fit around their schedule. One difference between these two groups was that management interviews often took place in quiet offices away from clinical practice, free time carefully allotted in diaries. Interviews with medics were often fitted around clinical or theatre sessions, during lunch breaks and wherever a quiet corner could be found. This process of finding respondents may well have impacted on who took part in the research, the type of responses they gave and how much time they felt they had to answer the questions. Therefore, it may not be possible to consider this a fair or representative sample. However, arranging these interviews and 'finding my way' around the organisation did help me to familiarise myself with the ISTC. For example, while secretaries in the main administrative office were extremely helpful in putting me in touch with departmental managers, it proved difficult for them to arrange interviews with individual nurses or clinical staff, and it was only through the nursing managers and their equivalent in other departments such as imaging and physiotherapy that contacts within each clinical group began to be made. This was perhaps my first experiences of the inter-occupational boundaries between administrative management and clinical staff.

The introduction to the second case study - General-ISTC - was rather different. As already mentioned, this case study was initially contacted as part of a separate research project. Therefore the initial negotiations were made by the project principle investigator, and were in the first instance with the NHS managers of the departments due to move over to ISTC. Following this, we undertook several interviews with members of staff within the NHS hospital about their work prior to the move. In order to keep the boundaries of the comparative cases roughly similar as identified above most of these interviews were not considered here as part of the analysis on General-ISTC. Some however were called upon to illustrate the process of transferring the staff over from the general hospital. In addition, these interviews undoubtedly had an influence on the rest of the research at within the ISTC. For example, it was inevitable that respondents referred back to work 'in the old place' and discussion about the ISTC between myself and the respondents took on a comparative nature. As well as this heightened awareness of the background and prior working conditions of the transferred staff groups, the process of this case study took a different course. In addition to the qualitative interviews, eight months of observational field work were also undertaken within General-ISTC. Details of the data collected during this period is covered below, but included time spent in administrative and managerial settings, clinical areas including operating theatres and ward areas and staff rest areas such as the coffee room.

One issue raised by the course that this research took is the differing level of detail in the data collected at each site. Spending the same amount of time within the Orthe-ISTC as in the General-ISTC would not have been possible. This certainly could be considered a limitation in the comparative basis of the study. Mitigating this to some extent was the fact that during the period of observation in General-ISTC a number of trips were made back to Orthe-ISTC in order to gain additional data for the ESRC research project. This then allowed me to revisit ideas and emerging categories of analysis in light of my growing experience of the healthcare environment. For example, although I had read plenty of illustrations of medical autonomy and resistance to managerial control, it was not until the period of observation that I recognised the numerous ways this could be manifest in everyday practice. Returning to the Orthe-ISTC then allowed me to explore these themes further on this site in light of this experience. In addition, although no formal period was spent observing clinical practice in Orthe-ISTC, numerous informal conversations with staff took place

in addition to the recorded interviews and considerable time was spent in the inpatient ward adjacent to where most of the interviews took place. Further, part of the ESRC project involved conducting a social network analysis survey on ISTC staff. Because of space considerations, details of this data are not included here. However, collecting this data involved returning to Orthe-ISTC for an additional week conducting the survey often on a one to one basis. Nevertheless, despite these additional opportunities to experience the working life across both sites it is fully recognised that the far greater detail of observations in General-ISTCs may have influenced the study's findings.

4.7 Data collected

A case study strategy allows for collecting multiple sources of data, with collection described by Yin (2003) as a flexible process that:

‘does not follow a formal plan, but the specified information that may become relevant to a case study is not readily predictable. As you collect case study evidence, you must quickly review the evidence and continually ask yourself why events or actors appear as they do. Your judgments may lead to the immediate need to search for additional evidence’ (p 59)

Case studies also allow for ‘methodological triangulation’, in which ‘the flaws of one method are often the strengths of another’ (Denzin, 1989). Triangulation is one of the most widely recognised methods of achieving Denzin and Lincoln’s (2005) criteria for good research: trustworthiness, credibility, transferability and confirm ability. Therefore, several sources of data were collected across the sites.

A key source of data collection across both sites was semi structured qualitative interviews, with 72 interviews conducted across both sites (details listed in tables 4 and 5 below). The length of these interviews ranged from 30 minutes to 1 hour 20 minute, with the mean length of approximately 55 minutes. Each of these was fully transcribed. There was some effort placed in gaining respondents from across the organisation and in different professional groups (given the clinical focus outlined above) that would provide insight relevant to the research questions. This is roughly in line with ideas of ‘purposeful’ or ‘theoretical’ sampling (Glaser and Strauss, 1967; Mason, 1996), which has been seen as more appropriate for case study research than random sampling based on the need for statistical generalisability (Murphy et al

1998). More specifically several groups were actively sought out, having been frequently identified in the previous literature as important constituencies shaping and affected by HRM. Namely;

- HR Managers within the ISTC company
- Other 'corporate' managers from within the ISTC company
- Departmental 'middle' managers
- Medical staff
- 'Front Line' clinical staff, such as nurses, health care assistants and physiotherapists

Semi-structured interviews have been described as 'a type of conversation that are initiated by the interviewer for the specific purpose of obtaining research relevant information and focused by him [sic] on content specified by research objectives of systematic description, prediction or explanation' (Cohen and Manion, 1989: 307). Interview schedules were taken to each interview, although these were used only as a rough guide. A semi-structured format, with certain topics mapped out, allowed me to respond to the subject, letting them lead the content of the interview and to explore ideas or important issues that they brought up. The process of questioning in semi-structured interviews is described by Fetterman (1998: 41) 'The questions typically emerge from the conversation. In some cases, they are serendipitous and result from comments by the participant' and in other cases the researcher has a series of questions to ask the participant and will wait for the most appropriate time to ask them during the conversation'. Also researchers can 'change the way they are worded, give explanations, leave out particular questions which seem inappropriate with a particular interviewee or include additional ones' (Robson, 1993: 231). Changing the initial questions was almost always necessary, as answers to one question invariably covered aspects of others. Therefore, sticking rigidly to the questions would have meant repeating the same ground, and ignoring interesting or important points volunteered by the respondent.

In line the methodological insights previously discussed, a fluid and flexible structure operates from the position that knowledge is situated and contextual, and gives the subject the opportunity to form the basis of the narrative (Mason, 2002). Kvale (1996) suggests that the purpose of the interview is to 'attempt to understand the world from the subject's point of view, to unfold the meaning of peoples' experience,

to discover their lived worlds prior to scientific explanations' (p 2). This meant being attentive to issues that were seemingly important to the respondent in their own terms, rather than putting words into their mouths. It is not claimed however that in so doing I was able to elicit a complete or authentic retelling of the organisation or the respondents' experiences. It also does not mean privileging interviews above other forms of social interaction. Interviews themselves are complex social situations (Alvesson, 2003), in which respondents' accounts are in part produced to fulfil the social requirements of the specific interaction. Interview responses may reflect certain aspects of peoples' perspectives or moral forms, but these may not necessarily be manifest in daily life outside of interview (Silverman, 1993). In my view, and given my experience of comparing interview with observational data, the responses did capture something of the respondents work life outside the room (or corner of the coffee area) in which the interview took place. The type of talk respondents engaged in with me during interview did not differ completely from that which they engaged in with others across the organisation. Similar to the reflections of Parker (2000), the tone and formality of the interviews certainly changed dramatically depending on the age, gender, but particularly the seniority and profession of the respondent. However this also captured something of their role and position within the organisation. For example, senior managers' glossy spin on the organisations achievements, with the occasional confession of 'challenges', were repeated in meetings and peer group contexts (at least while I was present). Equally the troubles and complaints put forward to me by nursing staff were often those that were heard in general talk around the lunch table. Therefore, while not taken as directly representative of a concrete social reality, the interview data was used to build as complete a descriptive account of the ISTCs as possible, in ways that allowed adequate response to the research questions. Mason (2002) states that the semi-structured or unstructured interview has become the most 'natural' method for all qualitative researchers, and certainly within the limits of PhD study, they appeared the most obvious entry point to find out what the ISTC 'were like'. Further, this interview evidence was not seen in isolation but read in relation to wider knowledge of the context of the organisations, supplemented by other sources of data, identified below.

Table 6 List of Interviewees Orthe-ISTC

Interviewee Position	Number of respondents
Managing Director	1
WorldHealth Theatre Sister	1
WorldHealth Ward Sister	
WorldHealth Nurse	6
Agency Nurse	2
Company HR Manager	1 (interviewed twice)
Training and Development Manager	1
ISTC HR Manager	1
WorldHealth Healthcare Assistant	3
Director of Nursing Services	1
Physiotherapist	1
Occupational Therapist	1
Therapy Manager	1
Consultant Anaesthetists	4
Consultant Surgeon	4
Director of Medicine	1
Radiographer	2
Radiography Manager	1
'BigServices' Site Services Manager	1

Table 7 List of Interviewees General-ISTC

Interviewee Position	Number of respondents
NHS employed Theatre Manger (Band 7 Nurse)	1
NHS employed Seconded Sister	3
NHS employed Seconded Nurse	7
NHS employed Seconded ODP	2
BritHealth directly employed Sister	1
BritHealth directly employed Nurse	2
BritHealth directly employed ODP	2
BritHealth directly employed HCA	2
Administration Booking Manager	1
Consultant Anaesthetist	3
Consultant Surgeons	8
BritHealth HRM manager	1
BritHealth Medical Director	2
BritHealth Managing Director	1
Risk and Safety Manger	1
Brithealth Clinical Planning Manager (prior to ISTC opening)	1
Hospital Diagnostic Services Manager (prior to ISTC opening)	1

Within General ISTC, observations were undertaken on 85 separate days, mostly over an 8 month period. This amounted to approximately 220 hours of observations in clinical settings, such as wards, theatre and recovery, and a further 150 hours in non-clinical, administrative, social settings and staff rooms. This included shadowing 62 complete patient journeys through the day surgery process from admission, through surgical procedure, to discharge and also shadowing several members of nursing staff and middle managers to build a picture of the content and pattern of their working day. Whilst on site, observation notes were made including descriptions of events. When appropriate and possible to make more extensive notes these were added to with immediate reflections on the relationship of these events to existing theories, emerging concepts and new ideas about the ISTC. During the period of conducting these observations, I was on site for approximately three days per week. The time spent each day on site varied considerably, from attending a single meeting, to arriving with the early starters at 7.30am and leaving with the 'lates' at 7.30pm. During this time I engaged in periods of formal observation, particularly within the theatre sessions, where I sought permission from all of those present before entering and engaging in only fairly functional conversation in which the roles of 'researcher' and 'researched' were clear. At other points 'observations' involved far more informal conversations with ISTC staff (Gold, 1969). My role during this period is perhaps best described as one of 'peripheral membership' (Adler and Alder, 1987), with my status made clear to all those present where possible. Although I occasionally offered opinions to managers when asked, and did undertake mundane tasks for other groups such as carrying equipment when 'hanging around' clinical areas, any 'participant' role was marginal.

Aside from the notes generated during this sustained period within the ISTC, equally important was the familiarity it gave me with routine aspects of the work environment. These included the language commonly in use for conditions, treatments and equipment, the frequency and type of contact between individuals and groups, the changes in atmosphere and pace of work throughout the working day, the hold-up, delays and tensions that often occurred, the humour and routines of social interaction, and the wide individual differences in how people went about their tasks. In addition to these, the direct observations of practice allowed me to see certain incidents and processes that were revealing as to the character of employment and employment management. One example relating particularly to job

planning was in the transfer of the haemochromatosis service from the main hospital building to the ISTC. Over the course of several days, I attended numerous short formal and informal meetings between nurse managers in the department in which the service was to be housed. Wide ranging discussions took place including deliberation over work responsibility in terms of the administration of the service, questions of job design in terms of who would conduct the phlebotomy treatment and how it would fit with their other tasks, and logistical issues including finding space and time for the service to go ahead. During this period a healthcare assistant (HCA) was asked to temporarily carry out the treatment on an ad hoc basis while these issues were sorted out. Three weeks later, I asked the HCA what had happened to the service. Clearly upset, she showed me a handwritten list of patients and phone numbers with scribbling out and sometimes illegible text, and said that she 'had been given these and just expected to get on with it'. Even though, she said, she hadn't been given any special training, a number of the patient details appeared incorrect or incomplete, she did not have easy access to a phone to contact the patients or use of a room and there was no thorough administration system in place to keep track of the patients. Later, one of the sisters told that they were still thinking about the best way to handle the service, and for the mean time she was 'helping [the HCA] to stay on top of it' and they were looking to improve the record keeping. This arrangement stayed in place for the remainder of the time I spent in observation. Although no conclusions can be drawn from this incident in isolation, it could be seen to draw attention to several issues pertinent to the research themes including the role of the middle nurse managers in designing clinical services and jobs, the absence of HR managers from this process which was seen as a clinical responsibility, issues of rewards and responsibility, resource allocation, the interaction between the main hospital and the ISTC, the relations between the middle managers and the front line staff and issues of training and development.

In addition to the primary data collected from interviews and observations, numerous forms of supporting documentary evidence were also collected. This included; government documentation surrounding ISTCs, such as legislation and guides to good practice; national, local and trade press, which often included opinion pieces from local NHS clinicians and were illustrative of the political interests surrounding ISTCs; publically available minutes of meetings leading up to the ISTC contracts being awarded; company documentation such as publicity material; HR

documentation and internal communications. Particularly useful in providing an idealised overview of clinical processes were the detailed patient pathways produced in each site. Also, the key performance measures for both sites were obtained from the department of health following a freedom of information request. These all informed my understanding of the ISTC.

4.8 Data analysis

While qualitative data has been seen as 'attractive for many reasons: they are rich, full, earthy, holistic, "real"' (Miles, 1979: 590), analysing qualitative data 'is not a simple or quick task. Done properly, it is systematic and rigorous, and therefore labour intensive and time consuming [...] at its heart good qualitative analysis relies on the skill vision and integrity of the research doing that analysis' (Pope, et al, 2000: 116). In qualitative research, analysis usually begins during data collection, as the information already gathered is thought about and influences the remainder of the research (Pope, et. al. 2000). That was certainly the case in this instance. As previously discussed, it was only in the ongoing process of becoming familiar with the nuances of the healthcare environment that the full implications and meaning of the literature informing the study were fully comprehended. 'Analysis' therefore took place on a continual basis, as the data was gathered, as I became more involved with the research sites, and as I continued to explore relevant literature and previous research. As Ragin (1997) states, this adaptively is common as 'case-orientated scholars use flexible analytic frames that can be modified in light of the knowledge of cases that researchers gain in the course of the research' (Ragin, 1997: 27).

Away from the research site, interview transcripts, formal documents and written notes of observations all provided text for analysis; 'the "good stuff" of social science' (Ryan and Bernard, 2000: 769). The 'grounded theory' (Glaser and Strauss, 1967) approach to analysis encourages a systematic (purportedly) inductive approach to dealing with the research material, by a process of thorough coding, classify codes, grouping themes, identification of emerging key concepts, and testing them with other parts of the data (Miles, 1979; Bloor, 1978). Although I did not adopt fully grounded approach, as I developed themes around pre-identified consideration points (section 2.5) as well around the research data, this did provide a basis for systematically handling qualitative data. In careful reading of the text, I sought to identify themes and draw emerging themes together in hierarchical relationships.

Following the initial coding, the themes were checked for consistency, with contradictory ideas placed against each other for further consideration. The emerging ideas were continually related to the initial research questions and important aspects of the literature. Yin (2003) describes a process of 'pattern matching' in which the general shape of the data from each unit of analysis is compared to the predicted outcome scenarios. Others have described qualitative analysis in terms of the cognitive process involved in building themes from data:

'Textual analysis involves mediation between the frames of reference of the researcher and those who produced the text. The aim of the dialogue is to move within the 'hermeneutic circle' in which we comprehend a text by understanding that frame of reference from which it was produced, and appreciate that form of reference by understanding the text. The researchers own frame of reference becomes the springboard from which that circle is entered, and so the circle reaches back to encompass the dialogue between the researcher and the text' (Scott, 1990: 332).

A central part of this type of reading is paying close attention to what is being said by the respondent themselves, rather than attempting to squeeze the data into predefined concepts or theoretical points of view. That is not to say that my ongoing reading of related literature did not impact on the questions asked, who I sought to talk to or the way I heard the responses. Instead it was a question of engaging with the respondents answers and reflecting back on what I had understood from them. In order to handle the text and record the codes for emerging themes I considered various computer software programs and attended training for NVivo. Eventually however, the analysis was done in a Microsoft word document, using colour codes for different respondents and hierarchical levels in the 'outline view' to order themes and sub themes. The primary reason for this choice was flexibility and familiarity of use. In part this was also to facilitate collaboration with the PI on the ESRC funded project.

4.9 Ethical considerations

As already discussed, ISTCs have been a highly politically sensitive policy initiative. This is equally true of the employee terms and conditions and managerial actions within the private sector healthcare companies. Therefore common ethical concerns of social science research needed to be seen in this context.

In practical terms, the most pressing ethical concerns of the study related to seeking, recording and interpreting peoples' opinions, personal information and private concerns, and publishing them to a wider audience. The respondents could each be thought of as having an interest in how the ISTCs were viewed and presented, and also potentially harmed or adversely affected by certain portrayals. In particular, there was a concern prior to the study of managers seeking access to and controlling interview and observational data. This was discussed as part of the negotiations over access, and it was accepted that managers would have no privileged access to data above that which would be made publically available and details of specific respondents would not be discussed. That said it was often managers who were most interested in the process of the study and my impressions of the organisation. Therefore, aspects of finding were discussed with managers where this did not to break agreements for confidentiality and anonymity.

In addition to this, I sought informed consent from each of the research participants where this was possible. This is considered important in order to allow research participants to make a decision over taking part in a study in light of what the study involves and how their responses are likely to be used. Therefore before commencing each interview I provided participants with a brief summary of the research project, including its objectives, methods and outcomes. I also explained that their responses would be anonymised in any publically available outputs emanating from the research. During the process of interviewing and observation, much data was disclosed that could have been considered sensitive. This covered everything from insights into why managerial decisions were 'really' made, direct criticisms of management, personal conversations about family, to people 'dishing the dirt' on colleagues. On several occasions, respondents indicated that they would 'go no further' because of because the conversation was being recorded, usually with a knowing look to the Dictaphone. This was most common when staff were speaking in terms they saw as potentially defamatory towards the management of the ISTC, or when management were speaking in similar terms against their NHS counterparts. Occasionally people indicated to stop the recorder and continued stories and accounts in more personal terms. While these incidents were evidently indicative of the power relationships within the cases and shaped my own understanding, there was obviously a need to deal with this sensitively and confidentially, with these stories not reproduced in the findings.

The most challenging aspect of handling the issue of informed consent was during periods of observation in relatively 'open' areas such as the ward and coffee areas. Given the large number of people passing through these areas from different departments, including junior doctors and student nurses, it would have been impossible to make sure every person I 'observed' had provided consent. For example, I often found myself present when visiting doctors, who were in a rush to get started on their theatre session, discussed issues with ward nurses. Where possible I explained to those working in 'observation' areas what I was doing and the purpose of the research and asked if they were happy for me to be present. As with the interviews I explained how observation notes would be used and assured them of their confidentiality. Over time, this covered a large proportion of the full time ISTC staff. However there were frequently peripheral visitors who it would have been unfeasible to have interrupted and spoken to as they 'popped by'. In general I sought to be sensitive to the situation, and excuse myself from situations in which someone who had not given consent discussed potentially sensitive issues. In the instances of observing patient journeys, I spoke to each patient and provided them with study information. I also sought signed consent prior to the patient entering clinical areas. In addition, only adult patients (over 18) were approached to take part.

4.10 The Case Descriptions

In the portrayals of the two ISTCs that follow, it has been attempted to represent the structure and nature of work within each organisation, informed and supported by the various sources of data and previous concepts discussed in the literature. Each study is presented in four sections which focus on the foundations of the organisation and background to the staff working in the centre, the overriding character of employment, the roles of the doctors, and the roles of the other staff groups. In forming the accounts, consistent attention was paid to the possible foundations of the expressed views on clinical practices, wider organisational behaviour, work activities, whole jobs and treatment processes, taking into account the themes of the informing literature. In particular, this included reflection on the divergent interests and perspectives of the different groups based on job role, professional background, occupational background and other demographic characteristics. Also crucially important were potential tensions between the management and employees. In each case, both the name for the ISTC (Orthe-ISTC and General-ISTC) is used as well as the name for the private company managing the

ISTC (WorldHealth and BritHealth). This was felt to be necessary in order to distinguish between the ISTC encompassing staff members of various companies, and the more discrete unit of the private management company.

Chapter 5 Case Study One: Orthopaedic ISTC

5.1 Introduction

The first case study focuses on a relatively large orthopaedic Treatment Centre (Orthe-ISTC) in an English industrial town. The opening of the treatment centre was announced in 2005, when an UK subsidiary of an international health company ('WorldHealth') operating in North America and the Middle East, was awarded its first contract in the UK by the Department of Health following a period of open tender during the first wave of the Independent Sector Treatment Centre procurement program. The initial contract term was for five years, with the possibility of a further two year extension following review. Although the contract bidding process was largely run by central government, the contract itself was managed by the regional Strategic Health Authority. Payment was guaranteed at approximately £120million over five years on target for 5000 operations a years, with referrals primarily coming from seven local Primary Care Trusts, with extra payments made for additional operations outside of this area.

The ISTC was built by a large contractor commissioned by WorldHealth UK, on waste ground adjacent to the town's existing general hospital about 200 yards away from the nearest building. Although not a direct replacement for any single department within the existing hospital, a number of related services had been cut back during a merger with a larger nearby hospital over the year previous to the ISTC opening. With the design loosely based around models developed in WorldHealth's North American hospitals, WorldHealth UK described the ISTC as a 'one stop shop' where patients receive all diagnostic procedures, for instance MRI or CT scan, on the same day as their consultation, and receive a date for their operation in most cases within the following six weeks. Proclaiming a dedicated 'customer focus', the overarching 'mission' of the centre is to reduce the time patients spend in the system, both in terms of the wait between referral and treatment, and in terms of length of stay in the hospital through reduced waiting times, standardisation of procedures and short recovery times. The ISTC was build over three floors, with the top floor housing four theatres, recovery ward and administration offices, the first floor holding a single ward, with 44 inpatient beds split into two sections. On the ground floor stood the outpatient clinic, physical therapy department, reception, a café serving both the general public and staff, and offices for the site services sub-contractor.

Approximately 3500 surgical procedures were carried out in the first year, and 5100 in the second year (Hospital Episode Statistics). As there was no intensive care unit on site, and no accident and emergency facilities at the adjacent general hospital, the ISTC accepted patients only within lower risk categories for a limited range of procedures. However, over time, as waiting lists were reduced, a different case mix began to be accepted with more day-case treatments, and more complex hand and foot procedures. Patients that experienced complications such as blood clots during the operation were transferred to the partner hospital about 10 miles away.

In line with rules on additionality, Orthe-ISTC was prohibited from employing or engaging any healthcare professionals who were working in the NHS at the time, or had worked in the NHS at any time in the last six months (NHS Employers, 2006). This applied to all medical staff and nursing staff above 'band three' (Health Care Assistants). Following the initial building phase, Orthe-ISTC was mainly composed of people employed through two organisations. Namely WorldHealth, responsible for clinical activity on the ISTC site and a national property support services company ('BigServices Ltd.') responsible for cleaning, catering, engineering, porters and security. In addition to this there was often a large number of agency staff working in the ISTC, as well as two pharmacists employed by the local NHS Acute Trust.

The UK operations of WorldHealth were incorporated as a separate subsidiary of the parent company, with the headquarters in North America. The senior management team within Orthe-ISTC consisted of the registered manager, largely responsible for financial and administrative management, a Chief Medical Officer, responsible for managing the Orthopaedic Surgeons, Anaesthetists and Radiologists, and the Chief of Nursing and Quality, responsible for Nursing staff. These reported to the company Chief Executive, located in a separate head office. The dedicated HRM function consisted of a company senior HR manager, an ISTC HR manager and a HR administrator.

Forming a backdrop to establishment of the ISTC was the relationship with other local health providers and wider NHS. As with other ISTC projects there had been resistance and protest by local professional and community groups to the involvement of the private sector. A letter from GPs had appeared in the local and professional press complaining that they were being forced to refer patients to Orthe-ISTC above other hospitals in order to use the contracted value. And although

the ISTC called itself a 'one-stop shop', in the day to day running of the centre there was often a need to work directly with external organisations and general fit into the wider community. For instance, certain sterilisation and equipment services were carried out in the adjacent hospital, patients had to be referred from PCT and also 'repatriated' to the NHS for ongoing care arranged through GPs and physiotherapists, and certain clinicians looked to the other organisations for training and advice.

The following is a portrayal of the ISTC's activities, concentrating on the character of work and employment present in the ISTC and the forces shaping it. The first two sections outline the challenges of recruitment and building HR practices from scratch and the rapid turnover of staff related to short term nature of employment practices. The nature of work in the ISTC is then described, explaining the effort to arrange clinical work into a production line process, firstly in the push for standardisation of medical work and secondly in the increased regulation and control of other staff groups in the face of high levels of contingency and change..

5.2 Foundations of the ISTC: Recruiting outside the NHS

Given the arrangements for employment Orthe-ISTC could be seen as representing a 'clean break' from the NHS and presented an opportunity for a new approach to health service delivery. It was supplying a new dedicated elective orthopaedic service, within modern purpose built facilities, operated by an organisation new to the UK health market, composed of staff from a wide variety of organisational and cultural backgrounds. As such, the managers of Orthe-ISTC had to start many aspects from scratch with very few of the practices of the centre firmly set in place. In many ways the commercial objectives of the ISTC were clear, as the level of output, as well as payment, were agreed in the original contract. Further income could be made on referrals outside of the agreement made with sponsoring PCTs. Complimenting these comparative straightforward operating aims was a relatively shallow hierarchy within the hospital, with one manager in each day-case in-patient and out-patient care department, reporting to the general manager.

A fairly explicit set of aims were put forward by the general manager, chief medical officer and head of nursing services. The emphasis from the point of view of senior management based on the contract was on getting as many patients through the system, with as few complications as possible, in the shortest time while maintaining

quality and patient satisfaction scores. This approach was spelled out clearly by the CMO:

‘You wouldn’t have cars produced by a state institution, it just doesn’t work. And medicine always has this humanity aspect to it, but in general of course it’s a production process, the same as every other product and process and that applies to who pays for it and that also applies to the managerial mechanisms in place’ (Chief Medical Officer)

However, before the production system could get up and running, the management needed to recruit sufficient staff to fulfil the production requirements. Given that for the most part NHS staff could not be recruited, a major initial activity for the HRM as well as the management group in general was finding the number of staff needed to supply the contracted volume of service. In light of the dominance of the NHS as an employer for clinical health staff this posed a serious challenge and the struggle to recruit and maintain staffing levels continued throughout the course of the research, taking up the majority of the time for the HRM department. An initial Mobilising Staffing Plan was put in place by a consultant who had worked with the parent company’s overseas sites. This stated the minimum number of each type of staff needed to get services up and running and the minimum type of qualifications required. Initially based on overseas operations, this had to be adapted to the nature of operations, the regulations of UK practice, shortages of available staff and, moreover, the necessities of clinical work in practice:

‘we have this model and what we found was it was quite restrictive because we were very much focused on ‘Right, this is our model, so we need one clinical nurse, five operating department practitioners and we need 20 nurses for example’. And obviously you have to have something to work to for obviously budget reasons and everything else but as we were going on and as things become operational, you realise that actually this model is fine in sort of theory but in practice things are very very different.’ (Company HR manager)

Clinical staff other than medics were recruited from a wide variety of places; directly from qualifying, from private hospitals, directly from overseas, or from the NHS following a career break. Further, there was a divide between the routes for finding staff for more generic nursing roles, such as ward nurses, and the more specialised

positions, including doctors, therapy and imaging staff. Non specialised nurses were largely recruited from other lower paying nursing jobs in the local health economy, including nursing homes and private hospitals, as well as in some instances from overseas, (although restrictions were again in place for this). Pay levels and terms and conditions of employment were based on market rates for other private healthcare organisations:

'I've actually recently undertaken a benchmarking exercise with two other private providers. Because you know, I feel now that we're a private provider and that's who we should be comparing with because that's actually where we're pulling the staff from. Because we can't pull them from the NHS anyway' (Company HR Manager)

However, there remained a large difficulty in recruiting sufficient number of staff. Given the amount of staff required to become operational, the focus in the first instance remained on reaching minimal numbers, rather than proactively recruiting based on the nature of the service or a nuanced understanding of the required skill mix:

'Staff were taken on from nursing homes, who'd had no acute nursing knowledge for the previous six months. They were taking on students, so they had no post-qualification experience and were learning bad habits from those who'd been working in nursing homes. So there was experience in years but not in acute nursing.' (Discharge Nurse)

'Some nurses that we've had have been trained by the NHS and couldn't get jobs, so of course they've worked agency for a while, then have been employed here after that period of time.' (Ward Sister)

Accordingly, there were large variations in the knowledge of the nursing workforce employed, particularly in relation to the type of orthopaedic surgery being carried out.

'like a patient a few months ago deteriorated in the night and when I came I said to the nurse 'what's his MEWS score? [Moderated Early Warning Score of vital signs]' And I just got a look of 'what's a MEWS score?' Now I presumed that having done the basic nurse training, they'd understand what a MEWS score was, but they didn't.' (Ward Sister)

On the other hand, staff in more specialist positions tended to have been recruited through personal networks; in the case of medical staff beginning with the Chief Medical Officer, and often based on home-country ties. In this way orthopaedic surgeons and anaesthetists were recruited around three national clusters, with the final group consisting of three Swedish, five German and eight Hungarians. In order to for surgeons to 'hit the ground running' with no need for further training, the company looked only for consultant surgeons. Again however, the lack of staff availability did not allow the option of adhering to strict criteria above having the correct clinical skills in the selection process:

'one ex-colleague of mine knows a surgeon here and I just asked him if I could just come one day, to see hospital. I didn't apply for job I just wanted to see how they work [...] my English was really, really bad I thought to come at first for a few weeks before to go to language school but they needed [me] urgently' (Consultant Anaesthetist)

'And then I think [my husband, an orthopaedic surgeon] was head-hunted by [the CMO]. And [he] said no and [the CMO] asked him 'why?', 'because my wife can't leave her job, she has got her own company' and blah-blah-blah. And 'what is she doing?', 'she's a physio', 'excellent; I need one' (Physiotherapist)

As the second quote illustrates, similar pattern was also seen in other specialist areas such as radiography, physiotherapy and specialist theatre nurses. But whereas sufficient medical staff were found, many of the more specialist roles proved impossible to fill. Especially so as to a large extent the nature of certain roles are defined within the NHS, and therefore do not exist outside of that system.

'I realised they had no infection control nurse... again, people who do infection control work in the NHS and we needed an infection control nurse. Now there are no nurses not working in the NHS who are infection control, so we've had a nightmare getting somebody to do it' (Training and Development Manager)

Accordingly, the treatment centre was opened with a large amount of agency staff filling these roles. It could be said that the use of agency staff did provide the company some degree of control over who was employed through a system of trial

and error, as some of these agency staff were later taken on full time by WorldHealth UK (an example of informal 'temp to perm' contracts' Forde, (2001) whereby agency use acts as a prolonged screening process), while others were 'weeded out' (Theatre Sister). This temporary employment relationship did not though work only one way; at least one agency theatre nurse spoken to informally turned down an offer of a full time role due to the higher rates of daily agency pay, with agency staff mentioning on a number of occasions during conversation that they would not mind working full time for the company, but that they could not afford to. Regardless of the pros and cons of using agency staff, given the difficulties in recruiting for certain roles, ending the use of agency staff was often not possible in reality, at a high cost to WorldHealth:

'I think that they have to be realistic and know that they're agency and they could be laid off at any time. And as it happens they haven't been but that's simply because you know we need the numbers' (Company HR manger)

The ad hoc character of the recruitment process can be seen recurring across many activities of the HR function. In many instances there were large uncertainties due to a lack of specific policies and organisational templates for action, as well as the nature the clinical activities and regulatory environment of the Treatment Centre. Both illustrating, and in part, explaining this, none of the dedicated human resource managers of the main contractor had themselves worked previously in health care, and starting the ISTC involved piecing together practices and key resources as it went along, as well as for the individuals learning to cope in a medical environment. For example, the senior HRM manager of WorldHealth had previously worked for mainly leisure and fitness companies, and found many of the common procedures of healthcare new to her;

'like CRBs, occupational health, the references, the insurance, so following up on everything you know, the work permits from workers coming across from obviously like the more recent European countries since 2004. So all these things that you just sort of stumble across and it's very much like finding your way in the dark' (Company HR Manager)

In light of this lack of pre-existing familiarity of healthcare systems, key ingredients and resources for HRM were brought in from a wide variety of places. For example, specific legal guidelines for employment in health were researched directly from the

CIPD and rough guidelines for minimum level of pay from comparison with other private providers. The nature of clinical processes were in the beginning bought in from the international parent company, although this changed over time as individual managers and employees to bought in additional health practices. Demonstrating the need to find policies where they could, a number of specific employment policies, such as health and safety, infection control, and victimisation policies were in fact transferred from the property services contractor. BigServices Ltd already had contracts within a number of NHS and private hospitals, as well as working in many other industries including airports, hotel and leisure, and had far more developed and standardised employment practices than WorldHealth, including for example, pension plans, integrated pay scales and national training and development schemes.

In fitting these many restrictions and contingencies were central to how HR selected and translated practices. Aside from the key regulations of additionally, other aspects of recruitment, training, qualifications and terms and conditions are regulated by the Healthcare Commission, including audit and quality regimes.

‘Yeah, I mean we are scrutinised to the enth degree. I mean as an example, just talking about infection control still, we had a Healthcare Commission visit in ... I don’t know, maybe June/July time. Now at that time, we didn’t have an infection control nurse, dedicated nurse on site. So anyway, we had this visit and amazingly ... well not amazingly but our infection rates were like zero. And we were marked ... and this is what I’d call a typical NHS bureaucracy and public sector bureaucracy, we were marked as having not met the minimum level of infection control. Because they weren’t looking at the outcomes, they were looking at that we didn’t have that person on site.’
(Company HR Manager)

In addition, both the quantity of ‘output’, and the financing of this had already been agreed. In order to make an acceptable level of profit over the length of the contract, staff costs had to be kept within a fairly specific range. Given the difference between the planned level of staff and the numbers needed in practice, this meant tight budget constraints on what could be offered. Further, the activities of the HR function had to be frequently re-configured to a rapidly changing workforce, explored in the next section.

5.3 The Nature of Employment: Transient Production Work

Closely tied in with the difficulties of recruiting staff, were the connected problems of retaining staff, and training the workforce up to the minimum required standard. Throughout the six month research period, staff turnover remained very high in the ISTC, although the actual degree of turnover varied greatly between departments and clinical specialities. For example, following a period of rapid turnover to begin with where they had to often turn to locum doctors, a relatively stable group of consultant surgeons was established. On the other hand, there was a fairly continuous turnover of staff nurses and other clinicians such as radiography and physiotherapy. For the most part, this resulted in perceptions of a fluid workforce.

‘Yeah, absolutely. I think obviously we have had quite a high turnover of staff since you know, we’ve opened and we need to start retaining the staff that we’ve got’ (Director of Nursing Services)

‘We’ve had one or two that’s been here for like six months, then gone and then come back after another two or three months. We’re trying to keep the same staff’ (Ward Sister)

After only 20 months of being open, with a total WorldHealth workforce of approximately 150, (of which approximately 45 were trained nurses) a ward nurse commented ‘I think of the original staff nurses I’m the only one left here’. (Ward Nurse 1).

In some ways the temporary nature of work in the Treatment Centre was written into the terms of the contract. For staff, the finite end point created by the five year contract length added to the uncertainty of the new venture. Although the treatment centre was in the early stages of its life cycle, there were already concerns being voiced by staff about the future of the centre, with different suggestions and rumours being frequently mentioned;

‘we’re not really in the picture as to what’s going to happen. And we don’t really know what they’ve got planned for the next stage really, so that’s always at the back of everybody’s mind you know, what’s going to happen.’ (Outpatient Nurse)

Amongst managers, there was an awareness of the approaching time for re-negotiation, as well as a degree of uncertainty as to the intentions of either national and regional public bodies to place the contract up for renewal, the terms on which re-negotiation would be based, or indeed the possibility that the centre could be transferred to the local NHS Acute Trust. Therefore, while there was the possibility of the contract being renewed, there was also widespread realisation that the ISTC, and therefore their jobs, was not necessarily permanent.

More immediately, in several other ways the rapid turnover of staff was closely tied in to the nature of the ISTC and the type of work it offered. Work in the ISTC was focused on a very narrow group of orthopaedic treatments on healthy patients with no risk of complications, and therefore little room for variety in medical practice. Leading on from this, systems and procedures were intended to be highly standardised, with very little room for individual deviation from identified 'best practice'. Development opportunities were extremely restricted, and in general, people were employed to do a single highly defined job, rather than into a career structure. The effect of this was made even more dramatic by the fact that ISTC was seen as cut off from the rest of the NHS system with antagonised relationships with other local healthcare organisations leading to a sense of isolation. In addition, and related to the finances of the contract, employment benefits found in the NHS, such as pensions were not offered, and time off for sickness and doctors appointments were closely monitored. Each of these was a significant factor in the work of the ISTC and each is explored further in the following sections. However, in general these can be seen as manifesting themselves simultaneously, with the TC primarily viewed as a source of short to medium term employment by most of the respondents. It was the restriction of immediate development that was most frequently cited as a reason people were either considering leaving the Treatment Centre, or limiting the degree to which they saw the treatment centre as a source of long term employment.

'We had one, two, three ... I think we had four nurses, three anaesthetists ... three consultant anaesthetists and one of the OT's is going, she's going to senior post back in the NHS. There's nowhere to move, there's no room to go anywhere; you're here and there's no room for progression' (Ward Nurse).

Again this resulted in further agency nurses and temporary staff being required. The agency staff themselves often had more acute experience than the direct hire staff, and were often praised by management as being some of the best staff, although others saw them as a burden that had to be carried. In addition, there were attempts to keep the same temporary staff over time to provide week by week stability, although this was often not possible, with the presence of agency workers contributed further to perceptions of instability of the workforce.

‘this place would have sunk without the agency staff. They worked really hard, they were paid a good rate of pay but they’ve done really well and they’ve worked really hard and they’ve been involved in the setting up and commissioning of this service, which is ... which I think is really good. And they were actually appreciated but on the other hand, they were also ... there were also some that weren’t appreciated’ (Discharge Nurse).

‘... Another big challenge for Becks and I were the numbers of locums coming through at the time, to try and fill the gaps for us. Even though we had locums here we were doing very long hours. When you have locums coming through, and you can’t leave them in here because they don’t know what they’re doing.’ (Radiographer)

This more transient nature of the workforce undoubtedly had a bearing on the process of the research. Attempting to build rapport with groups outside the senior management team was problematic, as there were consistently large changes in the middle management within clinical departments. Over the period of research, the three ward sisters, two specialist theatre nurses, the manager of the physical therapies department and lead radiographer with whom I had had contact all changed at least once. Many of the staff interviewed had moved on by the end of the research period, making it difficult to build up a feeling of ‘getting to know’ the place, or follow up specific points with people over time. Interestingly the property services company had a relatively stable group of staff, with only three people reported as leaving during the first year. Throughout the research, reception and security staff acted as a point of contact and familiarity as they were often more aware than clinical staff of the layout of the building, which rooms were likely to be free for interview, and the comings and goings of staff across the various clinical departments.

It was also evident that the issue of staff turnover was strongly related to the type of training and more importantly opportunities for career developed offered by the centre. As part of the first wave of treatment centres, Orthe-ISTC was not required to provide training to medical or nursing students, and were to a certain extent free to provide their own models of training and development. Given the number of staff being employed that were new to acute care in general and orthopaedic care in particular, training resources had to cater in the first instance for those to get the required skill levels to practice, defined by both professional associations, local contract performance indicators and national regulations monitored by the Healthcare Commission. Although not in the initial plan for the centre, after only a few months a training department needed to be set up run by an experienced NHS nursing tutor who had recently set up training schemes in other private hospitals. Given the lack of knowledge of healthcare in the HRM department, the responsibility for identifying training needs and finding time to carry out sessions was then devolved to her, with the focus firmly on 'Bread and Butter' (Training and development Manager) aspects of nursing. In some ways this internal training model gave the company some flexibility as to the courses it supplied, and design training around the needs of the ISTC. For example, key skills training was offered to both WorldHealth and the site services staff when required. However, perhaps on a more fundamental level, the need to focus on generic skills resulted in a kind of a catch 22, in which the turnover of staff lowered the standards of the training provided, and the lack of training and development opportunities leading to the exit of the more highly skilled staff.

'So it's responsive, its fire fighting really. I want to move away from the fire fighting, to this kind of professional development. I want all our nurses to go on to the degree module for orthopaedic nursing because it's such a speciality. And that's what we should be focusing on but we can't yet' (Training and Development Manger)

As this quote suggests there was some hope that the situation will improve over time, but given present circumstances 'can't yet'. This view echoed by an occupational therapist that was in the process of leaving the TC, having already found a position within the NHS.

'It's improved a lot in the time I've been here but it's not as well-established, as it is within the NHS where I've worked before, and they have much more in-house training. Which is starting to happen here but we would do it maybe once or twice a month, have an afternoon or an hour session with either a specialist within our own team or within the Trust. But there's nowhere near as much of that here' (Occupational Therapist)

In order to deal with this a number of staff had gone to fairly long lengths to organise training opportunities individually. For example, one theatre nurse had arranged to work one day per week in her own time within a private hospital doing a wider span of surgical procedures. The NHS pharmacists on the other hand were allowed as part of the Service Level Agreement with the local trust to work elsewhere for part of their time in order to stay in touch with changes to practice and a wider social network. This type of training relied on the individuals' willingness and ability to find time to train outside of normal working hours and normal working environment. Given the strained political relationships with other local healthcare providers this was not always easy. Three other nursing and one other medical respondent reported getting in touch with other local health organisations with a view to receiving specific training or to build more general links with professional colleagues, but met with resistance or hostility. For example one nurse approached the adjacent hospital for training;

'And they said no because they didn't see me as a colleague, they saw me as an enemy. She said that directly to me. But I can see their point of view, they can see lots of money being poured into here and they've got wards closing down, people losing jobs' (Theatre Nurse).

This hostility also points to a final challenge the ISTC faced in retaining staff. The separation from other local healthcare organisations and wider professional communities left many people feeling isolated and cut off from outside networks. In some cases this also included growing feelings of resentment to the NHS for excluding them and dealing with the ISTCs unfairly. On an individual level, people did manage to form some connections outside of the ISTC. This was usually based on previous places they had happened to work, or through persevering with making contacts and joining professional groups in the face of antagonism. This problem was exacerbated for overseas staff who were not connected to national professional

institutions or personal networks, for example an anaesthetist seeking to join the Royal College reported she was unable to as this required nominations from two existing members. Others felt excluded from the informal knowledge exchange that was more freely available as part of the NHS:

‘The biggest difference is the networking. When I was in the NHS, I would ... if I had a problem, I could network with the other senior nurses within the Trust. So in comparison to that, I’m very restricted here, as to where I can pull information from. Whereas there I could go out and network and that’s the difference, that’s how I feel I feel I am it, there is nobody else, it’s me.’
(Ward Nurse)

5.4 Medical Roles in Orthe-ISTC

As previously indicated, there were a number of differences in the organisation of work in Orthe-ISTC compared to traditional NHS models. To begin with, the ISTC was designed specifically around a narrow group of surgical procedures and the associated support functions such as radiology and post-operative therapies. The emphasis from the point of view of senior management based on the contract was on getting as many patients through the system, with as few complications as possible, in the shortest time. The ethos was put across clearly by one of the consultant surgeons;

‘you can say it’s like a Ryan Air hospital, we don’t do any complications. Patients who actually need more input with a diabetic nurse or a patient who’s really ill that needs a new hip, they shouldn’t be operated here [...] we cherry-pick them and we should cherry-pick them because the contract is set up like a cherry-picking’ (Consultant Surgeon)

While ‘cherry picking’ patients is often levelled as a criticism against new private sector providers in both public discussions and statements by health professions (BMA, 2005), here it appeared to be embraced through logic of economies of scale and the rhetoric of patient choice. ‘Healthy’ patients requiring simpler, lower cost procedures are separated from ‘sick’ patients who require more particularised (expensive) treatment. Over the first year, the average length of stay following joint replacement of 3.28 days against an average in a local NHS hospital of 9.4 days (NHS Improvement Network, 2008). This should not be taken as a direct comparison as the

ISTC only accepted low risk patients (up to ASA level 3), with some research actually showing that the ISTC programme has pushed the average time of treatment for the remaining patients in the NHS up (Sayana, Wynn-Jones, 2008). However, it is indicative of the ISTC approach, seeking to limit the variety of patients, as well as variations in practice. Overall, the role of medics proscribed by the company can be characterised as one of highly skilled production workers.

This required a move away from the established professional role of hospital doctors seen in the NHS, with multiple areas of authority and responsibility, towards one of 'jobbing clinician'. Rather than employing a range of doctors at different career levels, the company employed only consultant orthopaedic surgeons and consultant anaesthetists that required no further training or development to practice within the 'production' roles. Further, compared to 'usual' work within general hospitals, the roles and routines of these doctors were more highly standardised, with a push for consensus over procedures and equipment. Although the medics came from a variety of cultural backgrounds with a variety of health practices, some pressure was put on them to converge on a single approach to each type of condition, for example, all surgeons using the same type of joint replacement. Although this was not contractually forced, deviation from TC standard procedure required a long process of research and evidence presented to the other consultants, in particular the CMO.

'we tried here to standardise the treatment and my view is try to keep it as simple as possible and the ones who do things more complicated has to prove the value of it. So we've had a lot of discussions about that but still in the main questions we have agreed on a consensus how to do things.'
(Consultant Surgeon)'

As well as a standardisation of practices, the ISTC also involved a certain narrowing of the doctor's role, with a reduction of input into the way work was organised. With the exception of one self-employed surgeon, all of the anaesthetists and surgeons were employed directly by WorldHealth on a full time basis, with their time and activity largely planned by the ISTC management and administration. Usually, this involved seven clinical sessions a week, either in theatre or consulting with patients, and three session of administration. In addition, they were also offered payments for doing additional cases by doing extra sessions or adding patients to existing lists. The lists were compiled by the group of schedulers who for the most part were in control

of managing the waiting times and arranging appointment dates, with some negotiation with the operating surgeon. While this might be ostensibly similar to other hospitals and theatre departments, consultants elsewhere may be expected to carry out a number of other duties, such as training other clinicians, involvement in administration and contributing to hospital policies. As many of these extra responsibilities were not present in the ISTC, in effect this allowed ISTC management tighter control over the doctors' time at work, as there were less competing pressures on them.

'I mean I'm happy to come in and do my hours, then when I'm finishing I'm going home. If I have a theatre session, I'm doing a theatre session, if I'm on-call, I'm looking after the patients who are going through the clinics.
(Consultant Anaesthetist)

In certain ways this extended to passing on responsibilities to other employees, as well as becoming more responsive to the flow of patients. As one of the major 'selling points' of the ISTC was that all pre-assessment as well as the consultation with the operating surgeon were to be done on the same day, this involved consultants making themselves available until all patients had been seen, even if they arrived on the wrong date, and allowing the nursing and administrative staff to organise their time:

'I mean this is different really because we work closely with the surgeons because you're running their clinic, you know. I think one of them said to me 'Will you come and be my boss today?' he liked me bossing him about because I run his clinics for him' (Health Care Assistant, Outpatients)

From the surgeons point of view this perhaps fitted in with their simplified role, allowing them to concentrate on their 'core production tasks', of surgery and consultation. Although none of the consultants had come from the NHS, in general the move to the ISTC represented a move to more straightforward, undemanding, routine work. In different ways all of the surgeons and anaesthetists staff recognised this changed nature of their role within the company. They clearly saw the orientation of the ISTC towards high speed, uncomplicated and routine operations, and replication of practice, with a relatively small role for development either in terms of personal learning or in terms of input into the way the treatment centre was

run. Therefore, all of the medics remaining in the employment of WorldHealth were to some extent either explicitly or implicitly accepting this new role.

A key question then was the extent to which this was willingly embraced. For most, there was some feeling that overall the ISTC represented a simplification of their working life; in contrast to their 'normal' medical practice, the work as the treatment centre was seen as straightforward and well rewarded.

'So I can go back to Germany but I don't want to do it because as I say to you, it was a really difficult job, Much more interesting than here, as a position, as an anaesthetist, much more interesting but difficult because all the nights, resuscitation, plus other patients, anaesthesia care ... so I can't because I got older, I can't do it longer' (Consultant Anaesthetist)

In some instances this feeling was tied into expressions of the health systems which they had left behind which required deep involvement in the large organisations and the associated politics, the demands on their time, multiple roles, the need to manage and teach others and take responsibility for difficult and messy medical practices.

'In Hungary I did not know in the morning what I had to do that day, even in the next three hours sometimes, I didn't stop, I had to see patients and I had to work in the theatre, I had a lot of patients up on ICU and I had to go for several meetings. It was absolutely crazy. And it wasn't just my department, there is no comparison' (Consultant Anaesthetist)

Most clearly stated, the work in the ISTC was described as a professional break from normal practice, a chance to live temporarily in the UK, follow other life pursuits and learn English: 'I tell everybody I am on a big holiday at the moment. And it's not meaning I'm not happy to work but I still feel it's a holiday' (Consultant Anaesthetist). This perhaps offers an explanation as to why doctors may have been willing to accept a more tightly controlled role. As a well paid 'holiday', the work in the ISTC was seen as an addition to, rather than alternative from, normal practice and everyday working lives. Indeed, most respondents talked about possibly returning to their own country, or moving on to other ventures or activities; in one case possibly exporting the ISTC model elsewhere, or in another case saving enough money to participate in voluntary work before retirement.

In this way, the ISTC could be seen as providing a type of choice in the employment market, allowing doctors to opt for a different type of work in a different type of health organisation, (although this choice is heavily curtailed by the employment regulations surrounding ISTC's). At the same time, many aspects of the roles on offer presented other concerns. Anaesthetists who had previously worked on a greater variety of treatments were concerned about their wider professional role and access to training and development opportunities, as well as the general downgrading of their skills through the routinisation of work. For this reason, one anaesthetist had arranged to spend two weeks working at the ISTC and two weeks doing 'proper' cardiac work:

'Anaesthetists do not only orthopaedic surgery, they can do other surgeon, thoracic surgery, neuro surgery ... but we have nothing here. It means if we just stay here, after a while we will be de-skilled.' (Consultant Anaesthetist)

Furthermore, it well recognised that by working in the ISTC they were giving up some of the status and support that they enjoyed within general teaching hospitals:

'At Frankfurt University for example, I was used to working with two younger surgeons at the table, doing a hip or knee joint replacement. In this country, I have a leg holder, which is a nurse, holding the leg and maybe a colleague doing some sections but all the rest I have to do myself' (Consultant Surgeon)

In light of this narrower role and the more temporary nature of the employment relationship, the level of pay was often cited as a key incentive for staying at the ISTC, with an idea that routine nature of the work was counterbalanced by the level of pay they received, above what could be expected elsewhere. While this was slightly less than similar levels in the NHS and countered some aspects of NHS employment with consistently higher pay for Surgeons than Anaesthetists, given the international cohort, this was usually measured against their home, and other European countries:

'My feeling is it's not stressful and the payment is very high for consultants compared to Germany, it's very high. If you ask me, I would ... maybe it's stupid but I think it doesn't need it.' (Consultant Anaesthetist)

In addition, amongst the respondents then there was a range of reactions as to how much their own circumstances allowed them to buy into the idea of the ISTC as a health production line. While this may have depended on many things, a key point

would appear to be how able they felt they were to give up some of the autonomy of usual practice in return for a more straightforward working life. Such a sacrifice would appear closely tied to the stage of their career, personal ambitions and opportunities and risks created for future employment. For some, it was seen as a positive, as long as it was kept in perspective; 'it's easy here if you have a straightforward approach and try to keep it simple and here,' and were happy to push for further standardisation is seen as an improvement; 'We can't reach 100% but we are, even the Germans now, they are closing together and they change their routines and so after a while, maybe we get closer and closer' (Consultant Surgeon). Others however described more reticence towards the ISTC and its management, and working in the TC was more matter of more passive acceptance rather than active engagement:

'Yeah, if you want to make any change, so you have to prove it that it works doing it financially, doing ... it's worth doing for the patient, it's better for the doctors, it's better for the nurses and you have to do everything and everything and everything. So sometimes I feel that it's easier just to give it up.' (Consultant Surgeon)

More overt medical resistance was reported in anecdotal evidence, such as a story repeated on a number of occasions of an anaesthetist who would insist on accepting patients above the recommended risk level, in spite of warnings from the pre-operative nurses. However, and perhaps again illustrative of the employment relationship between medics and the ISTC, by the time the research was undertaken this doctor had left.

5.5 Nursing and Other Work Roles in Orthe-ISTC

For the non-medical staff, similar themes of increasing efficiency and standardisation of practice could again be identified. To begin with, nursing roles were designed around the three separate areas of outpatients/pre-assessments, theatre, recovery and ward. For the content of day to day work, within each of these departments, the nature of nursing care was based around traditional roles and hierarchies, with tasks divided between senior nurses, registered nurses, operating department practitioners and health care assistants, with little directed push to dramatically re-configure these roles around new models of care. Equally, other staff groups were

often expected to get on with the proscribed work as best they could, according to training and previous experience.

‘Wherever you go, that role does not alter, you still have the same concepts, you still have the same knowledge of care. Before I’d left the NHS, I was a ward nurse anyway, so I’d been a senior ward nurse for quite some time. So my role here is virtually the same, although obviously the patients are orthopaedic and I wasn’t an orthopaedic nurse before, I was cardio-thoracic. But then basic nursing care is exactly the same’ (Ward Nurse)

However, before the centre opened there was some effort to more thoroughly make the content of these job roles more explicit, with detailed patient pathways and decision trees with standard operating procedures describing the order of work to be done for each treatment. This also conveyed which job roles were to carry out each part of the pathway and the minimum level of training and qualifications needed to do so. Although in the first instance these were developed with assistance from management consultants from the international parent company, these were also tailored specifically for the centre by the Head of Nursing Services, who had worked in previously in private hospitals on NHS contracts. Again the emphasis was on standardising practice and making sure all staff followed the same guidelines and procedures. From the management point of view, spelling out the exact nature of each role was felt to be necessary given the experience and short tenure of most of the staff:

‘If you get a member of staff coming in saying ‘oh we’ve got this patient to treat but we don’t know what to do about it’. But if you’ve got a policy and procedure in place, they can say oh yeah, if this kind of patient comes to us, we know what to do with this patient, we follow this procedure.’ (Director of Nursing Services)

‘There are lots of policies. Policies for everything. You have to follow all of the guidelines that are set and you don’t really deviate from that unless there’s a good reason. And then of course, you have to document everything as well. But there are quite strict policies for most things.’ (Outpatient Nurse)

This could be seen as an attempt by management to control nursing work, and make the activities of individuals and departments more accountable for each part of the process, taking away some of the requirements for individual input and autonomy. In making people stick closely to the rules, the ISTC was seen as reducing the scope of the nursing role, so that people could only act if officially sanctioned to do so. The pressure to work to guidelines set by management was clearly put across by a number of respondents. For some there was a feeling that the emphasis on explicit work guidelines meant certain aspects of nursing work were being removed or curtailed. This included a view that the ISTC was undermining the some aspects of the nursing role. For example one nurse stated the emphasis on set roles were reducing the degree of autonomy and individual judgment involved in nursing:

‘there are managers who don’t look at the person that’s in the role, they only look at the role and how that role’s being done. And if it’s not ... and instead of helping that person to do that role, they would rather slap them on the head and say ‘you’re not doing that role; you do it how I tell you or not at all’
(Theatre Nurse)

In other cases it was the more caring aspects of the nursing that were being removed:

‘As nurses, we are trying to look at the patient holistically, so as a whole; they’re not just a knee, they’re not just a shoulder, they’re not just a hip, they’re a whole person and they have everything surrounding them, their family... we have discussed this today; the ethos here... potentially the ethos of ... is that they’re a joint getting through the door.’ (Ward Nurse)

In general this was seen as challenging the ‘professional’ aspect of nursing:

‘Here, a nurse is a nurse, not an extended practitioner. We can do some extended roles but not as freely as we could within the NHS. There is no longer a recognised scope of practice as there used to be. Whether it will develop in the future, I don’t know, with competencies and evidence-based practice. But it’s making sure that the consultants here recognise those competencies and that evidence-based practice. And it’s a belief that the nurses are professionals not just their handmaidens. Within the NHS we’re

professionals; here, presently, we are just nurses, that's what I'm trying to say.' (Theatre Nurse)

In making an explicit contrast between being a 'professional' against being 'just nurses', appears to suggest that for this respondent, a comparison was being made between their role in the ISTC and what a professional should be. In this case, the emphasis of professionalism is on 'extended practice', 'evidence-based practice' and involvement in wider roles. For the most part, these views of reducing professionalism were most strongly perceived by staff who had worked at some point in the NHS, rather than nurses from the private sector or straight from training. Nurses from the private sector were far less overtly resistant to the work practices within the ISTC. While they also recognised that audit processes and paperwork played a large part in shaping their practice, they did not see this as something that was unique to WorldHealth and was common across many private healthcare companies:

'Yeah, I think it's because of the sort of atmosphere of litigation that's around but it's for people's safety. It's a bit of a pain sometimes you know, because sometimes you think if you just use your common sense or whatever, you have to ...So there's quite a lot of red tape really. But it's a culture that I'm certainly quite familiar with from [a private sector hospital]. And so are the people who work here.' (Ward Nurse)

As well as an attempt to control nursing work, this emphasis on regulating and explicating practices, and 'transparency', could also be seen in relation to the tight quality and performance measures the ISTC was under. Given the basis for commissioning, the management were under pressure to fulfil contractual and regulatory targets. Therefore, certain behaviours and activities that were to be subject to measurement and inspection sought to be tightly controlled. Aside from an emphasis on output, this included an increasing focus on waiting list times, audit trails, safety and legal procedures and scores of patient satisfaction.

Given the sensitivity of the ISTC project in the public eye, this final point of patient satisfaction was of particular importance for management seeking to establish a positive reputation. 'Customer service training' was supplied by an external management consultant that sought to "help all staff appreciate their role in helping to provide patients and customers with an exceptional experience" as well as

“establish appropriate behaviours towards patients, customers and each other” (Training Review Document). Detailed questionnaires to measure patient satisfaction were given to patients as they were discharged. In addition, communication from management often stressed how the work of the ISTC would be judged on keeping patients happy;

‘they are very patient orientated, management. What the patient needs is paramount, most definitely. A bit more than what I’ve been used to in [previous hospital], because it’s ... it’s not just nursing staff, it goes higher than that’ (Theatre Nurse)

For some staff, this focus on patient satisfaction could indeed be seen in some ways as extending aspects of certain job roles. Contradicting the view of more limited approach to healthcare work, there were some signs that a ‘customer orientation’ was extending the usual responsibilities of some staff. An example of this was in the HCA patient escort role, in which they guided outpatients through the system, making sure they arrived at each diagnostic appointment on time and in the right order so as not to disrupt the patient flow. This allowed them movement around the ISTC and to work more closely with different grades of clinical staff, and in part direct the flow of activity.

In general however, the focus of management was on compliance to guidelines and set procedures, sometimes seen as limiting the scope of professional practice and individual decision making. Although some aspects of nursing practice remained similar, it could be suggested that the management were trying to instil a particular version of nursing work. In this, there is some evidence that a different approach to work was indeed introduced. For example, daily schedules, theatre lists and planning timetables were stuck to fairly consistently; with senior managers often pushing departmental managers on the need to make sure individuals were maintaining their activities in line with ISTC goals. Evidence that this was achieved is provided by a host of performance measures including the KPI’s which indicated procedures were indeed being closely following including the generally short waiting times, and meeting the contracted capacity for operations and procedures. Also, there was constant pressure from senior managers to make sure new DoH guidelines, such as rules governing the way patient information was kept, and recording practices, were strictly adhered to. Again collected statistics support this, such as the 100% rate of

reporting of operation details for the National Joint Register, compared with an average in 2008 of 83% for NHS organisations and 93% for other private organisations in the region (njrcentre.org, 2008). Respondents also reported a push for all surgical sessions to start and finish on time, and the need to continue working until all patients had been seen;

‘like we start with our system here at 8 o’clock and by 9 o’clock the first patient will have been operated on and in recovery. In the NHS, the staff will start duty at 8 o’clock and by 10 o’clock the first patient would be on the table’ (Director of Nursing Services)

‘The clinic doesn’t have a cut-off point, or the last appointment five o’clock, and if there was 10, 20 or one patient to be seen, staff stay until that clinic finished with that last patient, that last patient has been seen off the premises’ (Consultant Anaesthetist)

Interestingly, it was recognised by management that the lack of experience and established approach to work of many employees increased their control over staff. This allowed them to promote the ‘correct’ TC approach and shape peoples work to the managerial, contractual and regulatory goals of the TC:

‘obviously we had to recruit from other [non NHS] private providers or from nursing homes, where they lacked the experience. And when you’ve got that calibre of staff, you can educate them and adapt them to the way you want your unit to run. And just really educating staff and sort of teaching them the efficiency of improving the service and what are the results at the end of it.’ (Head of Nursing Services)

So, while employing a certain ‘calibre’ staff may have been forced on the ISTC, this handed management increased authority to regulate practices and enforce rules. On the other hand, closely regulating practices seemingly had a number of negative consequences from the point of view of both management and staff. For example there is some evidence that while this may have resulted in compliance, regulation also involved perceptions of reduced autonomy of decision making. It also could be seen as contributing to a workplace that was generally seen as a short term job rather than career or vocation. Aside from the costs of recruitment and agency staff, this was seen as causing difficulties for both remaining employees and management.

In particular, people pointed to the difficulties in establishing stable working patterns, practices and relationships. Many respondents described a situation in which practices changed on a daily basis as different departments learned to cope with the type and quantity of work, and changes in personnel:

‘Because as I said, when they first opened, like all paperwork was ... watch this space, it changed as often as you changed your socks, the paperwork did, and you were coming in every day and something was different [...] Because there was no plan as such you know, how each department was going to be run. And it was just like stumbling along until you got the system in place’
(Theatre Nurse)

‘The fact that it’s new means that yeah, people are still learning the best ways of going about things and so, there’s a sort of constant feeling of change. But then, if that’s the way things are, that’s the way things are. So people don’t really worry about it.’ (Ward Sister)

Changes had to be made in response to any number of contingencies. To name a few common patterns, practices were altered to due to time constraints, bottlenecks in the flow of patients and communications between departments, patients and conditions that did not fit exactly into the patient pathway decision diagrams, different ways of working bought in by medics staff and departmental managers, the skills and competencies of the employees, glitches in the computer system, problems due to lack of patient information available from local NHS Trusts. For each individual contingency, a multitude of different forces and interests how individual issues panned out, but in general, these did often mean that the exact nature of people’s jobs and responsibilities altered on a day to day basis as new solutions and ideas were brought in. This offered a limited scope for clinicians to assert their own approaches to practice, with managers relying on departmental managers and staff to tell them how things need to be done. Furthermore, contradicting efforts to relate particular tasks to job roles and staff grades, responsibilities were often strongly affected by the individuals’ tenure within the organisation, particularly in light of frequent staff changes. So people who had been present longer in a particular department often found themselves taking on additional roles, regardless of their training. For example, following the rapid departure of three radiographers, two junior employees were asked to take over management of the imaging department;

'I came to England to travel, earn some money, have a look around. At home, in New Zealand, I was a junior radiographer, I was 12 months qualified. We came here and within a month and a half/two months of being here, Cath [other junior radiographer from New Zealand] and I were the only two people remaining in this department [...] And so I went from being a junior radiographer with no responsibilities to being a junior radiographer with the entire radiology department on our shoulders.' (Radiographer)

At the time of the above interview, an imaging department manager had been recently employed over them, although it was evident that the junior radiographers were, to a large extent, training him in the ISTC systems and IT, and by the time the research was complete he had again left (and so too had both of the New Zealanders). Equally, other staff who had remained at the ISTC for the first two years often took on additional responsibilities and training roles regardless of position:

'Well because ... well, when we first opened things were changing on a daily basis and I had to try and get everything as well run as possible. So ... and then any other staff that came after that, I trained them you know, what we did on a clinic day' (Theatre HCA).

On the other hand, more experienced staff in either temporary roles or who were new to the ISTC were limited in the scope of their practice due to the time taken to learn the new systems:

'It's difficult in the Outpatient Department getting agency staff because they don't know the pre-assessment process. So it's debatable exactly how much of a help they can be. So they tend to take on a far more junior role than they're probably capable of doing because we can't have them pre-assessing. So they mainly get to do the dressings, if there are any, doing people's obs you know, I think they find it a bit boring, just because it's very repetitive and they're not really using all the skills they have. (Outpatient Senior Nurse)

The lack of experience in the organisation, absence of established actions and patterns of behaviour, combined with gaps in staffing stood somewhat in the face of certainty required for managers to maintain control. So while senior managers were keen to enforce certain rules and guidelines for individuals to ensure the contract was maintained and targets and regulations were met, what these were and how

these fitted together changed very frequently as the ISTC developed. Alongside lack of room for development, the restricted nature of the nursing and other job roles could also help explain the rapid turnover of staff in roles which required more experience, such as theatre nurses. It could be suggested that management were able to push through their approach only at the expense of having continually find new staff willing to accept less clinical input, as well as the uncertain, temporary, employment relationship.

Therefore, the processes for producing high volume elective care surgery were built into the physical and social 'architecture' of the hospital, with the nature of tasks and their division between groups made more explicit. However, the emerging roles of different groups were also tied with the process and challenges of setting up the centre, including significantly the regulations over employment, as well as the conception of the ISTC as a producer of narrow healthcare services.

Chapter 6 Case Study Two: General ISTC

6.1 Introduction

The second case study focuses on a large general ISTC (General-ISTC) located within a large English city opening in 2008. This represented the first major contract for BritHealth, a UK start up private health company. This ISTC was based within a large purpose built extension to the rear of an existing large general teaching hospital, itself employing approximately 6000 people and part of a larger city-wide Acute Trust. The annual value of the contract was £40 million over an initial term of five years. The main Project Agreement was signed by seven sponsor PCTs in the region, from which patients were to be referred.

The original contract specified 13 specialities were to be transferred from across the Acute Trust. Namely the specialties transferred were Cardiology, Respiratory Medicine, Diabetes, Rheumatology, Dermatology, Orthopaedics – General and Hand, Gynaecology, Colorectal Surgery, Vascular Surgery, Hepatobiliary Surgery, Gastroenterology, Pain Management and Oral Surgery. These were gradually transferred across from the Trust to the ISTC over a period of approximately two years. This original schedule for transferring each specialty was periodically modified as different issues arose, with specialties often partially transferred for a given time. For example in some cases, clinics for seeing patients pre and post operatively took place on certain days of the week in the ISTC, and on the others within their original location within the Trust. Levels of service were based on outturn levels in the year previous to the treatment centre opening.

The contracted activities of the treatment centre were specified in the main Project Agreement which outlined precisely the services that the ISTC would supply, involving agreements with the PCTs commissioning the services and referring patients and with the Acute Trusts in terms of which services would be replaced in the adjoining hospital and the associated management arrangements. Governance and performance management involved a complex structure of committees, schedules for inspections and review, performance indicators, throughput volume requirements, and quality and safety checks. In most cases these involved participants from the sponsoring PCTs, as well as representatives from the acute trust. As patient pathways often crossed between the Acute Trust and the ISTC, some

of the review systems involved reviews of activity that encompassed both organisations.

Two additional important initial contracts were drawn up during the planning stages, binding the ISTC to the Acute Trust. The first covered the purchase of clinical services and facilities management by Brithealth from the acute trust through Staff Services Agreements (SSA's). The second covered the supply of services needed to support the ISTC, such as diagnostic services, known as Service Level Agreements (SLAs), some of which took place both within the ISTC and the General hospital. For the most part, medics working in the ISTC retained their original contracts, but saw some of their sessions moved over to the ISTC. In practice, both of these involved the secondment and physical transfer of staff and managers to the ISTC, while they retained the employment conditions of the NHS in terms of pay, benefits and employment conditions.

In a similar structure to the previous case this chapter presents a description of employment activities within the ISTC. The first section examines the origins of General-ISTC, illustrating how this could be seen as an extension of existing organisational activities in the Acute Hospital Trust, rather than a distinct break from the past. The second section examines the overriding character of the centre with regards to the nature of employment and the mixed workplace within the General-ISTC resulting from the secondment of NHS employees working alongside directly employed staff. The final two sections discuss the roles of medical and nursing staff, emphasising the interplay of existing professional groups, as well as the influence and divisions of the multi-employer workplace in the emerging norms of work, jobs content, divisions of labour, and medical and healthcare practices.

6.2 Foundation of the ISTC: Transferring the Service

In line with national policy, amongst the early team of BritHealth and seconded managers involved in starting up the ISTC, there was an expectation that the new organisation could be a catalyst for wider change. One manager interviewed in the year preceding the opening of the new ISTC facilities emphasised ideals of change, efficiency and patient focus:

'This is the whole reason for the treatment centre in the first place, for the trust to engage in it and for it to be a catalyst for change, and it would kind of

shine a light on the way we do things at the moment. And we would get real opportunities that we could transfer from patient to patient' (BritHealth Clinical Planning Manager)

However, although General ISTC may have been intended as a new venture intended to introduce innovation in many ways it can be seen as connected to the existing general hospital with several aspects of continuity as well as change. In the previous chapter it was described how Orthe-ISTC was created away from existing NHS organisations, with the managers and staff bought together from a wide variety of cultural and organisational backgrounds. General ISTC was from the very beginning a completely different proposition. Many parts of treatment centres development were bound up within the activities of the acute trust, and involved many of the same stakeholders, including managers, medics, other healthcare professions, patients and representative groups. This led to widespread perceptions of continuity of existing practices and norms from the general hospital to the ISTC.

Perhaps the most important source of this continuity was the arrangements for employment, which were written into the contracts of the ISTC. In the main following the agreements noted in the introduction, it could be said staff within the ISTC were employed in four different ways. The first group of clinicians, and some administrators were seconded full time from the local NHS hospital under the SSA making up the majority of staff within the ISTC. The model for SSA's had already been negotiated nationally between the DoH and the main union leaders, and locally with staff representatives and were seen as a way of preserving employment of staff within the NHS while transferring staff to new organisations, sidestepping the opposition to more common TUPE arrangements (Kerr and Radford, 1994), and avoid perceptions of potential threats to pension rights and other benefits. The second group of support services staff were seconded under the SLAs on a 'sessional' basis from the Trust, with a large pool of staff (approximately 1300) each working within the ISTC on a varying number of days per month. Again, their primary organisational and employment base remained the NHS hospital, but a number of their working days were undertaken in the ISTC. Third, similar arrangements were made for medical staff such as surgeons, anaesthetists, and radiologists, retained their original contracts but saw a number of their clinics and work commitments transferred from the NHS to the ISTC, and again visited the ISTC sessional basis, with most of their working time remaining within their home hospital department. Finally, a smaller

group of staff directly employed by BritHealth in a minority of clinical roles (approx 20%) but largely based in administrative and management roles.

The nature of these staffing arrangements were of crucial importance in understanding the emerging character of the ISTC. In broad terms, the various secondment agreements stated that the day to day management of the staff fell under the jurisdiction of the ISTC management, with staff expected to carry out their work according to their job description and any duties 'reasonably' expected of them by ISTC management. However, the ISTC management could not make explicit changes to the staff terms and conditions, with the ultimate responsibility of employment falling under the jurisdiction of the acute trust. This meant the HRM department within the acute trust retained responsibility for maintaining the level of staff and skill mix needed to service the agreement, including finding replacements for departing staff or cover for sickness and annual leave of those under the agreement. Other key aspects of employment management, sickness absence, employee grievances, and payroll remained with the NHS Trust. For the seconded staff there were, therefore, many features of employment continuity, but for ISTC managers there were clear constraints to the ability to re-configure or transform working practices and arrangements.

'Obviously we are limited in the changes we can make for [the seconded staff]. It can be very difficult to make sure they stick to our type of practice, because obviously we only get some of the staff once or twice a month, so by the time they come back to us they have forgotten everything. We have to basically be patient' (HR Manager, BritHealth)

Where whole departments had been transferred to the ISTC, many of the existing occupational hierarchies and interpersonal networks also remained intact, further inhibiting the scope for change. In some cases, seconded staff were supervised on a daily basis by line managers who were also transferred from the NHS Trust. In addition, over time some of the HRM responsibility that ostensibly lay with the BritHealth HR manager began to be influenced by the NHS staff. A key example of this was in recruitment. At the set up of the ISTC, the BritHealth HRM department had been responsible for selecting the directly employed staff. However, following difficulties with these early recruits, some of the seconded NHS departmental managers and sisters reported that they had managed to 'win back' control over who

they employed and were allowed the final say on who was recruited to their department. Equally, where BritHealth HR managers sought to enforce NHS terms on seconded staff during the time the staff were inside the ISTC, this was usually done in negotiation with trust HR managers. For example, when the Brithealth managers wished to warn staff over sickness absence, this was not done independently, but through contacting acute trust HR managers who would visit the ISTC for collective meetings.

The continuity created by transfer of staff from the trust to the ISTC was joined by additional pressure for continuity in the process of designing and transferring services. In a number of ways the development and planning of the ISTC was tied up with the ongoing organisational issues within the Acute Trust, rather than being a clean break from existing activities. For example, before the services could be transferred over they had to be accurately defined and decoupled from other services. An important part of the planning process was therefore identifying the precise nature of existing services and the services the ISTC was contracted to supply. Also, the exact staffing requirements for each department and associated costs had to be agreed upon by all parties. It was realised that extracting existing services from their location within the hospital would not be a straightforward task, as each department was not an autonomous units, but enmeshed within a web of mutually dependent relationships across the whole hospital:

‘the services that are going are incredibly complicated in that it’s not as if you can just physically detach from the trust and the various connection that they’ve got and transfer easily over to the treatment centre. It’s like pushing over a set of dominoes you change one thing and the fact that someone else is dependent on that person and uses that service as well I mean it’s incredibly complex when you start moving services around’ (BritHealth Clinical Planning Manager)

To get the ISTC up and running it was therefore necessary to fully understand how each service was currently run, and how it could be ‘unbundled’ from other hospital activities. Departments and services had been developed over many years, and how each one worked on a day to day basis, and how they related to each other, had in many cases never been made fully explicit. A new head office was set up in a new out of town business park to map out the processes involved in each service, to design

new patient pathways through the system and to work out how the ISTC would fit with existing services. An important consideration was how different streams of income and incurred expenses would be distributed to between organisations and departments. In order to make the complex tasks and relationships involved in each department explicit, managers from all of the impacted services were brought on board, either fully through part time secondment agreements to Brithealth, or partially through the increasingly frequent inter-organisational meetings and data collection exercises over the two years prior to the ISTC opening. Therefore, although there was then an emphasis on service redesign, much of the planning was based around existing managers working on identifying established practices and how they could be removed and re-constructed within the new building and organisation. Part of the reason for this was that plans had to include how the services once transferred would be integrated back into the system that they had been removed from. In addition, internal hospital managers were also integral to working out the staffing numbers and costs of providing the services that would form the basis of the SLA and SSA contracts, basing the supply of staff and other services on what they already did.

‘when we first did the service level agreements we had to do them just to describe the basic service and what we could supply we weren’t tendering against any specification so we kind of did it in a vacuum in that way. BritHealth Co. couldn’t describe at the time what they did so we just tried to do it as we thought.’ (Hospital Diagnostics Services Manager)

In describing how these services were run and identifying how agreements to supply them could be planned out, managers partially or fully situated within the Trust were inevitably influenced by the existing norms, values and organisational politics of their home organisation. For example at the time of the ISTC planning, the Acute trust was going through a large merger in which two large hospitals were joined, with resources being moved between the two, services being reconfigured and peoples’ roles being changed. The implications of this had to be taken into consideration during on the managers’ assessment of how services would be provided by the Trust, their costs, and the need for large contingencies:

‘anyway, the Trust has been through a massive restructuring so it will change the way the service agreements operate and that will have a knock on effect and they will have to be reworked. So later when things are up and running

we will have an opportunity in the future to revise it.’ (Hospital Diagnostics Services Manager)

In view of this, rather than seeking to bring in dramatic changes straight away as the treatment centre opened, the large uncertainties meant that managers were initially concerned with ensuring the service was satisfactorily established, with a view to altering things in the future when the processes of ‘production’ were better understood.

Leading up to the transition from Acute Hospital to the ISTC, the operations of the two organisations became further entwined as managers and staff had to work out the practicalities of the centre operating on a day to day basis. Delays on completing the building and facilities meant the start date of the ISTC was put back on several occasions, and when finally complete there was very little opportunity for trial runs, staff induction or training in the new ISTC facilities. Negotiations between the Trust and the ISTC management had failed to meet an agreement on who would bear the costs for the loss of service that would have been required for staff to familiarise themselves with the new building, equipment and IT. For the initial departments to be transferred there was almost no preparation time at all. The units in the old hospital closed down at the normal time on Friday evening, and patients started arriving into the new building for surgery at 8am on Monday morning. Although staff had been asked to come and look round the new facilities at the evenings and weekends, unsurprisingly most declined to give up their free time, and many entered the building for the first time alongside the first patients:

‘none of us had had the training and the Acute Trust decided they didn’t want to release us, this is what I heard, so BritHealth did put out feelers and asked the question of whether people would be prepared to either stay on in the evening or come in over the weekend to have this training and of course everybody said no, because this was only a few weeks before we moved over and the feeling was ‘well you have known for long enough so no, we are not doing it’ so nobody did [...] we literally had to dump things and come over here because we didn’t have any time to clean up the mess. I felt, having worked there since 1991, I felt awful because of the state it was left in when we went’ (Seconded NHS Nurse)

Individual members of nursing staff who were due to be seconded were asked to work through the details of their role to prepare what they needed to produce the same service in the new centre. By this stage patient pathways had been worked out in some detail, with folders in each department full of process maps specifying each individual task, the order in which they were to be done, and assigning them to a specific job role. There was though initially very little time for individuals to refer directly to these in order to make decisions on how things should be done. In the rush to get things up and running staff were largely expected to get on with the work, picking up where they left off and, in general, produce the same services they were doing previously in the general hospital:

‘there was me and a colleague and so we were asked to look at processes and sort of get it going once we moved over here. But everything we had asked them to provide for us wasn’t here so we had to rush around on Friday afternoon. When the first patient turned up on Monday we just had to get on with it. We managed to cobble together quite a lot of things on the Friday afternoon because the rooms aren’t that big but obviously you had to find where things were such as cards for blood tests and stationary, all the basic things basically we just didn’t have, things like a diary, but luckily we had brought our old diary with us and communication things that we need when we are out here. We cobbled it together by Monday morning’ (Seconded NHS Nurse)’

Again this suggests a large crossover of activities of the hospital and the ISTC, as the actual tasks associated with producing the service were improvised by staff based on established ways of working. When the transfer actually did occur, on the face of it there were several areas of continuity for the staff. Over the course of a weekend, whole departments moved over to the Treatment Centre together, with people doing roughly the same tasks, within the same teams, treating the same patients, under the same employment contract on Monday morning that they had been doing on Friday evening and only five minute walk across the hospital car park from their old department. In addition, contact with Trust continued to occur on a daily basis with many aspects of service delivery intertwined, for example through shared resources, and with staff and patients moving between the organisational sites. This also included continuation of the clinical teaching and research activities, with trainee nurses and junior doctors having a full role in service delivery

However, when staff arrived for their first day of work in the ISTC, they found themselves in a very different organisational context, with new priorities, objectives and expectations. The ISTC was run by a private company, employing a completely different set of managers, with their own objectives, approaches and techniques. Perhaps the biggest departure from life in the general hospital was that all parties were initially faced with was the mix of employment models that saw fully transferred NHS staff, 'visiting' NHS staff and directly employed private sector staff working side by side and often in the same roles. This had important implications for how work practices were decided, lines of hierarchy and control.

6.3 The Nature of Employment: The Multi-Employer Workplace

Aside from physically moving to the new building and adapting to the new layout, and facilities, perhaps the greatest organisational change was the new arrangements for employment. As outlined above, the majority of clinical tasks were undertaken by seconded staff from the adjacent large acute hospital. This included the transfer of nurses, operating department practitioners (ODPs) and Health Care Assistants (HCAs), and administrators who were mostly seconded full time for the duration of the contract, as well as Surgeons and Anaesthetists, as well as radiographers and specialist practitioners who visited the treatment centre for 1-6 clinic or theatre sessions a fortnight. These were joined by the directly employed BritHealth staff who took a minority of clinical nursing/ODP/HCA jobs, as well as the majority of senior management and administrative roles. Middle management, in other words the nursing leads who ran each department on a day to day, was more evenly split between the two groups, with a concerted effort by senior managers to balance the transferred NHS sisters with a cadre of directly employed nurse managers. This presented a dramatically changed employment landscape in which there were several different employment systems at work side by side, involving for example, different terms and conditions, different implicit and explicit incentives, mixed opportunities for promotion and job security. In addition there were great differences in the organisational and professional backgrounds of the two groups of staff and a corresponding disparity in terms of skills, norms, values and employment expectations.

Perhaps the most immediately noticeable consequences of this, and for the transferred staff the largest break from how the services were provided in the Trust,

were clinical staff employed through different organisations working alongside each other in the same roles. As the services were transferred over to the ISTC, the staff in each department were introduced to a whole group of new clinical staff who were to be working alongside them. As the work got underway, these two groups had to get to know each other quickly, including working out the areas or practice they were capable of working in, their skills, preferences and levels of experience. This caused a number of points of friction. On an individual level people were keen to point out that they were happy to work alongside people from the other group, and downplayed any personal differences:

‘There are BritHealth staff and I get on with everybody, there is no problem, we work together. I don’t say ‘you are BritHealth staff, you are Acute Hospital staff’ we don’t do that, we do work together I find’. (Seconded NHS Nurse)

However, on a group level, most of the respondents working full time in the ISTC reported some degree of split between the ‘NHS’ and the ‘BritHealth’ staff. While obviously a sensitive issue that involved talking about relationships with immediate colleagues, a number of people up front about the divisions, and described in detail areas of emerging tension:

‘The only areas that I have seen where things don’t perhaps work as well as they should do is the mixture between BritHealth staff and NHS staff. We have a lot of lip service about saying we are one staff group but decisions are occasionally made which make it a very much ‘them and us’ situation’ (NHS Seconded Nurse)

“Well yes but there are, again for BritHealth staff, they don’t like it if you point anything out to them. With the other staff there is no problem, you just say to each other ‘is that alright’. They think that what they did in other BritHealth centres or whatever is better, but we don’t see it that way, we think our practice is good. Sometimes it is not easy for them to make the changes I suppose. It is not about getting them to switch to our ways of working, it would be if they hadn’t filled a form in or something like that. I think they sometimes think it is NHS staff ganging up on them, even though there is a BritHealth Sister, but they think it is that way because they are BritHealth staff’ (Seconded NHS Nurse)

Some interviewees explained the increased separation they noticed between the staff groups as a part of integrating new employees, becoming comfortable with each other and learning each other's skills:

'Before we would just speak to people and say 'oh is it alright if I bring a patient through in five minutes' and it would be like 'yes yes that is fine' whereas now we have new staff who we haven't had chance to interact with. It is better with staff that we have known previously although I feel that our relationships are breaking down even with people we have worked with previously, but especially new Brithealth staff who haven't had a chance to bond with us' (Seconded NHS Nurse)

As a new directly hired Sister observed, for the transferred staff the fact that so many colleagues had joined an established group was alone was a significant challenge to existing relationships:

'The staff that came over from the trust had their own little corners and their status, but it was then integrating the BritHealth staff into what was effectively a comfortable little clique. All of a sudden there were new staff and more staff than would normally come all at once. To introduce one new member of staff is ok, but all of a sudden they were introduced to I think it was seven direct hires all at once' (BritHealth Nurse Sister)

Others pointed to the different approaches, skills and abilities of the two groups, with contrasting stereotypes of NHS staff and BritHealth staff becoming apparent. The emerging consensus amongst the transferred staff was that the BritHealth staff were lower skilled with less clinical experience and fewer areas of expertise. NHS staff often said they had to make allowances for BritHealth staff and NHS sisters planning the skill mix in each area were often careful to mix BritHealth staff amongst 'their own' nurses:

'They have the same roles but what we have found is a slight difference. We had an interview process for the ones that were appointed for us and in terms of the experience that they have got, it is probably not what I would have appointed at the trust because they do often have to have a lot of support in getting them involved in all the clinical areas. Their documentation tends to be quite poor for example and some of their nursing

practice tends to be generally poor compared to NHS staff. A lot of my time is wasted to be honest managing their staff to be fair' (NHS Seconded Sister)

This view was strongly related to the fact that the BritHealth staff's previous professional experience which apparently immediately marked them as 'outsiders'. That BritHealth staff had generally been employed from other private hospitals and nursing homes was in itself seen with some suspicion:

'it can be summed up by saying that you have to ask yourself why they are not NHS employees to start with. One or two people we have who are really brilliant and they are out of NHS employment for very good reasons, but I would say that the greater percentage of BritHealth staff have not been NHS employees because they couldn't get NHS employment' (Seconded NHS Nurse)

On the other side of the equation, the BritHealth staff could be seen reacting to this lack of acceptance by the pre-formed cliques of transferred staff. Perhaps reflecting their minority status, directly employed staff was less open in criticising their NHS counterparts, but did on a number of occasions suggest that NHS staff were resistant to change, and felt left out of decision making process:

'since I trained I have been private and before that I was untrained staff in NHS hospitals. The mentality here that I find because mainly in this building there is NHS seconded staff, I think the difficulties come in because they want to run it like the NHS, and it is not NHS but it is NHS patients. We are a business, we are not NHS [...] I can go round any department in this building and it will be the same 'oh well we used to have that over the road and we used to do this and that over the road' and I am thinking 'get a grip' (BritHealth Principle ODP)

The above statement reflected the emerging language of everyday practice, in that people frequently talked in terms of the 'old' and 'new', 'NHS' and 'BritHealth', as well as 'us' and 'them'. For example, when making decisions about allocating staff to different areas, NHS nurse managers would often talk about making sure there were enough of 'our' staff in each team to make sure things were 'done properly'. Adding to the day to day impressions of separation and division, staff frequently commented on the different terms and conditions between the two groups. While the basic

salaries for the directly employed staff were similar to those of the seconded NHS staff which were based on the nationally negotiated agenda for change agreements, there were variations in other benefits. Those that were most frequently discussed was annual leave allowances:

‘There is no clear division between us, but sometimes it is a bit like ‘how come you have seven weeks annual leave when we have to take our leave from January to December’, something like that’ (Seconded NHS Nurse)

And also the degree to which time off sick was scrutinised;

‘The sickness policy and the pension and things like that is not the same. If they take a day of sick, they seem to come down on them much harder, they get checked up on more’ (Seconded NHS ODP)

In both cases, the seconded staff were seen as having significantly more favourable terms, although there was a view that this was changing and being ‘tightened up’, for example in the detail of how sick absence was allocated and the degree of notice for leave allowed:

‘we did have mixed opinions on what our sickness policy was. Like I had the day off with my little boy last week because he was really poorly and BritHealth policy is very different to the Acute Trust’s policy. Of course we do follow Acute Trust’s policy, we have to, but I did find that BritHealth’s input was a bit like ‘well you can’t do this and you can’t do that’. So if it is at the management’s discretion, then they tend to go towards BritHealth rather than how the Acute Trust would have done it before. In the past I had always taken it off annual leave, but now I have to pay back my hours.’ (Seconded NHS Nurse)

Although employment terms and conditions for NHS staff were on the surface maintained, this suggests that BritHealth management were seeking to enforce their own terms in marginal cases and more ambiguous situations. Few people described the exact contractual differences between the two companies, but these were a frequent topic of conversation and joked about on the shop floor of the ISTC. Many people were, on the face of it willing to accept these differences as part of the ‘realities’ of working in the ISTC, rationalising any disparities and differences as a natural or even positive part of work:

'I think people will always identify with whichever group you put them in, we are after all pack animals and people of different colour, creed or whatever, will all want to group together, that is just human nature and I don't think that is anything to worry about at all and I think that to a certain extent it gives people identity so you just have to get the balance right. I think it is always a question of balance and we get that balance right' (BritHealth ODP)

However, separation between the two groups was not solely based on the fact that some were 'new' and some 'old', but could also be seen as reflecting the differing basis for their employment. The fact that the transferred staff were not employed directly by the company running the ISTC was in itself of great importance, and breaks with traditional conceptions of the employment relationship (Simon, 1951). Rather than having direct authority over these staff and the ability to explicitly control their behaviour, including requesting changes to previous practice in line with a new production orientation, the management of the ISTC officially had only indirect authority over the staff in the form of a services contract for services with their employers. This difference between the direct authority over employees and indirect authority over non-employees was not a mere technicality, but fundamentally shaped the degree to which managers felt they could exert control. Issues relating to absence and performance were in theory dealt with by the central human resource management of the acute trust, although they only stepped in extreme cases, for example in the case disputed long term sickness absences, and were reluctant to get involved in the day to day management of staff. Therefore, the ISTCs own HR manager accepted that they had to rely on indirect methods, such as 'winning over' the clinical leads of each department to try to influence NHS staff towards BritHealth's objectives and processes. In another example, the HR manager also suggested there had been a conscious effort to create a mix of directly employed and seconded departmental lead nurses. These met on a regular basis, and it was hoped that directly employed nurses could help spread BritHealth practices:

'We have tried to do that, to mix the group up, then when they all get together and share their results, it could create a bit of an incentive for [seconded lead nurses] to keep up to speed with what is going on and hopefully spread a bit of the good practice' (BritHealth HR manager)

It also influenced how ISTC staff understood their roles, as well as the interpersonal relationships and lines of authority between managers and staff. The NHS staff had a degree of separation from management, and realised that there were limits to how much they could be controlled:

‘I think it would be fairer to say that we recognise that [BritHealth managers] think differently from the NHS, they are governed in a different way and so their responsibilities are different and it would be wrong of us to undermine what is required so we will play ball for the moment. We will question things at the time and we will say ‘well you will have to come back to us at a later stage because we are not sure that is required’ (Seconded NHS Nurse)

And in some cases staff were ultimately aware that they were not subject to formal sanctions internally in the treatment centre:

‘because we can’t be sacked here, I think the fear of blame has diminished here. I wouldn’t say that people worry about coming to work on a daily basis in case they get told off about something whereas they used to’ (Seconded NHS Nurse)

In this way, it could be said that as well being outside of the established bureaucratic control of the NHS, the seconded staff also felt in some ways protected from the ISTC management. On the other hand, this picture was very different for the directly employed staff who were in a far more conventional employment relationship and under BritHealth managements’ direct control. These staff were in much more frequent contact with the internal HRM manager, who was involved in their recruitment, performance reviews, pay, promotions and disputes alongside departmental managers.

Further, this difference was reflected in the wide variation in people’s interpretation of who they were working for. The split between professional loyalties and commitment to a particular organisation was stretched further as some groups were placed into multi-layered relationship between their employer, their professional group, their place of work, as well as their new and old colleagues. Balancing these involved different considerations on each side of the equation. Firstly, those employed directly by the Treatment Centre came mainly from other private sector companies as well as directly from training and had a relatively traditional view of

their relationship, viewing themselves as mainly working for the ISTC Company itself. Perhaps reflecting their perceptions of comparatively weaker position in the employment market, or lack of experience, several BritHealth respondents reported a relatively positive evaluation of the terms and conditions of their employment:

‘I actually applied for an auxiliary nurse post but they offered me a post as a qualified nurse instead. I was over the moon because I had had eighteen months out with no post reg experience so it was like ‘oh wow!’ (Brithealth HCA)

However, the presence of different factions of the organisation meant that commitment to the ISTC Company was not always straightforward even for these staff. Working alongside NHS staff, and sometimes under NHS middle managers, meant that prioritising company objectives and ways of working required the directly employed staff to balance between the organisation and their immediate colleagues:

‘the management of the treatment centre have taken a chance by employing me on a very reasonable salary and to me I have got to honour that and repay that. I have a small debt to them because they took me on chance, they took my references and they said ‘yes, we will take a chance with this guy’ and I think you have got to honour that so yes, I will prioritise to them rather than the NHS in so much as they don’t do anything that I feel is detrimental to patient care, if they did I would address it and take relevant steps’ (BritHealth ODP).

Turning to the seconded staff, a far more complex and uncertain understanding of the employment relationship and their commitments to the Treatment Centre was described. In general, people saw themselves as working only partially for the ISTC, partially for the Acute NHS Trust, or some combination of the two. Respondents reported recognition of the split employment relationship and somewhat divided loyalties between the Trust and the ISTC. Divisions in loyalty appeared to be tied to both ‘rational’ assessments on the nature of their contracts, as well as ‘emotional’ reactions to their own predicament. For example, some people expressed their views in terms of a personal choice over their relative job prospects in each organisation, for example in terms of their future career, more options were available within the NHS, as well as the fact that the NHS currently provides their employment benefits, training and development opportunities and pensions:

'I would like to stay here, but I wouldn't like to work for BritHealth because they are the private company, and they don't have like the sickness policy and the pension and things like that is not the same. Saying that, in five years I will be retirement age so I have got that option as to whether I stay with BritHealth or with Acute Trust if they would let me move over given my age' (Seconded NHS Nurse)

'Obviously we have been seconded so there is a clause in our contract, but in terms of picking up training or development I would probably have to go back to the trust but to be honest, I am happy where I am at the minute. Family life is coming first for me at the moment' (Seconded NHS Sister)

Others expressed having far more mixed feeling towards the two organisations, often related to views on working for the public sector and private sector more generally. For example, some of the transferred staff felt extremely let down, or even betrayed, by the NHS Trust for the way the move was handled and seconding them out. This did not necessarily mean their previous attachment was displaced to the ISTC, and this appeared to open the possibility for confusion about the nature of their role:

'Well I don't feel like I am anything to do with the Trust anymore because like I said, we have nothing to do with them now, we feel like we don't exist over there anymore. We don't see anybody so I feel I work for this place [the Treatment Centre], although I couldn't tell you directly who, I just come in and do what I am told to do by the senior sister usually' (Seconded NHS Nurse)

Others retained a stronger attachment to the Trust, related to notions of security that they saw the NHS as providing:

'I see myself working for the Acute Hospital because I have been seconded from there. I don't see myself as working for BritHealth, no, definitely not. And I am hoping that if there is any problem it will go to the QMC human resources, that is what I am hoping. If I have a problem I don't go to one of the BritHealth Managers, I go to one of our old sisters who have moved across here with us.' (Seconded NHS ODP)

'it was frightening at first thinking that we were going to come over here and become the private sector and knowing that they work a lot different to us,

but we are not, we are still NHS and we still have all the powers of the NHS. If they want us back over there, we can get taken over there' (NHS Seconded Nurse)

These comments point to enduring feelings of separation between the two groups, supported and reinforced through separate systems of employment. There were significant differences between the directly employed staff and the transferred NHS staff, both in terms of the actual mechanisms of employment, as well as in the perceptions of the nature of work. This did not only have the potential to create intergroup tensions but also came into play in shaping the character of peoples jobs and work roles. The conflicting interests and mixed lines of authority involved in two distinct employee groups the divisions of tasks, hierarchical divisions and the content of roles were negotiated. The following two sections illustrate the work roles arising in the ISTC, taking into account the mixed lines of authority, control and commitment at play in this environment.

6.4 Medical Roles in General-ISTC

Beginning with medical staff, the degree to which managers in the BritHealth managers could shape medical work was severely limited as much of the medics work remained outside the confines of the ISTC. In the vast majority of cases doctors continued to be employed by the acute trust and were situated for the majority of their working time within their 'home' departments situated in one of the two hospitals bought together in the recent merger. There was therefore no possibility for BritHealth managers to dramatically change the terms, conditions or working patterns of these staff, given for example their work within the ISTC had to fit with their timetable and commitments elsewhere. In this case most medical staff responded that in many ways the content of their clinical work remained similar to previous experiences within the Trust.

'On a day-to-day basis the nuts and bolts of the surgery haven't really changed. We have probably got more equipment but a similar number of consultants. I think the biggest impact has been in terms of procedures and communication in that they are taking everything down to the 'nth degree, it can be very time consuming' (NHS Consultant Surgeon)

This continuity could be seen as especially true for medics, who in any case often carried sessions in theatres or clinics as 'visitors' to the department, even before the move to the ISTC. When the day surgery was located within the general hospital, surgeons and anaesthetists would arrive and carry out their lists, before returning to their own departments or 'main' hospital theatres. In addition, as many of the staff within each department had been transferred they were often working with the same teams of scrub nurses, ODPs, and HCAs within theatres, and organising work with the same administrative staff and lead nurses as they had done previously.

When changes were sought to be introduced by ISTC management, these were strongly resisted by medical groups. Many elements of the emerging relations between medics and managers can be illustrated through the system of scheduling patients. A major change initially introduced by BritHealth management was a centralised system of administration, with all of the booking of patients' appointments, patient communication and the order and timing of clinical and theatre sessions conducted together away from the clinical front line. In the past individual medics, or individual specialties and departments had organised their own work, and centralising administration aimed to give the Treatment Centre more authority to plan the work themselves, giving them greater control over what was being done and when. For example, rather than individual consultants having their own lists of patients waiting for an operation, the ISTC could distribute patients amongst the theatre sessions themselves to fit with their own targets and deadlines specified in the contract for patients to be treated within 18 weeks of referral. This was done by establishing an off-site call centre staffed with a pooled resource of administrators, many of whom were new to health care, offering a potential efficiency savings from replacing individual medical secretaries were replaced with less experienced staff in a narrower role.

However, as soon as the ISTC was open, this innovation was strongly resisted by all groups of clinical staff, with a variety of complaints and problems a constant source of discussion between the visiting medics and the ISTC BritHealth managers:

'Sometimes [BritHealth managers] will suggest something and we will say 'actually we need to do it this way', there have been episodes like that. One of the classic cases was to do with the call centre at the business park which was a stupid system. The theatre lists are made up there and they required

us to do the vetting because there are no medical staff over there and they don't have any medical understanding, they are just secretarial staff and they couldn't understand why we were having problems. There were several factors that governed a list of operations and that was not being adhered to. So when the patient arrived we would find we needed to juggle the list around to the correct order, then we would have to look and check they had got the correct time, then there would be little complications like the wrong patients would turn up for the wrong operations at the wrong times and we wouldn't have their notes. We got very frustrated as we wanted to get on and operate' (NHS Consultant Surgeon)

Another commented:

'well previously I would just sit down with my secretary and we would take into consideration all the things we needed to take into consideration and generally we got it right. But here you had no idea how many patients were on the list and how many would turn up. It could be two it could be twenty, and it was just impossible' (NHS Consultant Surgeon)

Within the first few months of the ISTC opening, medical resistance and the above problems meant that this arrangement became untenable and the decision to 'offsite' booking and administrative functions was reversed. All of the booking staff were moved back inside the ISTC building, as close to the departments for individual specialties as could be found office space for. This not only changed the physical location of the function but also the structures in terms of management. Rather than placed under the control of one single central BritHealth manager, the responsibility for booking and scheduling was returned to within the departments themselves. Therefore, each department had a group of administrators with a nominated manager, who would then work closely with the lead nurse in the department, and each administrator given a nurse sister 'buddy' to consult on decisions for example when addition patients to a particular list. Again many of these lead nurses and sisters had been transferred from the hospital and were familiar to the medics visiting the departments. Frequently then scheduling decisions would be discussed between the nurse buddies and the medics responsible for carrying out the procedure, either in person or via emails between the ISTC and the medics home department. In this respect the buddies acted as a kind of 'buffer' between the

medics and the BritHealth administrators, for example informing the administrators what the medics would normally accept or asking the medics to get their input into scheduling decisions.

In effect then this put the scheduling of appointments and arranging of lists to a partially back under medical control, but with some input from the BritHealth administrative team. Medics now had the final say on the booking decisions. Within this picture, the lead nurses had to balance both the demands of the medics who would frequently go to see them when unhappy about aspects of practice within the ISTC, and the demands of the BritHealth administration, who were concerned with meeting the waiting list and output targets. This often resulted in ongoing negotiations between the medical, administrative and nursing groups. For example, there was some degree of pressure on administrators to schedule appointments so that patients did not breach their waiting list targets. This was backed up by weekly meetings in which the administrative managers would identify breaches that had either happened or looked likely to happen, and question the administrator in charge of booking their appointment. Therefore, when this was likely to happen the administrators would look for a way to fit the patient into the existing schedule. This was sometimes supported by the administrative manager who would look for the possibility of adding additional overtime theatre lists, and discuss the proposals with the lead nurses, who would have to decide whether the request was possible in terms of their own staffing arrangements and the reaction of the medics involved. This process happened on a continual basis with lead nurses and administrative leads in continual discussion about difficulties of scheduling potential solutions. The degree to which the lead nurses were ready to 'defend' the medics from the BritHealth demands depended on a number of things, including their relationship with the medic, the degree to which they would resist and make complaints about changes and the length of the breach. For their part, medical often based their resistance to changes on their specialist knowledge and concern for clinical outcomes. For example, pointing to the quality concerns of adding additional patients without sufficient notice or onto clinical sessions. In some areas of the booking process the medics gained complete control. For example, BritHealth managers made some effort to set the order of theatre lists before it was commenced. It was suggested that over time they might seek to stagger the arrival of patients, rather than have them arrive all at once before the list began as pre-surgery waiting times was seen as

a major source of patient complaint. Also, it was suggested that knowing the order of patients would help to plan the workflow, for example placing patients in the morning list with a longer recovery time at the beginning of lists to make sure they were ready to leave before afternoon patients arrived. However, the pre-planned order of lists was rarely carried out. Medics freely moved patients around the list, citing the practicalities and necessities of clinical practice:

‘yeah I renumber that [the list] as soon as I arrive. I like to do all the left hands (on a carpal tunnel surgery list) first as you can set up the room and rip through them. Or if the next door theatre is free and you have someone with you you can set up both at the start, one for the left and one for the right and do them basically simultaneously.’ (NHS Consultant Surgeon)

Away from scheduling patient appointments, this partial regaining of control by medics and re-establishing existing norms of work could also be seen in many other examples. A relevant example is in attempts to pay medics individually for agreeing to take on existing work, particularly conducting theatre sessions on the evening and at weekends. This was done to some extent unofficially, but reported to me by a number of medics and BritHealth managers. Rather than paying a set fee for all overtime theatre lists, managers including some medical managers working for BritHealth had attempted to weight payments as they saw necessary to induce medics into working the extra lists, largely based on how open they were to extra work and how hard they negotiated. This meant that different medics were paid very different rates for similar tasks, unrelated to their NHS pay scales. It was also suggested by one manager that this could be used as a way to sidestep the initial staffing agreement with the acute trust, for example by directing a greater number of additional payment lists towards medics that were willing to fit with the ISTC ‘ways of working’. However it was also later reported that this practice had been stopped following complaints from individual medics and concerns that these types of payments should be set across the medical staff.

One factor that could be said to affect the balance of control over work was between the clinical content and the wider context of work. That is, doctors largely held sway over the clinical content of work while managers were more able to alter its context. For example, the visiting medics would respond to any managerial interference in the provision of direct patient care or decisions that could be seen as having a negative

effect on it. For example, there was little acceptance of managers attempts to standardise equipment use or developments aimed at 'rationalising' workflow processes. For clinical processes, medics remained largely in control over how tasks were done by both themselves and the other nursing staff working with them. To give one example of how this was done across both the hospital and ISTC site, one surgeon had drawn up a 'map' of the operating theatre, instructing staff as to her preferred positioning of the operating table, equipment, and team members such as the scrub nurse. This was stuck to the whiteboard within the theatre with instructions to consult it before her arrival on site. In addition, the degree of change that medics were prepared to accept placed limits on the degree to which management could re-organise tasks. Doctors working across boundaries between the local trust and General-ISTC persistently challenged managerial decisions that they viewed as impinging on their work. A key part of this picture was that the ISTC was only one location of the medics hospital work, including the wider teaching and training duties. The consultants overseeing medical work were joined by medical students, senior house officers and registrars. As in general teaching hospitals, clinical sessions were often used for training altering the tasks, pace and order of work depending on the exact personnel present. Given the requirements of training, with allowances written into the contract, BritHealth managers had little choice but to leave many of the activities to medical discretion.

However, managers were more able to exert their influence on the wider context in which the direct clinical work took place. To some extent this was done prior to the ISTC opening with the design of the building and purchase of equipment. Within the theatre department, one of the most commented upon differences to work in the hospital 'main' theatre department was the absence of a dedicated anaesthetics room, with general anaesthetic administered within the main operating theatre. The reason commonly cited for this design was in terms of patient safety, as patients did not need to be moved from where they were anaesthetised to where they operation took place. However, both surgeons and anaesthetists often remarked how this dramatically changed their daily work as they had to wait for one case to be completely finished and the patient moved out of the theatre before anaesthetising the next patient could begin. It also meant that both the anaesthetic and surgical teams worked closely, side by side throughout the procedure. Perhaps paradoxically

giving the ISTC emphasis on workflow and efficiency, this was generally seen as slowing down the theatre 'production line'.

Aside from the physical environment, certain purposeful changes to the administrative systems were placing some additional managerial controls over medical work. For example, there was some effort to standardise the arrival times for medics to an hour prior to theatre lists scheduled start time. Similarly, there was attempts to increase the output of medics who were seen as 'low performers' towards the average for each specialty. As it would have been virtually impossible for the 'non-employers' to enforce this through overt sanctions, this type of control was attempted through publicising performance lists, printed out and stuck on the wall near the theatres, including average cases performed as well as arrival times. These attempts at increased managerial control were widely recognised as such by the visiting medics, with some reacting against it:

'I don't think there are differences in how the staff work, but I do think there are differences with the management, a different style, more aggressive. I think it's a much more managed environment, and I think there is a greater emphasis on economic issues. It's much more a managers and workers scenario than it was previously.' (NHS Consultant Anaesthetist)

Another anaesthetist stated:

'it's a new type of philosophy, and most surgeons have been doing surgery for a long time. There is sense of why change things that have always worked efficiently and we have always had lots of happy patients. And the reason is its now run by a commercial company and they have different overriding goals to the NHS. These are not necessarily competing ideals, but not always compatible.' (NHS Consultant Anaesthetist)

Although the changes that were made were largely to the administration of the ISTC, the separation between content and context is slightly artificial as these type of changes inevitably had a knock on effect on the clinical work, decreasing the availability of staff or changing the opportunities for interaction. For example when administrators were successful in placing extra patients on lists, or when more lists were scheduled simultaneously with the same number of nursing and support staff, this had the effect of reducing the time possible to be spent on each case, or reduced

breaks between cases. In general, the medical respondents were generally negative about these changes, with these feelings often tied to general frustrations of the problems of moving their work to the ISTC. However, it was recognised that some did 'buy in' to the new managerial style and emphasis on throughput:

'some doctors may think its brilliant to rush patients' through and make lots of money, others might be more resistant to that' (NHS Consultant Surgeon)

In general however, again given that work in the ISTC made up only a fraction of their whole work role, the overall picture here was one of continuity of previous work, with continued attempts by management to seek ways to begin to impose new restrictions and controls on the time spent within the ISTC.

6.5 Nursing and other Work Roles in General-ISTC

A similar picture portrayed in relation to medical work between continuity and managerially imposed change can be seen in the work of nursing staff, including Nurses, ODPs, and HCAs. As describe in the previous sections, in many ways there was no clear break from practice within the general hospital and as staff moved over, they often brought with them established ways of working including the way tasks were divided and carried out. Again respondents often commented that on a day to day basis the content of their work in the TC was very similar to how it had been previously:

'Well apart from the fact that we have got a new building and new equipment I would say that it really hasn't changed an awful lot, it's just that the environment that we are in is a lot bigger and therefore it is little things like having to walk much further now, things like that. Generally speaking I wouldn't say my job has changed very much at all' (Seconded NHS Nurse)

In addition, to some degree the continuation of prior NHS practices extended to the minority of directly employed BritHealth clinical staff, as the norms of practice were transferred and continued to be set by the majority NHS staff. For example, BritHealth staff recruited from other private providers described a less directly financially driven environment:

'There is a difference here between this hospital and the private hospital where I worked, at the other place it seemed that a lot of the surgeons, their

main aim was to get the patients out as quickly as possible [...] Whereas here it seems to be less financially driven I would say whereas in the other place they were banging them through as quickly as possible because they did a lot of NHS work and the profit margin is very small' (BritHealth ODP)

However, unlike the medics, many of these other occupational groups worked full time in the ISTC, and reported being generally more heavily affected by the changes to the working environment. Aside from the cross-organisational employment system, a number of additional differences shaped the nature of work. Major changes for staff within the new facilities included a greater use of IT, altered care pathways, different processes for booking and communicating with patients and a focus on audit and performance measurement. On top of these, BritHealth managers had attempted to introduce numerous changes to the day to day clinical practice, such as changes to the order of work and division of tasks. Many of these were laid out explicitly in the workflow diagrams that complimented patient pathways, specifying which work role should carry out each part of the service production. Again, these were not straightforwardly implemented and in many instances attempts at re-configuration met with resistance or indifference from staff.

To provide an example of this, the theatre department had been designed by the managers to separate the discharging of patients from the pre-operative ward. This was explained as an attempt to replicate a continuous 'conveyor belt' type patient journey as they seamlessly flow through various stages of treatment without doubling back on themselves. This was attempted in both architectural design, for example, with a new clinical space was created to move patients from recovery into rather than back to the wards, and through work re-design, for example with a new 'discharge' role envisaged specifically to process patients exit from the hospital. However, many of the practices necessary to enact this process were not put into place. Although staff were aware that the department had been intended to support a particular 'production' process, this would have involved changing practices which had been developed in the general hospital and transferred to the ISTC. Instead, discharging patients continued to be done the general ward nurse, and the intended discharge area was used as an ad-hoc extra ward area for when they ran out of cubicles:

'What should happen is a patient should go to the cubicle, go to theatre, go to the discharge lounge, now they don't, they go to the cubicle, the theatre, recovery, back to the cubicle because at the moment we are not running five theatres, when we go to five theatres we are not going to have enough room, there is going to be a bottleneck, so I suspect we will have to start reviewing those processes' (BritHealth Sister)

Translating the plans for work process change into practice required all groups to be willing and able to change their established practices and enact them through their work. For a number of reasons this was often not the case. To some extent there were complaints about the nature of the changes themselves, with the changes in layout referred to by nurses as a way in which the building had been 'Americanised'. Respondents frequently reported the impracticality, wastefulness or confusing nature of the managerially endorsed practices, and emphasised how they had attempted to push for more suitable arrangements for work. However, the basis for this resistance was in many ways different to that of the medical groups, with an emphasis on 'common sense' and time in the job over expert knowledge. Often nursing staff emphasised their experience and insights that came from working in a particular role on a daily basis:

'I don't know why [BritHealth Managers] think they can come up with better ways of doing our job than we can. Some of us have been doing this together for about twenty years, if there was a way to save time and make things more efficient do you not think we would have done it by now?' (Secoded NHS Sister)

'We used to have to go the whole length of the unit; you know the little bay on its own? That was the only place we could get food or drink for the patients, so if your patient was at the top end and they wanted drinks and a sandwich you had to walk all the way to the bottom, fetch it and bring it back and then the patient would say 'can I have another cup of tea?' straight away we said it didn't work to the clinical manager, and we just changed it' (Secoded Ward Nurse)

Where management did seek to force through changes, these were often met with overt rule breaking and non-compliance, as in this account theatre staff breaking waste bin lids counter to new infection control policies:

'The bin holders were ordered with lids on which makes them quite difficult to use and we were told that we had to have lids on the bins for certain infection control policies or whatever, even though we had never used lids on our bins over at the Main Hospital theatres, never. We said 'look, we can't work with these lids it is driving us all nuts. You are trying to put stuff in bins with one arm and doing things with the other arm and it is really difficult', to the point where one member of staff had broken the lid off the bins. Now it is a case of having lots of broken bins and that is how, if we want things to change [...] it is, a lot of it is down to what we can get away with and which boundaries we are willing to push and which ones we are not.' (Secoded Theatre Nurse)

In some ways, the resistance could be seen in terms of attempts to assert professional autonomy and control over work. However, characterising the action of staff looking to reinstate previous working practices as reactivate resistance to new management control may be slightly simplistic. Given the number of transferred staff on the shop floor as well as in middle management, there was often considerable support throughout the organisation for clinical staff wishing to alter new practices and work routines in line with their knowledge and experience. Transferred staff presented themselves as in a more legitimate position to shape effective work practices. They often held stronger relationship with other NHS staff higher up the organisation, particularly senior medics and clinical leads, than the privately employed BritHealth middle managers. This meant that the BritHealth managers themselves often suggested they were outnumbered and isolated, trying to enforce particular policies or practices amidst groups of non-employees. In an extreme illustration of this, when the ISTC first opened a directly employed BritHealth manager was put in control of the day surgery department. The large majority of staff in the day surgery had been transferred together including the group of sisters who had previously run the department, but were placed under the control of this new BritHealth manager. Despite this, the staff saw themselves as answering to the transferred sisters for whom they had previously worked. Rather than submitting to the authority of the new manager, they viewed her as suspicious and saw her as imposing unfairly and arbitrarily on their work:

'My own personal opinion is that she has got her own agenda. She is going to have targets to meet and she will have to meet those targets or her job

will be on the line and she doesn't care what it takes to meet those targets. She has lost sight of the patient as a person and the patient has become a commodity to her, that is my opinion. I don't think she can understand that one pre-assessment can take ten minutes and another can take an hour and a half, she expects everybody to get through within the set time of twenty minutes and it isn't always possible' (Seconded NHS Nurse)

Following a long period of disharmony including accusations of bullying and complaints from the NHS staff and sisters, as well as similar views from visiting medics, the departmental manager was asked to leave by the BritHealth board. Regardless of the actual content of these claims, this could be seen as an explicit consequence of pre-existing hierarchies, norms and values, and the limited possibilities of overt displays of control by the minority BritHealth management.

In light of this, other managers recognised the need for a more 'evolutionary rather than revolutionary' (Risk and Safety Manager) approach to change. Modifications to transferred practice were often limited to smaller post-hoc efforts to 'rationalise' work processes, cutting resource waste, for example by improving the utilisation times of theatres and clinics by organising extra sessions in the evening and weekends. Also, managers had to seek agreement and 'buy in' before major changes were made. For example, frequent improvement and involvement events were held in which staff themselves were asked to look for ways to improve the efficiency of the service:

'we went through the patient process when they are in for assessment and what happens on the ward and in theatre to break down those processes and see what is good and bad, whether we needed to make any changes and where we needed to pat ourselves on the back and say 'actually we have done very well'. (BritHealth Medical Director)

At the same time, managers still found themselves under pressure to meet specification of the contract and performance indicators, increasing the adherence to audit requirements around waiting times and safety procedures. And despite the participative rhetoric and more incremental pace of change, staff from an NHS background still reported experiencing them as increasing pressure and reducing clinical autonomy:

'I had never been in a private organisation and I didn't know how they functioned. It is so different to the NHS and even now I would say that the standards of care and what is expected from you is different there is a lot more audit work and in the trust they would never really come around looking at what you are doing. Yes, you are much more under the spotlight which is a good thing, but I think expectations, even my expectations and those of the staff, I don't think we would be as closely monitored as we are being. [things like]: Documentation, theatre practice, general people practice.' (Seconded NHS Sister)

The tension between managers needing to act to fulfil ISTC goals, and being in a position where explicitly and overtly changing working practices created a workplace that could be characterised as dominated by piecemeal or 'creeping' rationalisation. Rather than definitive accounts of smaller roles, tightly defined processes or tight control, staff reported a more gradual squeeze on their work, and attempts to redefine their roles at the fringes of practice. In this environment respondents often described their actions in terms of surface compliance:

'There has been a new management structure recently and people have gone and different people are in and they have new ideas and the workload is going to increase because we have got to get the workload through. We have eighteen week deadlines to meet and I think that is part of the agreement between NHS and the private, I don't know, that is not my domain and I don't understand the policies of it all and what has been agreed, all I know is what I do and what I have got to do' (Seconded NHS ODP)

By making claims to 'just' fulfil narrow job descriptions and work demands can be seen to suggest strong opposition and resistance to the goals of management, with individuals unwilling to align themselves with the new TC or go beyond the minimum that is required of them. This is reflected in increasing questions raised over the meaning of work and the purpose of their role. For many, placing themselves in relation to the TC was not straightforward, and people reported increasingly uncertain about who or what they were working for:

'in the back of your mind you know you are seconded means that in a way you feel like you are not totally part of the company and you perhaps feel a

bit like an agency nurse. I suppose I see myself as an NHS employee working for an organisation that is working alongside the NHS. I think it is at the forefront of your mind when you are having a bad day and you are thinking 'who am I working for, why am I doing it' (Seconded NHS Nurse).

Staff often described confusion about the aims of the organisation and what was expected of them:

'we haven't been given any goals or objectives for us to achieve apart from doing our jobs on a daily basis and I keep saying 'I don't understand what my management wants'. I could be walking in any day and I could be cocking it all up, I wouldn't know. Primarily the role they do is look to see if we are being as effective and as economic with our equipment, we have changed to an awful lot of disposable stuff which we didn't have before to cut down on waste, but that is all it really boils down to. In terms of anything else I just turn around and say 'that is not my problem that is a management problem, you sort it out' (Seconded NHS Nurse)

This does not necessarily imply there was less clarity from management than in the NHS; rather these types of dispute appeared to suggest that there were only limited foundations for mutual decision making. People strongly perceived the appearance of new managerial motivations, expectations and ideals, and there was therefore more suspicion over the purpose of decisions and in whose interest they were being made. Combined with the fragmentation associated with the multi-employer workplace this resulted in a low likelihood of decisions being followed unquestioned. The resulting practice wasn't transferred precisely from the general hospital, rather there were the longstanding staff attempting to re-create previous practices, taking into account new constraints and opportunities. Staff across all groups persistently challenged managerial decisions that they viewed as impacting on their work. Many of these conflicts were gradual in nature, overlapping with no clear point of resolution. These were played out in a new employment environment characterised by divergent groups often with contradictory ideas and interests. No single group was allowed complete control of the way things in the treatment centre were done. In some areas of practice the old NHS staff were able to dominate, for example where clinical concerns were seen as taking precedent, whereas on other occasions BritHealth managers and administrators were able to introduce changes and enforce

them through for example by appealing to new policy requirements, legal issues, the interests of patient safety and efficiency. These altered social dynamics played out alongside, rather than above or instead of existing professional and occupational dynamics.

Chapter 7 Comparing the Cases: Joined Vision - Divergent Social Relations

7.1 Introduction

This chapter summarises the differences between the two ISTC described in the two previous chapters (5 & 6), bringing together the exploratory descriptions of the two organisations in the previous two chapters to form a comparative picture of the PPP context. The management of both ISTCs envisaged comparable consumer orientated health production systems, influenced by organisational forms and approaches in other private sector industries. However, the ability of managers to bring about aspects of these production systems differed markedly between the two sites, and as strongly influenced by the nature of the partnership arrangements. These partnerships were underpinned by contractual as well as socio-cultural relations between the various groups coming together to form the ISTC, establishing the relational dynamics between partnership organisations, between various occupational and professional groups, and between employees and managers. The first section summarises how Orthe-ISTC was in some ways more representative of a 'health production system' envisaged by managers. This is then explored through a comparison of inter-organisational, inter-professional/occupation and manager-employee relations in both sites.

7.2 ISTCs as a Health Production System?

The first area in which to compare the two ISTCs was the degree to the two centres adopted distinct working practices line with the ISTC ideals envisioned by management. In both centres the managers described the ISTC project as a way to fundamentally change the way elective care surgery was produced through introducing organisational innovations. Although there were differences in the approach taken by the two management teams, in both cases a more efficiency/production orientated approach to healthcare was advocated focusing on throughput, outcomes and consumer perceptions. Efficient production was frequently cited as a reason for the ISTCs establishment and implicit in the managerial attitudes to healthcare work. Common ways in which managers sought to enact this approach were standardising routines of production, reducing unit costs by cutting down on wasted resources and increasing focus on consumer preferences.

Prevalent areas for managerial scrutiny across the two sites were increasing utilisation of the fixed assets, e.g. increasing the number of theatre sessions including evening and weekends; improving the efficiency of working practices, e.g. reducing the amount of downtime between cases and altering the skill mix; decreasing the costs of equipment usage e.g. monitoring daily use of clinical supplies; improving patient experience e.g. conducting all pre-operative tests, consultations and scheduling in a single visit. Illustrative of this approach, managers in both cases called upon metaphors of budget airlines as an ideal approach. These were held up as a model industry that was profitable, met modern consumer demands, maintained basic safety and quality requirements, sought to continually cut costs and allowed savings to be passed on to the customer (or in the case of the ISTCs, the taxpayer).

In neither case was this vision completely representative of the experience of respondents. Managers had to seek ways to interpret the general approach to the specific context they were faced with, such as the actual nature of the treatments in the contract, the various staff groups required, the types of patients, the physical environment and the resources available. At all levels contingencies were encountered that meant practices frequently had to be improvised, with emerging practices dependent on for example the local knowledge and skills responded to the given environment. For example both ISTCs produced detailed process maps of patient pathways in the early stages of development, plotting each stage of the 'production' process including decision trees, a breakdown of tasks by job role and measures for monitoring and reviewing patient flow. However, these were subject to frequent change for example in response from demands from outside organisations such as the primary care trusts for different regimes of appointments, treatment or discharge. Also in neither case were pre-defined models reported as closely followed in daily practice. Often the individual practitioners carrying out the details of treatment and adapting to the specifics of each case continued to be led by historic norms and personal professional judgement.

Moreover, creating these efficiency/production orientated workplaces involved asserting a managerial model of healthcare work which was in many ways counter to the traditional views of healthcare present amongst the clinical professional groups. Managers remained reliant on gaining the active input of doctors, nurses and other clinical groups with specialist knowledge and legitimacy to diagnose and treat patients. In both sites there was scepticism and resistance from clinical staff towards

this approach. For example, key areas of concern for nursing staff was the level of audit and paperwork, the degree of managerial involvement in how day to day tasks were done, narrowing of job roles and general work intensification. For doctors, key areas of concern were in the control they had over the treatments/procedures selected, having sole responsibility of individual patients and the scheduling of work. Across all groups of clinical staff questions were raised about the ownership of the treatment centres, the purpose of their work and the appropriateness of the profit motive. Therefore, in both sites, managers had to engage with embedded professional norms value and interests, and overcome difficulties to enact the health production organisations.

However, it could be seen that practice in Orthe-ISTC developed more in line with the managerial vision. Recalling the differences between the sites, four examples provide points for direct comparison and illustrate how organisational innovations were more straightforwardly introduced in Orthe-ISTC than General-ISTC. Firstly, Orthe ISTC re-organised hospital departments to compliment a new production system, with 'administration' largely separate from 'production'. For example, it introduced a centralised scheduling system in which all patient bookings and associated administration were conducted by a single office. A very similar approach was attempted at General-ISTC, but this was deemed unworkable by clinical staff who were used to having control over how each session was organised including the number, type and order of patients being treated. Over time the booking and scheduling staff were broken up and moved back within each department where they could be more tightly watched over by the medics and other clinical staff. Secondly, clinical roles were more easily altered in Orthe-ISTC towards those associated with a 'mass production' system, such as greater standardisation and narrowing jobs. For example it reduced medical consultant work to the 'production' parts of their role, focusing on a small range of procedures, and removing their involvement in wider learning, teaching or research activities. In General-ISTC, major changes to roles such as these would have been impossible given the majority of clinical staff continued to be employed by the NHS trust under nationally agreed terms and conditions. Thirdly, in Orthe-ISTC company policies in line with new audit and administration regimes were enforced, with managers in a stronger position to directly ensure that clinical staff followed. These included booking patients based on waiting time targets rather than clinical priorities, the auditing of paperwork and

following new rules for handling patient information. In General-ISTC administrative changes were frequently not translated into practice, with managers' ability to enforce new regimes often constrained. Fourthly, in Orthe-ISTC the focus remained on small range of pre-specified orthopaedic treatments, providing the opportunity to specialise and streamline activities. General-ISTC offered a much wider range of treatments in the first instance requiring a greater range of expertise, support and equipment. Moreover these were subject to more alteration over the study period with new treatments and additional services being introduced, closely tied to the ongoing reorganisation of activities in the wider trust.

Therefore it can be stated that managers in Orthe-ISTC were generally able to push towards a 'health production system', although this in itself could be seen as introducing a range of new challenges and growing difficulties, particularly in retaining staff and maintaining quality. Managers in General-ISTC on the other hand faced myriad obstacles in terms of embedded norms culture of the transferred professional groups and struggled to bring about the envisaged changes, although the move to the ISTC did change practice in a number of ways. Alternatively stated, it is suggested that the sites differed in the amount of power managers held over other staff groups to bring about new forms of healthcare delivery. This can not only be seen in the direct displays of authority of the managers, but also in the degree to which the new order of the health production system was internalised and accepted across the two organisations (Lukes, 2005). Even when there were no outwards signs of conflict, instilling the managerial agenda of what each ISTC 'was about' can be seen as demonstrating a degree of power and control. In order to unpick the reasons for the differences in the power relations between in the two sites, the next sections explore these by considering the relationships within and between organisational, professional and occupational groups and directly between management and staff. These are compared below.

7.3 Inter-Organisational Relations

Orthe-ISTC was to a greater extent separate and distinct from existing local health care organisations. Although built within the grounds of an existing general hospital, the ISTC was not a direct replacement for existing facilities (although it had itself been subject to recent department closures and redundancies) – rather it offered a new amalgamated orthopaedic service for the region. Management and evaluation

of the contract performance was done only by offsite contract managers based in a separate NHS Trust, with contact at this level only on occasions of official review and audit. For this reason, Orthe-ISTC could be seen as under only 'arms length' contractual control.

General-ISTC was to a far greater extent integrated into existing health organisations, with established relationships between both individual actors both within the ISTC and across the boundary with local NHS Trust. Contact with NHS Trust occurred on a day to day basis and many aspects of practice were intertwined through for example shared resources, staff moving between the Acute Trust and the ISTC, patients being treated across both sites as doctors moved the location of clinics, and knowledge and ideas were exchanged. Input from the local NHS trust occurred on a formal contractual as well as informal basis as non-employees carried out their work within the new workplace, influenced by existing norms and culture. In this way General-ISTC was under much closer scrutiny by one of the organisations involved in managing the contract. This could, in some ways be related to the ideals of partnership based on trust and reciprocity (Hornby, 1993), but included here should be a recognition of the multiplicity of actors and objectives bridging the two organisations, not merely senior managers with mutual organisational goals. Interpersonal networks between the two organisations existed at all levels, with for example nurses and doctors still involved in the hospital community, carrying with them the pre-existing professional and departmental loyalties and commitments (See figures 2 and 3 overleaf).

These inter-organisational relations were reflected to some extent in how staff viewed their roles and the basis for their work. In general Orthe-ISTC staff generally saw themselves as working for the ISTC, on a short or medium term basis, albeit with a relatively low commitment to it. For the most part, staff in felt separate from the mainstream NHS and cut off from wider professional institutions and tended to refer to their peer group as either colleagues in their home countries, or a small network of fellow countrymen working temporarily in the UK, or other international workers. Most were 'outsiders' from the NHS. Not only were staff drawn from a wide variety of national cultural backgrounds, they were also disconnected from other local NHS health organisations which viewed the ISTC with distrust. In this case, there was no consistent influence or universal 'reference point' for the employees regarding the norms, aside from individuals' multifarious backgrounds and to some extent aspects

of training. Indeed it appeared that employees that had spent the most time within the NHS were the most critical of ISTC practice.

Figure 2 Key Inter-organisational Relationships Shaping practice in Orthe-ISTC

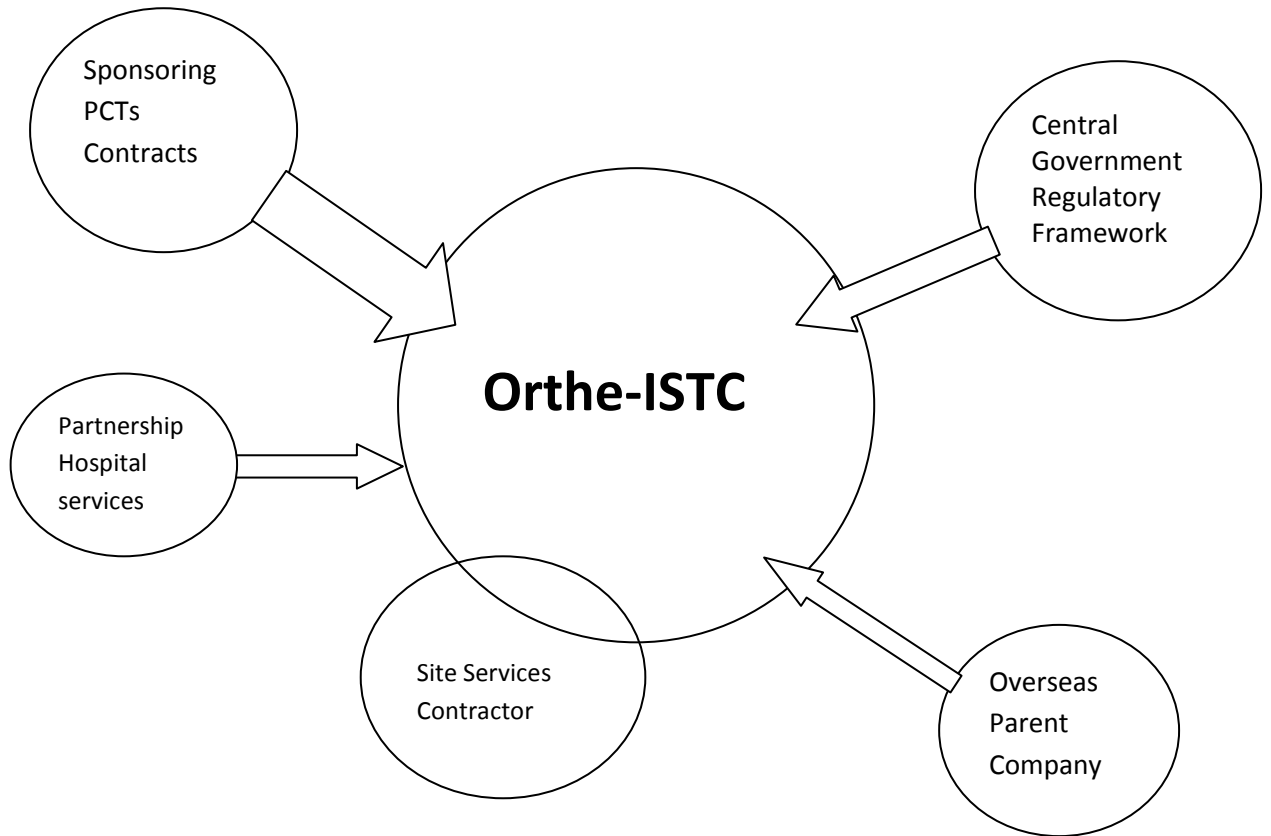
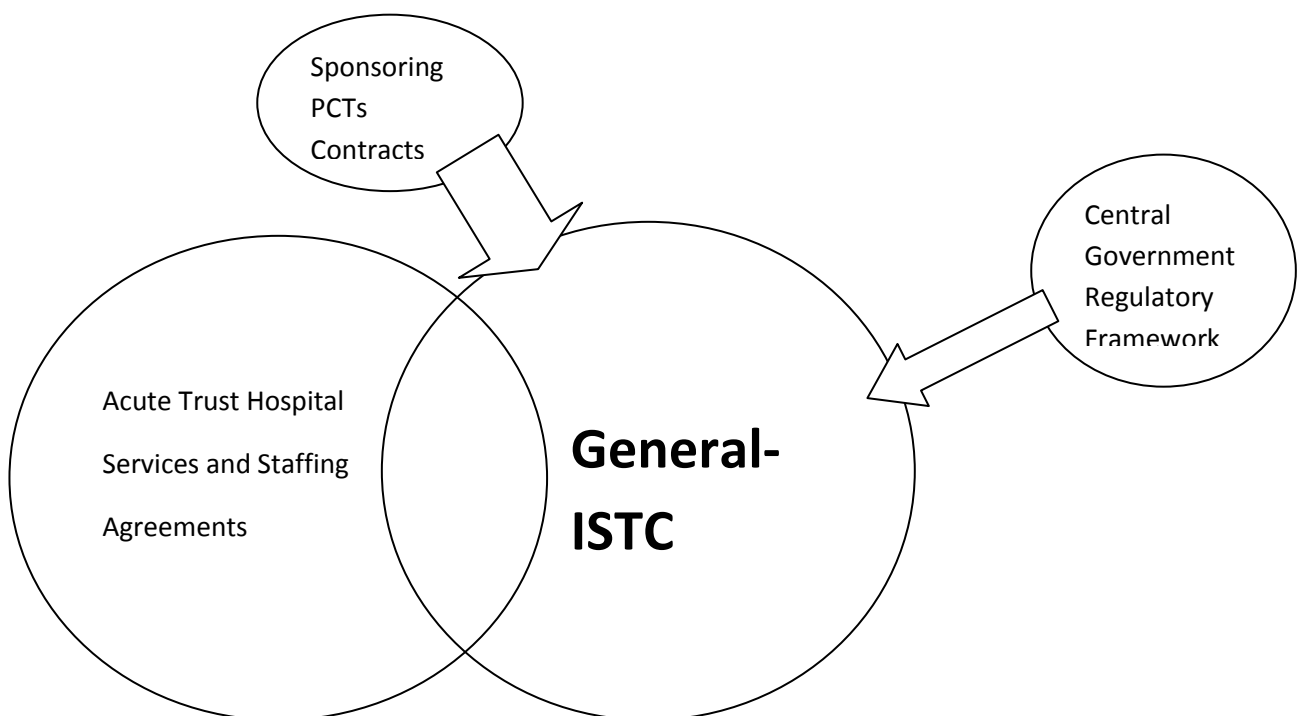


Figure 3 Key Inter-organisational Relationships Shaping practice in General ISTC



In General-ISTC there was a greater mix and less clear picture of who staff felt they worked for. With some exceptions, the full time seconded NHS staff were generally resistant to the idea of the ISTC. Some of these sought to emphasise their continuing commitment to the acute trust, for example seeing their future careers back within the trust following a short period within the ISTC. Other full time seconded staff were more hostile towards the acute trust, which they blamed for being 'forced' to move to the ISTC. Similar to the findings of Hebson and Grimshaw (2002) in some ways these respondents felt betrayed by being exposed to private management, as though they had been pushed aside following in some cases years of service. Even these however usually retained some contact with colleagues within the local NHS, albeit weaker than before to the move, and also their wider professional membership. Moreover, those who worked only partially or occasionally within the ISTC remained strongly attached to their home departments, seeing the ISTC as separate from their main place of work. Rather than temporarily 'becoming' part of a new organisation, with full recognition of ISTC management structures, ways of working, aims and visions, these staff broadly saw the ISTC as a new set of facilities or work area, rather than requiring a new form of organisational commitment. Alternative forms of practice encouraged by ISTC managers became something to cope with while temporarily working within the new building. Occasionally, actors on either side of this relationship- BritHealth managers or visiting staff- would find the actions of the other group unacceptable, and there was then a degree of negotiation to find mutually acceptable ways of working. For the most part however, the ISTC represented a temporary break from 'normal work', and ISTC management struggled to exert what they thought was a reasonable level of control. Full time BritHealth employees had a far more straightforward relationship with BritHealth as their direct employer. In some ways the BritHealth managers attempted to use these staff under direct authority as a point around which to spread changes, for example trying to place some BritHealth staff within each department. However, aside from the senior management team these represented a minority of clinical and administrative staff, often in less influential roles, and outside of the established networks and professional groups transferred from the acute trust. This is discussed further in the section below.

7.4 Occupational and Professional Relations

The second category of relationships that appeared to differ markedly between the two organisations was those within and between occupational and professional groups internally to the ISTCs. The two organisations drew together a collection of employees which varied in terms of their professional and cultural backgrounds and in terms of their familiarity with each other. Although inevitably each inter-personal relationship was shaped by wide range of factors, in general, Orthe-ISTC could be characterised as promoting more instrumental relations between professionals. Relations within the centre were more tightly limited to functional interaction that took place within the comparatively narrower jobs in terms of task and role variation. This was underpinned by the more transient nature of the workforce and lack of homophily in terms of organisational, cultural and national backgrounds. In General-ISTC longstanding patterns of relations were largely transferred into the treatment centre from the local general hospital, but altered by aspects of the new organisation including the multi-employment system, the architecture of the building and working across organisational/sectoral boundaries.

This can be seen firstly in the extent to which the professional and occupational groups in each centre saw themselves as a cohesive group. The international cohort of staff working in Orthe-ISTC had a highly restricted network of professional relationships, with those who had come directly from overseas limited in their contact in the UK to others working directly beside them in the ISTC. Other staff had been drawn together from a wide variety of organisational backgrounds with prior interpersonal relationships only between individuals rather than as a whole group, for example when staff had been recruited together or through networks, rather than on a collective basis. This can be seen with the medical staff who had been bought in through personal networks, but split between distinct national groupings, that continued to remain separate with language playing an important role:

‘But here we have different nationalities and we can discuss ... find a way to manage. Because the Germans, they are very different to Swedes and Hungarians, we have all different traditions. I don’t mind if people speak in their own language. But maybe what should happen next day or something they, maybe they should tell me that [...] I miss the feeling of collegiality.’
(Consultant Anaesthetist – Orthe-ISTC)

This could be seen as illustrative of fragmentation within professional groups across the Orthe-ISTC. Equally, relations between different professional groups, such as between medical and nursing staff, were reported as being more distant within Orthe-ISTC. Although the consultants were mostly working full time in the ISTC alongside the nursing staff, they were seen as a largely separate group with a different culture, and subject to different rules, incentives and pay levels (for example with a bonus scheme for consultants based on extra productivity). As well as the heterogeneity of the staff pool in general, divisions between professions can also be related to the nature of the roles for different groups, the distribution of work, and also the large difference in experience between the consultant grade medics and often inexperienced nursing staff. As previously stated, in order for the consultants to concentrate on surgery and seeing patients in clinic, nurses had to take on additional administrative tasks, but also stick to guidelines and follow the orders of medics and take fewer independent clinical decisions. In addition, the newness of the TC and rapid turnover of staff created less opportunities for individual relationships to develop that may bridge the gap between staff groups. Together these contributed to a perception of greater detachment between nursing and medical staff, particularly from more experienced nursing staff:

‘it causes us a lot of problems. I don’t think some of the surgeons believe that nurses are valuable. They are still very much into the mindset of when I trained back in the 1969/70s, they were the doctor’s handmaidens’ (Theatre Nurse – Orthe-ISTC)

With the cultural background of the medics again sometimes coming into play in people’s feelings of distance and separation:

‘I’m going to sound a bit racist here but the consultants here are all foreign, they’re German and Swedish and they have a different attitude towards ... they’re coming from a different place when they talk to you. So there’s very ... they’re not quite as open to suggestion as British doctors.’ (Senior Nurse – Orthe-ISTC)

However, while differences in cultural background may have played a part in creating or exaggerating perceptions of distance between staff groups, there was a feeling from respondents that it was the specific working practices of the ISTC and its adherence to production goals and regulations also supported divisions between

groups. For example, in order to achieve throughput volume, roles were described as tightly defined so as to minimise the time taken on each case by the more specialised, and highly paid, medical staff. Rather than merely reflecting practice in the medics home countries, in some cases this contradicted respondent's previous experience;

'Okay, I don't know about how it works in the UK but if I compare to [private company] in Sweden, this work is ... here the surgeon is the central and everything is made to facilitate for the surgeon to do his work. so they can sit and see the patients as much as ... be in theatre as much as possible. So ... and in Stockholm, there were ... the nurses had a lot of importance and they were ... it wasn't built up around the doctors the same, the same way. So it wasn't that efficient because the surgeon was drowned in paperwork'
(Consultant Surgeon – Orthe-ISTC)

In comparison, within General-ISTC the staff who had been transferred together remained in longstanding groupings, with established patterns of relationships within and across professional groups staying largely intact. As previously discussed medical staff remained for the most part within their home departments in local NHS hospitals, visiting the ISTC as previously they had visited theatre departments and clinics, and retaining their existing wider professional networks. Therefore, in a continuation of previous working practices they stayed for the most part separated from the other occupational groups who worked together day by day within each department, and who largely built close relationships amongst. However, given that the personal remained the same, several close relationships had been built up over the years that bridged professional divisions, for example within theatre teams existing relationships between surgeons and scrub nurses, and anaesthetists and ODPs continued largely as they had done previously. Some important changes were having a more subtle impact on the nature of relationships, for example the changes to the size and physical layout of the building, the large number of new staff and the different working patterns broke up some existing groupings. While some respondents felt this allowed a greater freedom, more often these changes were described negatively, in that that they made interpersonal relations more difficult and fragmented. In general however, most respondents in General-ISTC emphasised continuity rather than change with respect to relationships with immediate colleagues.

One important area which contradicted this picture of generally stronger intra and intra professional relations was the state of relations between groups of staff working for different employers within the two ISTCs. Specifically, there were more noticeable signs of strain and tension between staff working for the two main employing organisations in General-ISTC, namely those seconded from the NHS Trust and the Brithealth directly employed staff, than they were between the WorldHealth and separate site services staff working in Orthe-ISTC. Two reasons for this suggested themselves. First, within Orthe-IST, there was a far clearer separation of roles between the two main employing companies, with the staff from the services subcontractor employed only in non-clinical roles. Although staff these often required BigServices staff to interact with patients and work side by side with WorldHealth Staff, or in comparable roles such as reception and secretarial staff, each specific job role was filled only by staff from one or the other organisation. For example, the building reception was staffed by services staff whereas each departmental reception was staffed by WorldHealth staff. This meant that norms for interaction could be established without direct encroachment on one another's areas of work. In contrast to this, in General-ISTC there was a large overlap between the roles in each company, with staff from both employers working in clinical, administrative and site service roles. Often these were directly interchangeable, with clinical and administrative staff from each employer used in the same role on different occasions. This opened up far more potential for comparison, cross evaluation and conflict as staff employed through the two organisations went about the same tasks in different ways, under different pressures and managerial expectations. For example, the priorities of directly employed staff that closely following company procedures were viewed with suspicion by transferred staff.

Second, employment for both sets of employees in Orthe-ISTC could be seen as being founded on a more equal basis. Both groups of staff were employed by a profit making organisations, directly under management working within the ISTC, and according to private sector norms and priorities. The two main employing organisations were operating on a comparable contractual basis, with their outcomes evaluated on Key Performance Indicators by a contract manager. In this way both could be seen in some ways as 'playing the same game', with similar commercial concerns amongst management. This meant that similar values expressed by management on both sides:

'We're not here to rip the backside out of the contract, because from day one they knew what it was that we were going to make out of this contract, and agreed because at the end of the day they're a private company and they're here to make a profit. On NHS projects we have worked on it is much harder, they are always suspicious of your motives' (BigServices Manager)

This convergence of managerial values meant policies and practices could be sought that were mutually beneficial for both sets of managers. For example, as the performance of both was judged to some extent on the feedback of patients, both emphasised a 'customer focused' orientation amongst staff, pushing presentational aspects of service to be maintained across the board. In addition, although the workplace was structured along professional and occupational lines, the contractual nature of the organisations meant staff from both companies were in a similar position in terms of the fragility and uncertainty of their employment status, reliant on contractual renewal. Therefore, it could be seen that all employees in Orthe-ISTC were working under similar pressures and the fact that there were multiple employers made less difference to the comparatively weak intra and inter professional/occupational relationships that characterised the site.

In General-ISTC a different picture was apparent. The foundations for the two main employing organisations, and the nature of employment for the two groups of staff were fundamentally different. Public and private sector employees had different organisational backgrounds, norms values and expectations, and were under markedly different pressures and priorities. Therefore, while it could be said that while there was a stronger basis for occupational and professional relations amongst the transferred public sector staff working in General-ISTC, this was in some ways disrupted by the arrival of a private sector partner.

7.5 Management and Staff Relations

The final category of relationships implicated in the distinct partnership arrangements originating the ISTC's was the relationships between management and employees. The possibilities for management to influence the activity of the ISTCs towards a health-production system differed markedly between the two sites. From the other side of the relationship, it could also be said that there were differing possibilities for professional and occupational groups to resist management control. Given the multiple perspectives of the various occupational and professional groups

involved in healthcare, bringing about the managerial vision of the ISTC depended in part on managers' capacity to influence and direct the actions of others in line with it. This frequently involved seeking to change peoples' existing behaviours and overcoming resistance. While within the bounds of both ISTCs managers were officially in a position of formal authority, many other considerations entered into the balance of power between staff and management. Of particular relevance was challenge to managerial authority caused by distortion to lines of hierarchy within the partnership structure.

Within Orthe-ISTC managers played a greater role in defining the character of work than they did in General-ISTC. This difference in the comparative balance of power can be related to a number of factors, but perhaps most clearly to the structure of the two partnerships, the relationship Orthe-ISTC had with other healthcare organisations and the arrangements for staffing. To begin with WorldHealth managers had a more straightforward employment relationship involving the standard range of hierarchical powers and control. This includes the capacity to hire and fire staff, manipulate rewards for example through promotion, training, remuneration and bonuses, as well as the holding the power to penalise staff through limiting career progression, harming reputation for future employment and ultimately through the threat of employment termination. Within General-ISTC on the other hand, these hierarchical powers were heavily curtailed. The fully and partially transferred staff that remained in the employment of the NHS trust stayed on the terms and conditions set by their existing employment contract, virtually regardless of their actions within the ISTC. The managers could therefore only offer only very limited incentives and rewards for those performing extra work or working in ways that were in line with treatment centre objectives. For example, the managers in Genera-ISTC were not in a position to offer non-employees a promotion to higher clinical grades, aside from when a position was opened up by a seconded member of staff vacating a role that was in the Staff Services Agreement. Even in this case, promotion decisions were ultimately in the hands of the acute NHS Trust.

On the reverse side of this, General-ISTC managers had only limited degree of influence to directly prohibit non-employees against acting in ways that countered the managers' objectives for the ISTC. Although in extreme cases of breaching the employment contract the ISTC managers could contact the Acute Trust HRM department with a view to inducing formal discipline procedures, this was a far more

distant threat than would be the case in a more direct employment relation. Many of the front line transferred staff were overseen on a day to day basis by line managers who had themselves been transferred from the NHS Trust. Therefore, ISTC managers were reliant on NHS line managers reporting their NHS colleagues, many of whom had worked together for many years. Only then could they seek to take up issues with the management of the acute Trust. This meant that many front line staff were partially protected from any threat to employment. Further, many General-ISTC staff were only working in the ISTC for a small proportion of their working time. In these instances, the above limitations to ISTC managers' powers were significantly increased. Not only were they only in indirect control of their employment, in these cases they were also only able to seek to assert indirect control on an infrequent basis. In this case, BritHealth managers recognised it was very rarely worth seeking to change the behaviour of individual staff directly, and found it difficult to encourage staff to adhere to ISTC rules.

Aside from the direct control over staff, a further extension of management influence in Orthe-ISTC came from the type of work offered in the two sites. Although most Orthe-ISTC staff were on permanent contracts, work was relatively insecure in comparison to that in the public sector, and dependent on WorldHealth continuing to make a profit or win contracts past the initial first five year term. This changed the basis on which staff viewed managerial working practices oriented towards servicing the contract. For example focusing on meeting targets and achieving positive 'customer service' ratings was not only seen as important to meet managerial aims but also to increase the chances of receiving ongoing employment. In General-ISTC, there was a greater continuation of a more traditional approach to healthcare work. The ISTC was usually seen as an extension of 'normal' NHS work, rather than an alternative form of employment that required a different orientation to work. For the most part, staff had not consciously accepted a more routine role, and indeed continued to see themselves as part of existing NHS employment systems, career paths and professional development arrangements. Many staff worked only partially in General-ISTC and saw this as only a minority part of their job role and correspondingly remained attached to the NHS. For the full time seconded staff, continued employment was protected in the SSA agreement, and in general respondents felt that they were able to continue their career for the long term elsewhere in the NHS Trust if they so wished. This was of course not the case for

directly employed staff in General-ISTC, who may have been willing to accept a different approach to work.

Finally the balance of power between management and staff can also be seen in light of the degree of integration into wider health institutions. Coming from overseas or direct from training, staff in Orthe-ISTC often expressed uncertainty over norms of UK healthcare practice, standard conditions of employment, clinical responsibilities, and the expectations of management. In addition, Orthe-ISTC staff had a smaller potential pool of personal social and support to draw on in any challenge to management control, and less established alternatives to the managerial vision. In contrast, within General-ISTC the health care staff retained more conventional relationships with wider professional institutions both in terms of personal communication with colleagues in other health organisations and formal professional membership. Here, challenges to managerial authority were more commonplace with people drawing on pre-existing interpersonal networks of professionals encompassing medical and nursing staff as well as middle management within the ISTC. These provided a basis for staff to explore and put forward alternative points of view, and greater foundation for these alternatives to be seen as legitimate, particularly on clinical issues where existing notions of professional autonomy and expertise continued to take precedent.

The different balance of power between staff and management in the two sites can be illustrated by the degree to which staff felt obligated to work over and above their contracted roles. In general, the managers in Orthe-ISTC were in a far stronger position to persuade staff to take on extra work, and increase the pace of work, than in General-ISTC. Viewed from the other side of the relationship, the staff in General-ISTC were in a far stronger position to resist managers wishes, particularly those that had been partially or fully transferred from the local NHS Trust. This point is born out in the following two exchanges, in which an Anaesthetic Consultant in Orthe-ISTC and a Theatre Nurse in General-ISTC discuss their response to the drive from management for them to take on extra volume of work. In the first extract from Orthe-ISTC although the respondent says there are disagreements, these are understood on the terms of the management and a mutual understanding that the aims of the hospital is to 'get in patients'. In the extract from General-ISTC, the respondent recognises a set of different managerial values based on 'money' and 'the bottom line', which go against those of 'the old place', namely giving 'patients

their need' regardless of the queue behind them. Rather than accepting these new values and only questioning individual decisions based upon them, the respondent appears to be questioning the basis for the changes. Interestingly he also suggests he is using the indirect relationship with management to pre-emptively protect himself from any changes that are introduced.

Orthe-ISTC

'usually we have to work in the same ways as NHS hospitals where I have also worked, seven sessions a day, seven clinical sessions and three other sessions for administrative. But sometimes it is not ... we can't organise our job just seven sessions this way and three other sessions that way. And the management always wants us to work more and more and to evolve our admin sessions to the clinical sessions because we can do the procedures and we can increase the number of cases. So there are some disagreements but we try to sort it out and I do not think it's a big problem. But these are ... you know, I think the aim of the hospital is just to get in patients that we can show the NHS and of course we can treat people properly and it's very good and that's why usually they do not make payment for anything because we are happy to do it. Even it is in our admin sessions. Okay, but sometimes it's tiring, as you see now, it is 6 o'clock and I just got the last one at half past 7.

I Right. And how do you feel about keeping up with that pace of work?

Yeah ... okay, we can cope with it, so it's not a big problem usually. Just I wanted to tell you that in the beginning you do not know what the management wants exactly sometimes and you have got a normal regular way what you do. And sometimes they ... I mean for example, if you have got some work and you know that you have to do that work and one of your colleagues are on holiday, you have to change your plan, you have to change your daily routine, you have to take home your files and everything, just to sort everything out.' (Consultant Anaesthetist – Orthe-ISTC)

General-ISTC

'In all sense the management here haven't put any pressure on us and so I wouldn't say there is a tension now although I am mindful that there could be tension if they start using money. I am mindful that the bottom line is that it is a company and if the

company loses money it won't exist. I am always mindful that they are often looking to see where there is spare time to do operations within the time scale that is required. If they can do four easily could they possibly do five? Whereas over in the hospital you are saying 'we have got four patients who need treatment and so we will give four patients their need', I didn't even consider whether there was a queue behind them because that wasn't my concern, I was just presented with the four and I would do the four. I am now having to look a little further ahead but I don't unduly worry about it.'

I: ... 'who do you see as defining and setting the quality of your work and what is expected of you?'

'I still tend to think in my own terms and report back to my line manager who is an NHS employee and basically my sister. I always report back to her but she has to report to the private sector above here, I don't report directly to them so I sit one step away and that is a conscious step on my behalf so I don't get involved in the politics too much'

I: So it is almost like the levels of hierarchy can protect you

'Absolutely. I consider that is what they are paid for'

(Seconded NHS Nurse – General-ISTC)

For the above reasons, it could be said that Orthe-ISTC managers had greater degree of control of the work activities within their ISTC. In General-ISTC the balance of power between staff and management was more visibly contested, with relations perhaps best seen as a continuation of those well reported in mainstream public healthcare organisations. The divisions of a multi-employer workplace are imposed on top of, rather than in place of, these inter and intra groups relations.

These three relations between organisations, between professional groups, and between management and employees make up make up the context of HRM. The next section discusses this context in relation to the research questions and in relations to theoretical concern of HRM, healthcare management and public policy.

Chapter 8 Discussion

8.1 Introduction

This discussion reflects on the research question and consideration points posed in section (2.5), with respect to the literature covered in opening chapters. It seeks particularly to relate the findings emerging from the three key areas of literature, identifying how issues of generic models of HRM, translation to the public sector, and issues of permeable workplaces have been brought to light by the findings within ISTCs. In doing so it highlights numerous challenges and contradictions between the aspirations of policy over HRM, the managerial vision for the ISTCs, and the experiences of professional employment within healthcare. It finishes by reflecting back on the nature of inter-organisational relations. It suggests that the categorisations of partnerships in strategic terms may struggle to explain the emerging social order within current partnerships, and points to the ongoing interactions between actors at all levels within the organisation that contributed to the nascent character of HRM.

8.2 Facets of HRM

8.2.1 HRM Strategy and Style

This section reflects on how the findings relate to prescriptive strategies and styles of employment management. Key questions arising from the literature related the extent to which ISTCs sought and were able to define and enact consistent HRM strategies – across practices, time, occupational groups and departments - and how these were affected by partnership arrangements.

In some respects the HRM practices across the two sites are best be described as contingent, with no wholly consistent or pre-planned HRM strategy put into action. Employment practices were often established on an ad-hoc basis, in response to the unique pressures of their operating environment, staffing arrangements, and service expectations of the ISTC. In the face of contractual requirements to begin service production and maintain output levels there were few opportunities to align different HRM elements across the organisation, with different practices emerging in response to immediate operational requirements. For example in Orthe-ISTC, different criteria for recruitment, selection and promotion were used in different

departments, depending on immediate need to fill vacancies. In General ISTC, employment practices were observed as changing as the relationship between front line NHS staff and private management developed during the research period. In both cases, different departmental managers developed their own approaches to handling staffing issues in response to the varied challenges of establishing a new hospital service. As well as this, the nature of the partnership foundations placed additional constraints on the degree to which managers within either ISTC could select employment practices. Alongside the 'normal' limits of commercial pressures and market environment, the contractual nature of the organisation involved a number of national and local rules on employment.

Given this, and in line with previous studies, the label of HRM 'strategy' - either pre-planned or emergent - would appear to overstate the coherence of employment practices across the two sites (Legge, 2004). The conceptual ambiguity and evolving nature of ISTC policy meant there was little opportunity to pre-identify a single strategy; rather managers and employees alike had to be reactive and fit in with their rapidly changing circumstances. Consistency over time was also challenged in a number of ways, particularly brought about by the limited lifespan of the contract and also due to fact that the intricacies of operation only became slowly apparent during the start-up period. Both main health provider companies were relatively new entrants to the market and during the time of research were in an almost continued state of flux, not least in terms of turnover in management personnel. The start of the contracts called for a large focus on attaining minimum requirements to become operational; the recruitment of the right number of suitable employees in Orthe-ISTC and the arrangement of appropriate service level agreements in General-ISTC. Following this period and well into the contracts life, managers and employees can be seen responding to the great number of challenges encountered in the development of organisations providing complex medical services. 'Teething problems' were cited as an ongoing issue in both cases, which only had a limited period to get things up and running and meet the contractual obligations. This led to a constant pressure for change, with perceptions of inconsistency perhaps inevitable as fixes and solutions were bought in as problems arose.

Recognising the emergent and fragmented nature of practices separates this analysis from attempts to describe HRM activities as fitting wholly into any discrete normative category. On a comparative basis however some observations can be

made regarding the developing character of HRM practices found within the ISTCs and their relationship to generic HRM models. Although no comparison can be made with other industries or cultural environments, between the two sites, Orthe-ISTC could be seen as fitting more closely to the 'cost reduction' strategy presented by Shuler and Jackson (1987), with many of the observed practices indicative of a lower commitment or 'lower road' (Youndt et al, 1996) approach to HRM. This included an emphasis on standardisation of work practices and job roles, perceptions of tight management control and a seeking where possible to minimise employment costs. As the 'head count' was to some extent fixed, this largely took the form of work intensification rather than reducing staff numbers, for example trying to fit more patients onto theatre lists or expectations of staff working past contracted hours. Pay was largely based on market rates associated with the general grade of staff required, rather than an internal pay scale with wider reference to skills and competencies. Training was focused on 'firefighting' to maintain production. There was little provision for career progression within the company except on an ad-hoc basis, and although most of the staff were on permanent contracts, there were many concerns over job security following the end of the first five year agreement. Moreover, this could be seen in the attempts to focus work on 'production' activities with an absence of many of the wider provisions associated with public sector professional employment; internal career planning, long term security, professional development.

Taking this further, it could be suggested then that within the confines of Orthe-ISTC, this amounted to some degree of objectives-HRM fit (Shuler and Jackson, 1987), with a general managerial emphasis on production volume apparently matched by a HRM approach focusing on cost minimisation through lower-cost and low commitment practices. This type of approach has often been seen where human capital is replaced with technological and mechanical developments, reducing the requirements for labour in both the number of staff and the skill requirements of the staff remaining. In a similar way to that reported by Helfgott, (1988), this was enacted here through more standardised production processes, more structured jobs and reducing requirements for individual decision making in theory reducing the cost of staff. Within manufacturing this type of approach has been advocated by Youndt et al (1996) in view of strategies focused on reducing costs and eliminating uncontrollable behaviours. However, a number of important points problematise the logic of this

approach and suggest limitations in its appropriateness for a healthcare environment, from the perspective of management and clinical staff. First, many of the HRM practices were not designed specifically with organisational aims in mind, but imposed upon the Orthe-ISTC by the nature of partnership and surrounding regulation. Although there was little interference in the day to day management of staff from the partner NHS organisations, in other ways the ISTCs hand was forced by the nature of the contract, rules surrounding the ISTC and employment market, given the dominance of the NHS as an employer. Significantly, rules of additionality meant that the company was forced to look outside the NHS and were often able to recruit relatively low skilled staff or those unfamiliar with UK practice. This influenced the character of many the HRM practices. For example, training had to remain the level of basic skills, and many jobs were difficult to fill. In addition, output levels and payment had already been agreed, meaning there was little opportunity to adjust these in the face of shortages of staff. In turn, this resulted in departments lacking the required skill mix, or having to 'carry' a number of agency staff who were often generally experienced but unfamiliar with Orthe-ISTC's working practices. All of these limitations were to some extent written into policies, regulations and contracts preceding the establishment of the ISTC. Therefore, rather than a purposeful strategy, the 'low-cost' HRM practices could be seen as a by-product of the ISTC foundations. This would then appear to lend support to previous studies which suggest that such outsourcing relationships are increasingly likely to bring about 'lower quality' employment environments, less investment in staff and less well developed HRM practices (Rubery, 2004; Kinnie et al, 2005).

In addition, while the low-cost HRM character appeared to fit in some ways with a production orientation, it could also be seen that specific elements of HRM practice did not have a straightforward relationship with wider organisational objectives. For example the prescribed roles and increasing demarcation between staff ostensibly appeared to fit with both low-cost HRM and increasing production outputs. At the same time, the relatively narrow scope of jobs, the separation from NHS employment, lack of career progression and the insecure nature of were all seen as contributing to rapid turnover of employees and a generally more transient workforce. In the healthcare context, the low cost strategies were causing serious difficulties for continued provision of services. Short term efficiency gains were in part off set by wider costs of employment due to high levels of agency staff, ongoing

recruitment and training new staff. This also led to a lack of people trained into the ISTC system and job roles were felt to occasionally threaten the production output as new staff had to be continually integrated and took time to get 'up to speed'. Further, while the use of agency staff is typically associated with organisations seeking flexibility (in terms of employee numbers to meet short term demand) at the expense of quality (Kalleberg, 2001), in this case the opposite was sometimes true, with agency staff often having greater experience and higher levels of training than internal staff but at greater cost. Further, previous research has related 'low cost' employment strategies with moderate or low concern for quality (Schuler and Jackson, 1987; Arthur, 1994).

Although no direct comparisons can be made here of the quality output with other NHS services, other studies have tended to find associations between lower cost employment practices, less stable workforces and lower levels of quality and safety (Hendrix and Foreman, 2001; Tourangeau et al 2002; Ticker, 2002; Kovner, et al 2002; Clarke et al 2002; Eaton, 2000). As Hunter (1996) states high trust relations have traditionally been central to professional forms of organisation, and these lie counter to the low trust management practices of the type identified here. Indeed the serious failings in treatment centre clinical quality found by Kempshall, et al (2009) and White et al (2009) were within an ISTC under rules of additionality and composed of staff drawn from outside the NHS, although the reasons for this are not explicit in these studies. Staff shortages and turnover were also seen as a major difficulty for the ISTC management, who felt to some extent powerless to reduce turnover or increase commitment in the face of employment restrictions. These problems bring to mind the common tensions of employment management found throughout private industry, in particular the conflicting interests of management requiring both control over employees while also maintaining their active and willing input (Watson, 1986). This is explored further below (section 8.2.4). Although on the surface free from the prescriptions of NHS employment structures, this case would suggest that the contractual/partnership basis of the organisation limited the degree to which management could potentially act to balance these conflicting interests. This tension did not lead to immediate 'failure' of the organisation, as the contract value was guaranteed for five years and barring serious incident appears likely to continue for that period. However, without a stable workforce being established, the viability of the organisation in the current form beyond this initial contract may be questionable.

Turning to the General ISTC, the emerging HRM character did not resonate so clearly with any generic HRM model. For seconded staff, in comparison with Orthe-ISTC it could be said that many of the employment practices fit more closely with a 'high commitment' style or with Shuler and Jackson's (1987) 'quality enhancement' strategy. For the most part, retaining NHS employment meant pay and employment conditions were maintained, including wider pensions and sickness benefits and comparatively long term job security. Employees continued within the same nationally agreed systems of training and development, theoretically linked to work tasks and pay scale and career development, representing a comparatively structured and planned career path. As well as these explicit, formal employment practices, in some ways the aspects of employment dependent on interpersonal relationships such as trust and participation in decision making were also carried over to General-ISTC. Work practices, job roles and some established relationships between professional groups, and between middle managements and front line staff were largely transferred from the NHS trust. In view of this, employees held comparatively more autonomy and greater involvement and participation with decision making. In some respects these interpersonal aspects of the employment character were spread to the directly employed ISTC staff, as the workplace norms were set by the majority of NHS clinical staff.

Previous studies have shown how high commitment practices have been associated with numerous 'positive' evaluations and attitudes towards the organisation amongst employees (Guest and Conway 1997; Patterson et al. 1997), with these findings repeated within the UK public sector (Gould Williams, 2004; 2007). However given the split between private top management and NHS staff and the multiple arrangements for employment there appeared to be little opportunity for working towards overall consistency or purposefully matching the HRM character to the overall managerial vision of the General-ISTC. This led to unavoidable differences in the conditions of employment amongst staff, with directly employed staff not receiving the same wider benefits and pension provisions as NHS seconded staff, tighter management of absence for sickness and different terms for holiday allowance. This could be seen as undermining the basic premises of HRM and the link to wider strategy. As has been frequently identified, employment practices in themselves should not be seen as intrinsically motivating. Rather they are perhaps more usefully seen as part of the overall work environment. Explicit employment

practices are just one aspect of the employment 'deal'; what is expected, what is seen as appropriate and what is fair in the relationship between employees and managers (Watson, 2005; Hallock, 2009). As Watson (2004) states, high commitment practices are led by a principle of building a close long term relationship between managers and employees, with the implication that this may under certain circumstances lead to the active and cooperative involvement of employees. Similarly, and with specific reference to the current UK public sector environment, Gould-Williams (2007) argues that high commitment HR practice are an indication from management that they wish to engage in a positive exchange relationship. These notions have been explored in theories of social exchange and norms of reciprocity (Eisenberger, et al 2001 & 1990). Employees have been found to interpret HR practices and the trustworthiness of management as indicative of the personified organisation's commitment to them (Whitener, 2001; Koys, 1991). In turn, perceptions of the degree support provided by management are 'returned' by employees in terms of their level of trust and commitment to the organisation (Shore and Wayne, 1993).

In two ways the 'multi-employer' workforce could be seen to undermine this presumed link between HRM practices and employee behaviour. First, it creates a break in the direct relationship between those supplying the employment practices and the organisation to which employees work is contributing. Staff seconded from the acute trust saw their pay, pensions and wider career opportunities continuing to be supplied by the NHS, and these were not seen as a part of their relationship with the ISTC management. Therefore the nature of the existent employment practices may not lead to greater commitment to the treatment centre, regardless of their perceived quality, fairness or favourability. Indeed, there was some suggestion that the fact that NHS employment terms had had to be protected contributed to an environment of distrust towards the new private management who may have otherwise sought to cut pay or levels of staff, and in general undermine values seen as present within the NHS. Second, the split in terms and conditions of the two groups of staff in some cases reduced perceptions of the fairness and cohesiveness of the overall work environment, central to models of high commitment HRM. Perceptions of equity and fairness of HR practices have been found in quantitative work to be associated with perceptions of management support and trustworthiness in general (Whitehead, 2001; Koys, 2005). Here, for seconded staff the presence of

directly employed private staff was seen as creating new tensions and lack of group cohesiveness, and underlined the potentially conflicting motivations of management. For directly employed staff, comparing their own employment conditions unfavourably against their NHS colleagues who were in nominally identical roles may have detracted from any 'high commitment' signals from the management.

Therefore, in seeking the appropriate character of HRM, managers within both of the ITCs could be seen as struggling to balance the competing requirements for investing in staff and reducing costs in view of the demands of policy, partnership and their constituent workforce. The policy impetus for organisations supplying high volume, routine surgical procedures was matched in these cases by managerial visions within ISTCs of increasing standardisation and efficiency. Until recently, surgical health services have generally remained outside employment trends towards rationalisation and standardisation widely seen as advancing in other areas of industry (Littler, 1990; Braverman, 1974; Kitchener, 2000). The professional organisation of work, the status of the NHS, and the nature of healthcare practice afforded both organisations and employee groups some degree of autonomy and freedom from directly controlling forms of financial management. More recent analysis has suggested this is changing, or at least is subject to attempted changes from policy and managerial arenas (Kitchener, 2000; Harrison, 2002). ISTCs could be seen as a route to possibly sidestep the issues of control and autonomy in medical and healthcare work, and install efficiency orientated production manufacturing management approaches as far as possible within the healthcare. By recruiting from outside of the NHS, and often from outside of the UK, Orthe-ISTC was able to bring about these systems to a greater extent. However in breaking with established practices, this model of ISTC has already been found to be unsustainable and dropped from national policy. In General-ISTC employment arrangements introduced a break in the employment relationship and a greater fragmentation of the workforce. This would suggest that in neither case did contracting health services provide the opportunity to work towards more integrated, coherent systems of strategic HRM.

Table 8 Cross case comparison of employment Practices and consistency

		ISTC1	ISTC2
Employment Practices	Employment Terms and Conditions	Based on employment market requirements, but limited to predefined contract budgets.	Based on historical professional /nationally negotiated T&Cs for seconded staff, and mix between labour market and public sector norms for directly employed staff
	Work Roles	Set up for health production orientation. Narrow roles, stronger demarcation.	Continuation of existing professional roles, with some indication of work intensification
	Training and Development	Orientated to immediate skills gap	Based on national skills escalator.
	Career Progression	Ad-hoc, based on labour market shortages	Based on professional roles, but divide between seconded and directly employed staff
Overall HRM approach		'Lower Road' with some aspects in line with production orientated system	'Higher Road' due to protected employment with some pressure 'downwards' to fulfil commercial objectives.
ISTC Management control over employment practices		Medium: Direct employment relationship. Constrained by national regulations and dominance of NHS as employer and predefined production targets and regulatory environment.	Low: Mixed direct/indirect employment relationship. Constrained by existing practices, staffing agreements, contract and regulation
Perceived fairness of employment practices		Moderate: low expectations matched by low commitment based on transactional approach to employment	Low: Continued public service terms and professional orientation undermined by perceptions of being pushed out of the public sector, and multi-employment system

Internal consistency with HRM agenda: Employment practices 'fit' with ISTC objectives	Medium: control practices to enhance compliance to contractual terms. Low commitment and turnover confounded some aspects of healthcare.	Low: Employment systems geared to generic NHS context
External consistency with HRM agenda: Employment practices with wider policy objectives	Low. Transactional nature of employment, and lack of integration into wider health economy, career paths, skills framework.	Medium. National policy continued to apply to seconded but not to directly employed staff

8.2.2 Innovation and Workforce Reconfiguration

Policy surrounding ISTCs promotes the logic and priorities of manufacturing operations management, such as flow through stages of the production process, volume of throughput and reduction of waste. Within this approach, improvements in outcomes are seen as coming primarily through innovative managerial action to 'modernise' and rationalise' existing treatments, over and above the introduction of new medical knowledge. In terms of workforce reconfiguration and new working practices, such innovation are said to potentially involve mutual 'wins' for managers and employees, as for example more routine tasks are passed down to lower skilled members of the workforce (DoH, 2002a), who themselves see up skilling of their role. As part of the push for greater productivity, ISTC management across both sites could be seen as seeking to introduce various innovations and changes to workforce organisation. For example both ISTCs produced detailed process maps of patient pathways in the early stages of development, plotting each stage of the production process, including decision trees, a breakdown of tasks by job role, and measures for monitoring and reviewing patient flow. The central question here relates to the extent to which partnership arrangements within ISTCs aided or further prohibited the degree to which new working practices could be introduced.

In many ways the strongly managerial design of work promoted within ISTCs contrasts with existing forms of healthcare practice (Harrison, 2002; Harrison et al, 2002). The established role of hospital doctors in the UK is spelled out by Kitchener (2000) who stated that since the inception of the NHS, hospital doctors have typically

maintained technical autonomy in their role, and been handed control decisions over questions of treatment and hospital spending. This was 'won' as control over remuneration was handed over to the state in the establishment of the NHS. Administrators were not expected to intervene in clinical areas, and in general, quality concerns took precedence over productivity and efficiency. While this has long been seen as changing, with the power of managers in the ascendancy and that of professionals in decline (Ferlie, 1994; Harrison and Ahmed, 2000, Harrison, 2002), there is still frequently strong opposition to managerial led change and limits on managerial and bureaucratic control (Harrison and Ahmed, 2001). Alterations to roles and workforce organisations often involve movement in the boundaries between professional groups (Hyde, 2006), and the further elevation of managerial ideals above professional autonomy (Harrison, 1999; Hunter, 1996; Light, 1997). Therefore, changes to job roles can rarely be introduced unilaterally by managers or policy makers (Hyde et al., 2005; Currie, et al, 2009a).

As well as this, previous studies of partnerships and networks have suggested that workforce reconfiguration is made problematic by disruptions to employment relationship (Hunter et al 1996; Grimshaw and Hebson, 2005). In this study, the capacity of management to introduce new working practices is perhaps best seen in view of the balance of power between management and clinical staff. The partnership relations changed the balance of power through changing the relationships that clinicians held with wider health institutions, organisations and professional groups. In Orthe-ISTC pushing through changes associated with a production system was made possible by sidestepping the existing power structures, norms and culture of the NHS and imposing changes on more insecure or transient workforce. In General-ISTC where clinical staff retained stronger relationships with existing healthcare institutions, changes were commonly resisted or ignored, with professional autonomy remaining comparatively intact. This could suggest that where outsourcing arrangements undermine the status and autonomy of healthcare professionals for example by separating them from existing national structures, managers may be able to bring about greater degrees of workplace reform. Where partnerships undermine managerial hierarchical authority, changes to existing practice were more overtly contested and the divisions of a multi-employer workplace are imposed on top of, rather than in place of, existing dynamics of power and inter-groups relations.

Reflecting on this, the ISTCs could be seen as at forefront of the promotion a form of medical practice described by Harrison (2002) as the Fordist 'scientific-bureaucratic' model of medicine. In contrast to other approaches to medical care supported at different times and by different groups, the scientific-bureaucratic model stresses that knowledge is only valid when it comes from external research findings rather than personal experience, and that motivation for putting any particular piece of knowledge into practice in a given situation is that practices are written into organisational rules and protocols rather than due to a process of autonomous decision making. Harrison (2002) argues that this approach implicitly underlies much healthcare policy making by the New Labour government. Importantly here, given the emphasis on the adherence to rules and hierarchies of decision making, this model also advances what 'looks very much like a Fordist labour process, featuring increasing degrees of specification, standardisation and centralisation of control' (Harrison, 2002: 475). These themes were key aspects of the managerial efforts for change, with ISTCs perhaps representing a new 'frontier' for Fordist labour processes with healthcare. Over and above the introduction of any particular new workforce reconfiguration or innovation, ISTCs also mark an additional step in the ongoing political interface between medicine and management.

8.2.3 Consistency in Employments

In many ways this study reflects previous findings on multi-organisational partnerships in that show how such arrangements can involve the fragmentation of the workforce and introduces points of inconsistencies in the basis of employment (Morgan and Allington, 2002; Rubery et al, 2002; Cooke et al, 2004). While previous studies have mostly looked at the impacts of such inconsistencies for lower status staff groups such as services staff as well as contract managers (Hebson and Grimshaw, 2003), this study illustrates these processes in terms of the impact on relationships amongst 'clinical healthcare professional staff. Across the cases, certain aspects of the ISTCs created additional potential sources of differentiation; between organisations, between professional and occupational groups and between employers. The increases in inconsistency and the changing basis on which to judge 'fair' employment affected notions of work identity and the extent to which the employees in each centre saw themselves as a cohesive group.

The two ISTCs opened up the potential for different sources of inconsistency. Within Orthe-ISTC inconsistency stemmed from the greater differentiation between

professional groups based on the nature of work, insecurity of employment and larger demarcation between roles. Within General-ISTC, inconsistency stemmed from the mixed employment system involving directly employed, full time seconded, and visiting staff. Therefore, in various ways ISTCs can be seen as challenging policy aspirations for open and consistent systems of employment for people working under the banner of the NHS. As stated by Rubery (2004) this opens up challenges for management in terms of gaining the willing contributions of staff, as well as legal issues around equal treatment of employees. When multi-organisational partnerships lead to different terms of employment within one workplace, or even amongst colleagues in notionally identical roles as seen here, the challenge to consistency would appear even more immediate and likely to lead to tension.

Policy rhetoric around public sector employment is often roughly aligned with 'best practice' HRM (DoH, 2002a). For example, national training and development frameworks were promoted on the basis that position on the pay scale would match knowledge, experience and efforts (DoH, 2001). Contracting work out has generally been seen to contrast with these goals, as certain aspects of work are passed to the private sector with different norms and standards of employment (Morgan and Allington, 2002). Previously this has been seen as leading to a two-tier workforce, with high status professionals given secure careers and enjoying wider employment benefits and other staff groups employed on fixed term contracts with little job security (Sachdev, 2001). Some ISTCs take these trends further as full time professional posts were themselves taken out of national system, and were similarly based on fixed term agreements with no direct integration into standard career paths or pension schemes. In Orthe-ISTC some of the medical respondents appeared to be consciously selecting these types of roles as they offered a break from normal hospital duties. It could be suggested then that a lack of wider employment benefits did not appear to impact negatively on high skilled and well paid groups, who may benefit from a wider variety of work opportunities, giving them increased flexibility with less need for commitment to the organisation. While for those who are less able to pick and choose their work, non-standard employment contracts are usually assumed to pose a greater risks (Wooden and Warren, 2004), such as less career progression, training and development or intrinsic job satisfaction (Booth et al., 2000). However, Hoque and Kirkpatrick (2003) warn against simplistic assumptions around professionals in non-standard employment, finding that even at higher levels,

those on fixed term or part time contracts and particularly women are also vulnerable to marginalisation in the workplace, in terms of consultation and training opportunities. Indeed, it was the lone female medical respondent in Orthe-ISTC that most clearly vocalised their discomfort and feelings of detachment from working away from their home country with little professional support or collegiality. This may well have reflected the national groupings within the ISTC rather than indicative of gender differences in experiences of insecure work.

8.2.4 Commitment and Ethos

A cornerstone of mainstream HRM theory posits that greater commitment and motivation stems from high quality employment practices (Guest and Conway 1997; Patterson et al. 1997) with a growing body of evidence that a link may occur through norms of reciprocity (Eisenberger, et al 1986 & 1990; De Vos et al, 2003; Tzafrir et al, 2004). This has been looked at in various ways, for example through ideas of an implicit or psychological contract (Rousseau, 1989; Rousseau and Aquino, 1993), and through notions that HRM practices act as a signifier which indicate the trustworthiness of managers which under certain circumstances 'should' be returned by the level of efforts and inputs of staff (Tzafrir et al, 2004). One consequence of partnership organisational structures already identified above is that they may disrupt this chain between HRM practices, perceptions of trust, norms of reciprocity and organisational commitment. Further, in these cases, it was not simply that the less supportive HRM practices led to 'lower commitment', and that comparatively higher quality practices that remained in General-ISTC engendered higher commitment. Rather, the practices need to be seen in light of the broader context of the differing employment relationships between the two sites and wider public sector norms.

To characterise the employment relationship, in Orthe-ISTC where staff were directly employed by WorldHealth, the employment relationship could be summarised as broadly 'transactional' (Rousseau, 1990; Kalleberg and Rognes, 2000). People generally saw their work within the ISTC as a more short term, financial transaction with tightly defined tasks undertaken without the prospects of long term employment or job security. This could be said to have resulted in people viewing employment along the lines of 'new realism' (Hawkins, 1993), in which people had little expectation of wider employment support or career development, but then sought to move on at the first better opportunity. This model contrasts markedly

with established notions within both the public sector and amongst health professional groups (Boyne et al 1999), although there is some evidence that this picture is changing. Jones and Green (2006) suggest that in some areas of medicine expectations of professional devotion and long term commitment may be receding, with a greater acceptance of more transactional approaches to work and less responsibility in return for a better work/life balance. In the responses here there was some evidence of this attitude present amongst the well remunerated medical consultants and other individual staff member. These respondents looked upon the ISTC as an opportunity to take a break from more complicated 'normal' practice while pursuing wider personal interests and moving to a new country. These staff were apparently willing to accept less responsibility in exchange for more routine work, while giving less commitment. On the other side of this they could be said to be taking more responsibility for their own careers and long term security. Rather than a vocation, the ISTC offered staff work that was attractive for generally extrinsic or 'hygiene' (Herzberg, 1959) reasons, such as comparatively high pay (for overseas staff), convenience, or availability. In contrast, others staff groups reported less satisfied with their roles and stated their intention to move on. Indeed, within Orthe-ISTC this was causing difficulties in terms of generally low commitment to the organisation, skills shortage and staff turnover as they struggled to find the right calibre of employees willing to work in the jobs offered.

The employment relationship emerging in ISTC-General was far from straightforward and not easily placed along the continuum of transactional-relational employment (Kalleberg and Rognes, 2000). Rather there were multiple relationships between BritHealth management, their own staff and seconded staff, which could not easily be placed within a single category. In General-ISTC there was a greater mix and less clear picture of who staff felt they worked for, and whose interest they were working in. With some exceptions, the full time seconded NHS staff were generally sceptical and resistant towards the ISTC, despite terms and conditions being protected. For example, key areas of concern for nursing staff was the level of audit and paperwork, the degree of managerial involvement in how day to day tasks were done, narrowing of job roles and perceptions of work intensification. For doctors, key areas of concern were in the control they had over the treatments/procedures selected, having sole responsibility of individual patients and the scheduling of work. Across all groups of clinical staff questions were raised about the ownership of the ISTC and the purpose

of their work. In line with previous studies, there was certainly distrust of the profit motive amongst a number of respondents (Sachdev, 2001, Pollock, 2002). However, this did not necessarily lead directly to lack of 'motivation', rather appeared to lead in some cases to a reconsideration of the purpose of their work. Some respondents sought to emphasise their continuing commitment to the acute trust, for example seeing their future careers carrying on back within the trust following a short period within the ISTC. Other full time seconded staff were more hostile towards the acute trust, which they blamed for being 'forced' to move to the ISTC. Similar to the findings of Hebson et al (2003) in some ways these felt betrayed by being exposed to private management, as though they had been pushed aside following in some cases years of service. Even these however usually retained some contact with colleagues within the local NHS, albeit weaker than before to the move, and also their wider professional membership.

Mirvis and Hall (1996) state that under relational contracts, employees should be more likely to identify with the organisation as they are promoted, mentored and socialised internally ('I work for x'). On the other hand, those under transactional contracts should be more likely to utilise their individual skills and competencies as the basis for their employment exchange ('I do Y'). In healthcare these conceptions may already be more problematic as professionals are likely to have an existing split in loyalty and identification between their organisation and their profession (Hutton and Massey, 2006). PPPs may add an additional level of complexity in that employment may remain internal to the state employer, but work is externalised to a third party. This leads to multiple possible sources of identification and commitment in terms of professional group, employer, and workplace ('I am w, working for x, within z'). In this case, ostensibly more relational approaches to employment may well be associated with lower levels of identification and commitment as the organisation in which they work, if outsourcing involves reductions in trust and undermining intrinsic values. Tzafrir, (2004) states that over and above any individual employment practices, managers seeking commitment 'should be interested in, and nourish a high trust environment, and thus, need to provide strong backing and demonstrate their commitment to open communication, empowerment, and a just environment.' (Tzafrir, 2004: 641). Ironically, in General-ISTC, the endurance of a relatively secure formal contract with the NHS employer may well have provided the security to resist changes being made by the non-employer managing their work.

8.2.5 Training, Learning and Development

Within the case study sites, formal arrangements for training reflected directly the issues presented in national debates over ISTCs, in terms of the opportunities of training, the division of training responsibilities between partnership organisations, and in terms of integration into wider training and development programs. In addition, the cases highlight the consequences of these for both individual members of staff and the wider organisations.

In Orthe-ISTC training and development opportunities were comparatively restricted. Many of the distinctive features of the ISTC including the limited range of lower risk procedures, the nature of job design, employing only consultant grade medics and the absence of teaching facilities meant that training activities were dramatically reduced in comparison to similar NHS facilities. The training activities that did take place were to address the basic skills shortages stemming from the low skill levels of many nursing staff. This situation mirrored concerns raised over the impact of wave one ISTCs on the NHS; namely that such arrangements reduced the number of routine operations on which junior doctors could potentially train. However, no straightforward conclusions can be drawn from this case about the effects of this type of work on the training of the general health workforce. Within the ISTC, individuals did not respond passively to the lack of training opportunities, with a collection of people going out of their way to find other forms of training and to 'keep their hand in', for example working days off within NHS or other private facilities and seeking greater involvement in professional networks than demanded by daily activities. Others recognised the limited scope of practice and room for development and were conscious that they would need to move on to progress their careers. This model of ISTC could then be seen as passing the responsibility of training and career planning from the organisation to the individual. This represents a dramatic break from well established practice within healthcare and also counters the aims portrayed in national HRM training and development policy (DoH, 2001, 2002a).

In General-ISTC, training activities were protected and to a certain extent were merged with existing arrangements within the adjacent general teaching hospital. Junior doctors and student nurses were continuously on site. Although the time ISTC staff dedicated to supervising trainees had been agreed within the partnership contractual arrangements, on a day to day basis these were not referred to as

training continued under the supervision of hospital consultants and nurse mentors who maintained established norms. A similar case could be seen in the continuing development of full time ISTC staff, who continued to have access to Trust wide training opportunities. The major issue referred to as problematic in relation to formal training was in regards to the period of transfer. Due to negotiations between the organisations over transfer dates, little preparation time was available, with most respondents reporting difficulties and concerns over safety during the first weeks of operation.

Aside from these formal training elements, across the two sites there was little to suggest that learning had taken a higher priority or had been improved through changing interpersonal relationships. Indeed, the findings suggest that the particular history, management style and organisational context of ISTC may present additional barriers to open communication and the development of the close interpersonal relationships. This is view of discussion on the inter-professional barriers to knowledge sharing within healthcare settings, and the importance trust amongst colleagues and in management for learning sharing (Hartley and Bennington, 2006; Mooradian, et al 2006). These barriers can be seen in the more instrumental nature of relationships identified across Orthe-ISTC, and in the low trusting, often tense relationships identified between different employee groups. In general this study would suggest that within ISTCs, existing institutional barriers are joined by additional factors which may reduce the organisations conduciveness to learning, including the contractual arrangements, regulatory context performance measures, and the increasing demarcation between occupational and professional groups.

8.2.6 The role of the HRM function

The final aspect of HRM to consider is that of the activities, position and prospects for the HRM function within the ISTC organisations. This has been to some extent covered in the previous sections which have discussed in a general sense the people management activities dispersed throughout the organisations. Here we consider the parts of management that are explicitly seen as concerned with undertaking 'HRM'. It has been suggested by policy and market reform advocates that within smaller, more independent units, HRM may take on a more strategic role, able to drive through employment innovations and achieve greater flexibility to make managerial practices fit with organisational objectives (Bosenquet et al, 2006). Across the two ISTCs the HRM function took on different roles and guises, with varied issues to contend with

during the establishment of the organisations. The complications and idiosyncratic challenges of the organisations opened up new roles and types of activities for the Human Resource Managers.

In Orthe-ISTC the HRM department itself took on a central role in the establishment of the centre, particularly with regards to recruiting a sufficient workforce. Regulations surrounding employment and the limited employment market outside of the NHS meant this was a central focus of senior management during the early stages of the ISTC, ongoing throughout the research period. In contrast to reports from other healthcare settings (Proctor and Currie, 1999; Lupton and Shaw, 2001) this placed the HR manager firmly at the centre of the developing organisation. However, this central role for the HR manager should not be seen as necessarily indicative of the wider acceptance of normative HRM ideals across senior management. Nor did it necessarily lead to any overarching consideration of the most appropriate or collectively acceptable ways of managing the employment relationship given the character of work, nature of employees and objectives of managers and employees. In these respects the activities of the HRM department could be seen as less well established and more informal, a trend observed as common across SMEs in comparison to larger organisations (Dundon and Wilkinson 2003; Earnshaw et al, 1999). Although subject to the health regulatory environment that meant certain roles had to be fulfilled, the practicalities of starting up the ISTC overrode any objectives for long term HRM strategic planning that may have been present. In order to get sufficient numbers of staff to become operational, recruitment was a primary and continuous activity and often had to be done on an ad-hoc basis, rather than retaining strict criteria for selection. This focus on recruitment was continuing to take the majority of the HRM departments' time, leaving them little opportunity to develop other aspects of managing the employment relationship. This extended into the day to day management of staff, where the HRM department had only recently and informally begun to consider issues relating to 'styles' of management, staff involvement and communication. Only given the ongoing problems caused by the level of turnover and difficulty retaining staff was the HR manager beginning to consider the tensions surrounding employment in the ISTC.

In the General-ISTC, the HR manager was in a very different position, and one which in many respects reflected the issues brought up by previous work on partnerships and networked organisations (Colling, 2005). That is, the role, responsibility and

jurisdiction of the internal HR department were not immediately clear and were influenced by the inter-organisational relations. By the HR managers own admission, there were limited in the degree to which they could directly influence people to the company's own 'ways of working' given their indirect authority over non-employees, particularly those only working partially within the ISTC. The 'usual' tasks of HRM had to be shared with both the main HRM department within the acute Trust, and the seconded line managers. Examples of this included seeking compliance to the procedures for sick leave and holiday entitlement. These differed between the two employee groups, and the BritHealth manager could not seek to monitor or enforce compliance for the NHS employed staff. Instead they had to negotiate with line managers the acute trust HR manager to enforce these aspects of employment. Further, in the key issue of recruitment responsibilities were divided, with the trust HR department responsible for replacing their own staff working inside the ISTC. Even for directly recruited staff, seconded NHS line managers had reported having an increasing degree of influence over who was employed, with early appointees seen as not up to standard by the seconded line managers, who stated they 'won back' the final say on later recruits. In light of this, the HRM department in this case could be seen as taking on a familiar 'weak' (Lupton 2000) administrative role in the face of professional power in healthcare. This could be seen as increasing as the BritHealth HRM department suffered from lower organisational status as well as lower professional status in comparison to the NHS doctors and senior nurse managers. Although they were more able to make some decisions for their own staff in ways that did not directly impact on seconded employees more independently, the power relations in partnership meant that prospects for spreading a single, consistent approach to managing 'human resources' across the ISTC were curtailed.

Therefore, in different ways, new opportunities and limits for the HR departments across both cases arose from the nature of the inter-organisational arrangements. Many of the tasks traditionally associated with HRM may become more central to the operation of organisations as they are required to find solutions for problems of managing employment in complex inter-organisational relations (Hickson, et al 1971). For example three of roles Ulrich's (1997) recommended that Human Resource Managers should seek to take on appear likely to be in demand in the transition to partnership working. Namely those of providing employee support in periods of change, providing expert administrative and legal advice and acting as a

bridge between employees and managers. At the same time ambiguities within partnership relationships and indirect employment may make these tasks more challenging and require ongoing monitoring of legal precedents and norms for staff participation within these environments. Moreover, Ulrich's fourth role of aligning HR practices to global business aims may also be more difficult to achieve. The opportunities for HRM were not necessarily directly linked to any single wider espoused organisational goals of the different organisations involved. Hunter et al's (1996) proposal for new HRM roles within networks focused on how clients may encourage HR systems within their suppliers that matched their strategy such as cost reduction or quality improvement. Here, looking from the suppliers perspective, there was little attempt from either side to align HRM efforts in any consistent approach across the partnership. Instead the ISTC HRM had to cope with the demands of the NHS on a national level, in terms of regulatory frameworks for healthcare employment in general and the specific rules for staffing ISTC, as well as on a local level in terms of meeting contracted outputs, staffing levels and other performance indicators. In addition, where feasible they sought to fulfil their own corporate aims, which mainly took the form of efficiency improvements. HRM could be seen as reacting to the various demands within the specific local context and configuration of interests. This indefinite role of HRM could be seen as reflecting the blurred lines of partnerships across the public and private sector. This is explored further in the final section of this discussion below.

8.3 HRM and PPPs: The Sector Divide Outside and Inside the Workplace

Previous studies have suggested an exploration of the structure of contractual relationships with types of employment practices (Hunter, et al 1996; Scarborough, 2000). Reflecting on this, this section attempts to consider the interaction between types of partnerships seen here and the HRM practices identified above. The categorisations presented in section 2.4 by Child (1987) and Bovaird (2006) are useful but also in many ways appear inadequate when looking at the processes and interpersonal/intergroup relationship of inter-organisational partnerships. These taxonomies of partnership have tended to focus on the level of the organisation, for example attempting to draw a line between characteristics of the market and the structure of agreements between organisations. Both of the cases presented here were in these respects fairly similar; both ISTC companies had a single customer and

service levels and prices were agreed and fixed over the medium term. This would appear to fit with ideas of relational or co-ordinated contracting. A link here could be presumed between this overall partnership type and employment practices that could support them. However, it would be difficult to relate these directly to behaviours associated with ideals of partnership working. The 'partnerships' were not a single relationship between organisations, but ongoing relations between individuals, work groups, departments, both within and across hierarchies. They could also be seen changing over time, not merely in logical stages or partnership life cycles (as identified by Lowndes and Skeltcher, 1998), but with degrees of cooperation, trust and control altering on a case by case basis.

Within the cases, many instances could be pointed to of active co-operation and areas of mutual interest. Agreements were negotiated and routines were developed to aid interaction between groups within both sectors. At the same time, in neither case did 'partnership' arrangements appear to lead to any lasting or wholesale convergence between partner organisations and there were points of tension between actors at all levels. Therefore rather than a direct relationship between partnership structure and employment practices, the way market interactions were structured and regulated altered the context in which these day to day interaction were played out. In Orthe-ISTC, the boundary between public and private existed outside of the workplace and the bounds of the ISTC. The contract and regulatory framework stipulated approximate expectations and levels of output, and negotiations over these took place between senior managers of the ISTC and the contract managers within the NHS. Separated by distance, this was done by contract negotiation, formal communications and scheduled meeting. Tensions within the workplace, for example over the pace of work, were on the level of management-staff relations. In General-ISTC the boundary between sectors was not as clear cut. Discussion and disputes between the public and private sector on the norms of practice took place on a day to day basis, for example as managers sought to increase the patient throughput and meet contractual obligations. Although this could be seen as bringing sectors closer together and increasing interaction, it could also be seen as amplifying the tensions, as disparities and divergent interests were continually played out along a greatly expanded 'front line'.

A concept that may help to describe the nature of these inter-sectoral relations is that of a negotiated order. Negotiated order has been frequently applied to a

healthcare context (Strauss, et al 1963; Svensson, 1996; Allen, 1997; Currie; 1999), most often in the portrayal of the relationship between professional groups, such as the interplay between doctors and nurses or between management and employees. Broadly this suggests that in contested or uncertain areas of work not governed by explicit rules or policies, different interpretations of the nature of the area or activity and its meaning come into play. Without reviewing these insights here, this concept accents both the context, in terms of the intuitively accepted relationship between groups as well as more unmovable rules and hierarchies, and the micro processes of interaction in determining how work tasks, responsibilities and areas of control are split between groups. These are mutually constitutive with existing social order giving form to negotiations, and negotiation contributing in part to the constitution of social order. Each group may attempt to portray their own actions as legitimate by for example by calling on various rationales, values or moral discourses in support of their position. These are, in part, based on the existing social order and the roles that each occupational or work group play within it. Instances from the case studies, particularly the multi-employment environment of General-ISTC suggest that negotiations such as these came into play as the bounds of the work activities of the public and private employees were founded. The most salient example is perhaps in the instance of the ISTC manager dismissed from the company in the face of complaints and disharmony from the NHS staff. Similar processes could be seen in the daily discussions between ISTC administrators and clinical staff over the number of patients seen, paperwork completed, equipment used, speed of work, timekeeping and order and division of work. Within these disputes familiar ideological concepts associated with the public and private sector as well as the public sector management (Pettigrew et al, 1992) often came into play. On the side of private management: value for money efficiency, reducing waste, rationalising, streamlining and output. On the side of healthcare clinical workers: expert knowledge, experience, patient care, and process (Harrison, 2002). It is on negotiations within this context that the employment practices that do emerge are contingent.

In this way PPPs shift the divide between public and private sectors in the provision of services inside the workplace. When the sectors are closely intertwined, the dividing line between the two are as much between actors at the individual level as between organisations. In these instances, sectoral boundaries were no longer

separated on the basis of industry or service provided, but on the level of individual relationships between management and employees, between colleagues and co-workers. In the case of original PFI 'design, build, and operate' schemes, there was a degree of separation between sectors in the form of a dividing line between different functions of the organisation with contract managers undertaking negotiations over levels of service and performance standards (Grimshaw et al, 2002). While these would often require interaction across groups, there was a point at which the jobs of those in one sector are separated from those of another by titles, responsibilities and job descriptions (Hebson et al 2003). In the case of ISTCs where people from different sectors have ostensibly the same job titles, but with different priorities and under different pressures, it could be increasingly difficult to distinguish between the two, even if for internal actors the differences are stark and important parts of their understanding of the organisation. There remained differences in perceptions of the two sectors, and these may be most apparent and important for people working on the front line, for example as they are compelled to cope with the actions of others on the other side of the divide. Given this, within PPPs the boundaries between sectors are not removed or perhaps even diminished. Instead they are complex and intricate, and dependent on self and group identities, people's interactions with their colleagues, and everyday disputes as well as forms of cooperation at work. When people from both sectors work together on the same activities in structured relations, boundaries are to some extent constructed with respect to the ongoing process of daily practice.

Chapter 9 Conclusions

9.1 Introduction

This concluding chapter draws together the research findings and summarizes the theoretical contributions to the three areas of literature informing the study; namely Human Resource Management, Health Care Management and Public Private Partnerships. It also reflects on the practical implications of the findings, particularly for HR managers. Finally it points to a number of limitations of the study and future research directions.

9.2 Contributions and Practical Implications

The overall contribution of this study lies in extending research into the relationship between new organisational forms and employment into the highly professionalised field of healthcare and considering the implications for HRM. Previous studies have shown how inter-organisational relations can lead to tensions in the employment relationship, a break between employers and employees and more controlling forms of management as dominant organisations seek to influence employment across a supply chain network. This study contributes to this literature, supports previous findings and illustrates how employment practices are shaped by the particular structure of contract relations involved in two Independent Sector Treatment Centres. More uniquely it also illustrates how the additional factor of inter-professional relations was altered within this context and played into the emerging relations between organisations and between managers and employees. The break in the employment relationship not only reduced managers responsibilities towards 'non-employees' in terms of providing secure careers and development opportunities, but also changed the basis on which healthcare professionals and managers both employing and non employing interacted.

This introduced new contingencies for public sector HRM. Inter-organisational relations played out on top of existing inter-professional and managerial-clinical relations, which already place restrictions in the degree to which managers can shape employment practice. At the broadest level, normative HRM theory suggests that managers should seek implement HRM practices that support the organisational aims and will benefit overall organisational performance. Although ISTCs represented smaller, operationally more focused organisations than general NHS teaching

hospitals, they did not appear to offer a greater opportunity for more purposefully tailored HRM practices. Where staff retained their existing employment contracts and remained within existing professional networks, the existing barriers between managers and clinical staff were increased across organisational boundaries. On the other hand, where there was greater independence from national employment structures and professional institutions placed managers in a greater position of power over clinical staff. However, rather than presenting the HRM department with an opportunity to freely select HRM practices in tune with the overall managerial objectives, the nature of the contract ultimately led the organisation towards lower commitment forms of HRM.

Within this picture, the study raises important points for current HRM theorising. At the broadest level HRM theory remains concerned with the link between adoption of HRM practices and overall organisational performance. Studies continue to both seek the link between the adoption of HRM practices and overall performance, and seek to identify underlying reasons for such an association (Marchington and Zagelmeyer, 2005). This study suggests that any link is very difficult to assume when employees work is separated from their employers, with people conscious of who supplied the employment benefits and who profited from their work. This suggests that HRM theory seeking to link practices with outcomes should pay much greater attention to the interpretations of the wider context of employment, not merely an association between certain behaviours and the presence or absence of, for example, job security or particular training regimes. In terms of fairness and consistency, this study generally supports previous studies which have highlighted how inter-organisational contracts open gaps for inconsistencies in employment and the application of management practice. An important extension to this found here is in terms of inconsistency across the public sector workforce as a whole, as different contract arrangements and regulations between the sites investigated here led to an entirely different form of employment relationship.

For healthcare management the study illustrates new dimensions of the interface between management and clinical practice. For management, ISTCs were generally interpreted as an opportunity to install a healthcare production system. That is, a form of surgery and diagnosis that promoted volume, efficiency, output, streamlining workflows and meeting consumer demands. This can be seen extending the ongoing policy push for 'scientific-bureaucratic' forms of medicine and the promotion of

managerial logics within healthcare (Kitchener, 2000; Harrison, 2002). The cases presented here show how the nature of the relationship between managers and professional groups are not uniform, but are impacted by the power dynamics supported by the organisational structure, here shown by the contrasting outcomes in different partnership arrangements. By sidestepping existing health institutions, one of the ISTCs was able to make certain changes away from more traditional forms of healthcare provision. However in doing so, many aspects of emerging practice appeared to counter prevalent ideas on quality. Further, without the support of the professional associations, and following questions over training and impact on existing services, ISTCs operating completely outside the NHS proved impossible to sustain at the level of public policy, with subsequent ISTCs integrated more fully with the NHS. This would suggest that while the direction of change in healthcare may be continuing towards more 'managed' forms, there is no immediate end point in this process, with managers and policy makers unable to introduce change outside of the influence or involvement of health professional groups.

Reflecting on the studies contribution to the field of public private partnerships, the study provides an illustration of the interaction between sectors not just on a strategic, organisational level but on the level of individuals carrying out their work. Part of third way rhetoric claimed that policy decisions should be 'beyond dogma' and not related to ideological standpoints. Within the study sites there was little indication that tensions or differences between the public and private sector have disappeared. For some, these were experienced more starkly in the day to day activities of healthcare practice. The findings would appear to have ongoing relevance for public policy. In its final two years in office, the 1997-2010 New Labour government appeared to have rowed back on some of its original predictions for the level of involvement for the private sector in public services, for example revising estimates of the amount of elective surgery to be provided by ISTCs from 15% to 5% (DoH, 2008 a&b). In addition, it has been suggested that a number of the facilities already open are to be purchased back by local NHS trusts, and other contracts with ISTC providers cancelled after the first term following changes in economic conditions and implications for the most pressing health service demands. While the ISTC program may have fallen out of fashion with policy makers, new forms of organisation that include relationships between private sector companies and public services are set to take their place. This is especially true in light of recent economic

conditions and the current emphasis on cutting budgets and reducing costs. In light of the association between markets, private interest and improvements in efficiency and value for money in neo-classical economic theory, calls for increased involvement of the private sector in public services are almost certain to increase. The incoming Conservative-Liberal Democrat government are again strongly invoking market ideals as the means to cut waste, and advocating an expanded role for the private sector. In February 2010, plans had already been announced for private sector management to take over 'failing' and heavily indebted NHS hospital. Many of the findings of this study would appear relevant for such an 'innovation' including the mixed hierarchies between public sector staff and private management, conflicting interests, working and managing for those outside of one's own direct employer (TimesOnline, 2010).

The findings of the study have practical implications for all groups involved in public service provision, for public policy, health service management and professional and employee groups. To begin with, the study highlights some of complexities involved in cross sector partnerships, and the unintended consequences of contracting out aspects of service. Although literature on partnership frequently stresses the requirements of inter-organisational trust for supply relationships to run smoothly and efficiently, the study shows political and cultural tensions can surface during partnership arrangements that have a bearing on the extent to which contracts can reach their managerially desired objectives. Therefore those making decisions on whether to contract out should be alert to the fact externalising work is not risk free. This is especially true in the public sector context, where the contracting organisation is often seen in the eyes of the public as retaining responsibility for supplying the service. In decisions to contract services out, the perceived efficiency or competency benefits of bringing external suppliers needs to be balanced with the continued requirements of accountability and control. More specifically this balance also relates to how HR managers within partnerships understand their role. The transition to partnership working requires knowledge of the legal issues involved in transferring staff between sites and employers and equal opportunities regulation to ensure that employees under different contracts are treated fairly. In the highly regulated public sector, responsibility for managing subcontracted staff may be shared between partnership organisations in ways that are not immediately apparent from the initial contract. The ability to influencing activities across organisational boundaries

depends on numerous contextual factors and may continue to change and evolve in an ongoing basis. Finally, for occupational and employee groups this study points to some of the opportunities and threats of working within partnership arrangements. Even when work is protected, the nature of jobs may change incrementally under new management, with only indirect routes available to make the voice to management heard. Partnerships may however offer the possibility for changing working practices and potential career development opportunities for those in occupational groups under-supplied in the labour market. This includes the possibility of striking a different employment deal to those usually expected within a healthcare environment.

9.3 Limitations and Suggestions for Future Research

Limitations can be identified with several aspects of this study. Qualitative case study research is always to some extent necessarily incomplete as artificial boundaries have to be drawn in terms of scope and time. Here we focus on the limits of the interpretations and the wider applicability of the findings. As identified in the methodology chapter, qualitative research in general and case studies in particular do not allow for straightforward statistical generalisation. Therefore, no a priori assumptions can be made as to the applicability of the findings reported here to other PPP contexts, or even other ISTCs. In light of the high degree of variation observed even between these two cases, caution should be exercised in viewing these two instances here as 'types' or 'models' of ISTCs that may be representative of other sites where similar rules for staffing or structure of inter-organisational relations can be found. Only through additional experience could a reader of the research identify which findings reported here are repeated elsewhere. The discussion covered above does however help to place the study in relation to previous theory and research, helping to build cumulative knowledge on the interaction between organisations and its impact on healthcare employment and management. Further caution is also necessary about generalisations within the cases. In general this study has attempted to look for trends and themes within each case site, through which comparisons between the two cases could be made. However, there could equally have been description of variations within each case, for example between individuals or over time. Each ISTC 'case' in fact involved a collection of individuals that could be compared in any number of ways such as social class, gender, personal history or national background, and not merely on how and

where they were employed. Assumptions cannot be made about the behaviour of non-respondents, or that of people acting in ostensibly similar circumstances.

Some of these limitations in terms of generalisability could be partially addressed in future studies investigating inter-organisational relations and employment in public services. For example, some attempt could be made to quantify certain findings in order to identify wider trends. Little is currently known about the job security, turnover and levels of employee satisfaction within ISTCs, and this type of data would appear highly useful to inform policy, managerial and job seeking decisions. Addressing a more theoretical question, one possible route for study that would appear to build on existing attempts in HR to investigate link between employment practices and employee perceptions, is the notion that when managed by 'non employers' the link between positive employment practices and increased commitment may be reduced. One problem with these types of studies is the large degree of variation that is likely to exist between each instance of independent sector service provision. Given the rapid pace of policy change and the continued shifts in regulation surrounding the engagement of independent providers with the NHS, ongoing exploratory qualitative work would appear necessary to maintain knowledge of contemporary organisational arrangements within healthcare. Over time these could contribute to a greater understanding of the dynamic interactions of independent sector organisations, the state and professional groups in a healthcare environment that is increasingly characterised by a plurality of provision. For example, from a HRM perspective studies in this vein may draw out the relationship between different contracting models and the degree of influence HRM departments hold over shaping job content. Greater emphasis could be placed on identifying the factors that determine the respective jurisdictions of HRM departments in supplying and contracting organisations. This type of work may simultaneously contribute to study on the sociology of professions, investigating how the stratification within particular professional groups is impacted by the varying degree of movement to independent providers. For example, does externalising certain types of activity lead to the 'downgrading' of particular branches of surgery as work in these areas is routinised and tightly managed? Alternatively does this offer an opportunity for surgeons to become more involved in the management of independent providers and gain greater independence from the state? This type of

research would appear necessary in order to understand the nature of a healthcare system in a continual state of change.

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