

**Exploring Labour-Management  
Partnership in NHS Scotland**

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**Thesis submitted to the University of  
Nottingham for the degree of Doctor of  
Philosophy**

**June 2012**

## **Abstract**

The past few decades have witnessed a change from traditionally adversarial labour-management relations to a new type of partnership arrangement in British industrial relations in some organisations. It is expected that such arrangement may provide an opportunity for Britain unions to return from political and economic exile, and secure mutual gains for the primary parties to the employment relationship.

This thesis is concerned with partnership arrangements in NHS Scotland which were developed against the background of a post-devolution consensus on how health services should be organised. Based on a longitudinal research method, this study has assessed the partnership arrangements in three health boards of NHS Scotland. Each of these case studies includes a programme of interviews with senior managers, human resource managers, Employee Directors and other trade union representatives, and analysis of minutes of partnership consultation meetings and board archives.

The main objectives of the research were outlined as follows:

- to describe the general context in which partnership arrangements play out in three cases,
- to describe how partnership operates in the three cases,
- to explore the evolution of partnership in the three cases,
- to compare and analyse the outcomes of partnership in the three cases.

A key conclusion of the research is that mutual gains can be successfully secured through a partnership approach. However, the extent to which mutual gains can be obtained by both management and trade unions is greatly shaped by the external and internal contexts surrounding the organisation and the way partnership is implemented.

## **Acknowledgements**

I would like to express my gratitude to all those who gave me the possibility to complete this thesis, in particular to the following: to my supervisors Nicolas Bacon, Peter Samuel and Kim Hoque for their patience, unwavering support, warm encouragement and thoughtful guidance; to all the managers, employee directors and union officials who have participated in the research, providing precious materials and sharing valuable views on the labour-management partnership; to my father and mother who I am forever indebted for supporting me throughout; and to my wonderful fiancée XiaDi Su, whose unwavering love were undeniably the bedrock upon which the past three years of my life have been built.

Sincere thanks are due also to staff and friends at Nottingham Business School. Of my full-time doctoral contemporaries, Wei Gu, Kai Dai and Lei Zhang, have shared most of the pleasure and the sorrow along the way. Finally, I would also like to thank all library and administrative support staff.

Xiaoguang Zhou

Nottingham

2012

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## **Abbreviations**

ACAS	Arbitration and Conciliation and Advisory Service
APF	Area Partnership Forum
CHP	Community Health Partnership
DTI	Department of Trade and Industry
HRF	Human Resources Forum
IPA	Involvement and Participation Association
LPF	Local Partnership Forum
NHS	National Health Service
NWC	National Workforce Committee
SEHD	Scottish Executive Health Department
SGC	Staff Governance Committee
SGHD	The Scottish Government Health Directorate
SNP	Scottish National Party
SPF	Scottish Partnership Forum
STAC	Scottish Terms and Conditions Committee
SWAG	Scottish Workforce and Staff Governance Committee
TUC	Trade Union Congress

# Chapter 1. Introduction

## 1.1 Overview

The past few decades have witnessed a change from traditionally adversarial labour-management relations to a new type of partnership arrangement in industrial relations in some British organisations (Ackers and Payne, 1998; Bacon and Samuel, 2009; Brown, 2000; Terry, 2003; Johnstone et al., 2009). The emergence of such arrangements was located in a specific context of trade union membership decline, organisational weaknesses and government transition. Since the first of four consecutive Conservative governments in 1979, trade unions have been weakened due to profound changes in workforce composition, macro-economic conditions, the strategies and structures of unions, and most importantly, the policies of Conservative governments (Gall and McKay, 1999; Metcalf, 2004; Millward et al., 2000; Tailby and Winchester, 2005). This is supported by evidence which suggests that trade unions' influence is falling, both at the workplace and in the political arena (Brown, 2000). Under such circumstances, trade unions had to find alternative ways to revitalise. From the early 1990s, the Trades Union Congress (TUC) encouraged its members to adopt a partnership approach in management-union relations. After its election in 1997, the New Labour government also supported the idea of partnership, which formed a key plank of the government's employment policy of 'modernisation' (Stuart and Martinez-Lucio, 2005a).

Three main stream of literature on workplace partnership has emerged, with advocates, critics and contingents offering competing and overlapping views on its effects upon workplace employment relations (Ackers and Payne, 1998; Kelly, 1996; 2004; Kochan and Osterman, 1998; Oxenbridge and Brown, 2002; 2004; Samuel,

2005; 2007). Advocates emphasise the opportunities for the rhetoric of partnership presented to trade unions to rebuild their institutional presence, and to deliver mutual gains (Ackers and Payne, 1998; Kochan and Osterman, 1994). This is further supported by evidence which suggests that all employees, employers and trade unions can benefit from working in partnership. Commentators have reported that partnership can provide employment security, increased training and involvement, and better terms and conditions for employees (Brown, 2000; Guest and Peccei, 2001; Oxenbridge and Brown, 2004). Employers can also benefit from working in partnership with trade unions, gaining unions' assistance in managing change, increased productivity and superior financial performance (Brown, 2000; Guest and Peccei, 2001; Oxenbridge and Brown, 2004; Wills, 2004; Samuel, 2007). As for trade unions, they can benefit from being recognised for their legitimate role, improved information sharing, and increased opportunity to influence management decision-making (Ackers et al., 2005; Guest and Peccei, 2001; Oxenbridge and Brown, 2004).

Critics of partnership suggest that the dominant role of employers in British industrial relations does not change under partnership arrangement, and partnership may be used to incorporate unions which may lead to compliant unions, thus limiting the ability of unions to attract members (Kelly, 1996; Taylor and Ramsey, 1998). John Kelly, who is believed to be the strongest British critic for partnership (Ackers and Payne, 1998; Guest and Peccei, 2001), perceives that militancy is trade unions' only chance of institutional survival and membership support and growth (Kelly, 1996).

More recent studies have emphasised that partnership may not necessarily hold any single consequence, stressing that the outcome of partnership is shaped by distinct and sometimes contradictory forces, for example, economic and organisational factors, political and regulatory context and trade union engagement factors (Heery et al.,

2005; Oxenbridge and Brown, 2004; Wills, 2004; Samuel, 2005; 2007). Other commentators have also sought to shift ‘the stalemate’ of the partnership debate by conceptualising partnership as a process, suggesting that outcomes cannot be fully understood and reliably interpreted without understanding the process (Johnstone et al., 2010; Stuart and Martinez-Lucio, 2005a).

This thesis therefore intends to contribute to the partnership debates by sketching a holistic picture of labour-management partnership in three health boards of NHS Scotland containing the context, operation, evolution and outcomes.

## **1.2 Definition**

Though the partnership concept has attracted a rich research literature, there is so far no agreement on the definition of partnership from both the academic literature and political statements. Theoretically, Guest and Peccei (2001) suggested that the meaning of partnership can be understood by considering three approaches. The first is a unitary model that seeks to integrate employer and employee interests, while at the same time maximizing employee involvement and commitment to the organisation. This approach has close links to the so-called ‘high performance work systems’ and sees little or no role for trade unions (Provis, 1996). The second is a pluralist model that has close links to the use of representative systems emphasising the difference of employer and employee interests. The third is a hybrid approach which combines elements of the unitary and pluralist models, exemplified by the mutual gains perspective of Kochan and Osterman (1994).

In practical, different researchers tended to emphasize potentially different elements and dimensions of partnership. For example, Towers (1997) uses the term ‘partnership agreement’ as a label for a type of collective agreement promoting the mutual recognition of legitimate interests. Terry (2003) emphasises the commitment of both

employers and employees to business success, a quid pro quo between flexibility and employment, and the representation of different interests. Kochan et al. (2008) defined partnership as a form of labour-management relationship that affords workers and unions' strong participation in a broad range of decisions from the top to the bottom of the organization. It is felt that this definition is more suitable for the purpose of this study, as the partnership agreement in NHS Scotland has particularly stressed on the engagement of staff through a trade union channel and a consensus to decisions through joint problem solving (Scottish Executive, 2006). Thus, throughout this thesis the object of study is explicitly upon partnership agreement as a specific form of joint problem solving approach that engaging staff and their representatives at all levels in the early stage of the decision-making process.

### **1.3 Context**

This research focused on the partnership arrangements in NHS Scotland where such arrangements are legally mandated at national and local levels. The partnership approach in Scotland's health services sector merits careful assessment because there are several important features that give it a distinctive character. Firstly, the origins of these partnership arrangements are to be found in the unique circumstances following Scottish devolution which creates greater political autonomy and financial flexibility to NHS modernisation in Scotland. In addition, the political devolution has also been an important factor which caused great divergences in the process of Scottish NHS modernisation (Bacon and Samuel, 2009; Greer and Trench, 2008).

Secondly, studies revealed that the outcome of partnership varied across different sectors with different product/labour market conditions and different industrial relations traditions (Oxenbridge and Brown, 2004). So far most debate on partnership has focused on the outcomes of and challenges for private sector trade unionism. In

contrast to the view that partnership agreements are unlikely to last, most of the partnership agreements survive in Britain and recently employers have signed a far higher than expected number of partnership agreements in the public sector (Bacon and Samuel, 2009). The rapid growth of partnership in the public sector could be attributed to the higher union density, and particularly, the New Labour government's interventionist policy and mostly 'hands on' in respect of the NHS, while the approach adopted in the private sector was 'voluntary' (Martinez-Lucio and Stuart, 2002: 253). However, to date, less research has been done on public sector partnership. Therefore,

Thirdly, among the partnership agreements signed in the public sector, it appears that they were particularly well established in certain part of the health care services sector (Bacon and Samuel, 2009). It is in the context of profound structure changes and consistent reforms in this sector that partnership agreements were signed between the government, the NHS employer and the trade unions, especially in the devolved nations. Aiming to deliver high standard of quality health services, the New Labour government linked increased expenditure and established specific targets for its "modernisation" agenda, including pay reform, finance and HR targets (Department of Health, 1999a; 2004; Scottish Executive, 2000; 2005b; 2007). To fulfil these targets, partnership working was actively promoted with the aim of securing union cooperation in reorganising the delivery of health services (Department of Health, 2007; Scottish Executive, 2003; 2005a). Partnership agreements were signed in NHS England, NHS Scotland and NHS Wales, albeit at varying speeds and in different forms (Greer and Trench, 2008). NHS Scotland has led the way setting up the first national labour-management partnership in health service in 1998, and developing arguably the most ambitious and comprehensive partnership so far attempted in Britain (Bacon and Samuel, 2009; 2012).

Finally, among the limited case studies conducted on partnership in the health services sector, most of them were focused on NHS England (Munro, 2002; Tailby et al., 2004; Bach, 2004; McBride and Mustchin, 2007). Partnership in NHS Scotland is notably different from its counterparts in England because NHS Scotland presents a case of established social partnership created by a devolved Scottish Parliament that abolished the internal market in health, and appears to have adopted some of the features of social partnership in the coordinated-market economies of other European countries (Bacon and Samuel, 2009). Since the political devolution in 1999 in Scotland, significant steps have been taken to implement the concept of partnership working at regional and local levels. With strong political support from the Scottish Parliament, employers and staff representatives, partnership working has been recognised in NHS Scotland as a critical success factor in achieving the aspiration of a world-class health service designed from the patients' point of view (Scottish Executive, 2005a). It therefore appears to be the most established, legally mandated and embedded partnership arrangement in Britain and it is worth in-depth research attention (Bacon and Samuel, 2009).

## **1.4 Theoretical Framework**

Several theoretic perspectives are applied in order to underpin the framework of this study. First of all, the broad theoretical framework guiding this research is adopted from Kochan et al.'s (1986) general framework for analysing industrial relations issues. A key premise for this framework is that industrial relations processes and outcomes are determined by a continuously evolving interaction of environmental pressures and organisational responses. Therefore, this research will start by reviewing the context in which partnership arrangements in NHS Scotland are situated, focusing

primarily on the political devolution, the distinct NHS modernisation agenda in Scotland and specific organisational features in each case.

Secondly, according to mutual gains model (Kochan and Osterman, 1994), for partnership to be effective, substantial partnership structures and process need to be established from the strategic to policy and workplace levels to ensure early-stage staff involvement in developing plans that have traditionally been the prerogative of managers (Kochan and Osterman, 1994; Kochan et al., 2008). Therefore, another primary focus of this study is to examine the partnership structures in NHS Scotland and the extent to which staff representatives are involved in the decision-making process.

Thirdly, the behavioural theory of labour negotiations (Walton and McKersie, 1965) has provided a useful analytical framework to organize the study of bargaining behaviours and outcomes. At its core is the distinction between ‘integrative’ and ‘distributive’ bargaining tactics. An important implication of the behavioural theory for the study of partnership is that participants from both management-side and staff-side are seen as needing to cooperate and share information to improve performance and also to conflict and ‘hard’ bargain in order to capture an acceptable share of the gains from performance improvements (Bacon and Blyton, 2007).

## **1.5 Research Objectives**

Based on the theoretic framework above, the overall purpose of this thesis is to engage in the partnership debate by presenting original research evidence on the context, operation, evolution, and outcomes of partnership arrangements gathered through three NHS boards in Scotland. Accordingly, four main dimensions of partnership arrangements were analysed. These are as follows:

1. to describe the general context in which partnership arrangements play out in three cases.

2. to describe how partnership operates in the three cases. In order to address this issue, the partnership structure, scope of partnership agenda and participants' voice and behaviours will be studied and analysed in depth.

3. to explore any changes that have occurred in partnership working in the three cases in terms of structure, agenda, voice and behaviours and identify the potential factors that may have driven the changes.

4. to compare and analyse the outcomes of partnership in the three cases.

## **1.6 Research strategy**

The research project was developed in two distinct stages and was stratified across senior managers, HR managers, other middle-level managers and union officials. The main component of the first stage is documentary analysis. Key documents include published annual reports and Chief Executive's self-assessments of the three NHS boards from 2002 to 2009, union materials and minutes from the partnership meetings of the three cases. Utilising Nvivo 9 software, the data generated is stored, coded and analysed for the scope of agenda, "voice" and behaviours in partnership meetings. The second stage of the research comprises in-depth investigation of the three NHS boards between 2008 and 2010 using multiple methods. These methods include a series of non-participant observations of partnership meetings, and interviews with senior managers, Employee Directors and HR managers.

In terms of case selection, all three cases were selected from Scotland's health services sector that share a similar context at the macro-level, for example, political and financial environment, labour market conditions and industrial relations traditions at the national level. It therefore provides a unique opportunity to explore the

experience of partnership in various organisational contexts within a similar macro social context. Thus, the principle of case selection was the degree to which partnership has been embraced, considering the possibility of gaining important insights into the operation of partnership, as well as the outcomes over time, and allowing the comparison of partnership arrangements in various organisational contexts. Three cases, which include NHS Highland, NHS GG&C and NHS Borders, were selected based on these standards. There are some key features associated with these three health boards: NHS Highland covers the largest area geographically and embraces a strong local community identity and a cooperative industrial relations culture; NHS GG&C, which has the largest population, the biggest organisational structure and the longest history of conflict tradition of industrial relations, is highly political and heavily populated with severe health problems; NHS Borders is rural and covers the smallest area and population and it is generally out of the spotlight.

## **1.7 Contributions**

This thesis contributes to the partnership debate by providing a review of the experience of partnership arrangements in NHS Scotland which are distinct from partnership arrangements in other sectors. Basing on non-participate observation and documentary analysis, the study has provided a multi-faceted account of partnership arrangements in the three health boards and an analysis of their external and internal context, operation, evolution and outcomes for partners. The partnership arrangements in NHS Scotland are unique, given the strong political commitment and support from the Scottish government, NHS employers and staff representatives. Therefore, studying partnership in NHS Scotland may provide important lessons for engaging staff to improve health services in other nations.

One weakness of the current British literature on partnership is that most of the research is single-case studies or researchers were comparing partnership arrangements between organisations from different sectors (Guest and Peccei, 2001; Kelly, 2004). There is a lack of comparative ‘firm-in-sector’ case studies which enable comparisons to be made between organisations operating with similar constraints in terms of their political and economic contexts and labour market conditions. Therefore, this study has focused on one sector with similar external contexts by selecting three health boards from NHS Scotland. This allows comparisons to be made between organisations operating within different internal constraints, which are relatively scarce in the British partnership literature (Guest and Peccei, 2001; Kelly, 2004).

The theoretical contribution involves applying the industrial relations theoretical framework to explain public sector partnerships in order to understand the relationship between the policy and sector context (Dunlop, 1958; Kochan et al., 1994), the consultation process under partnership (Walton and McKersie, 1965), and the outcomes of partnership (Kelly, 2005).

## **1.8 Structure of the Thesis**

The structure of this thesis is as follows. Chapter 2 reviews the literature on the partnership debates and articulates the research questions to be addressed. The chapter begins by conceptualising the meaning of partnership. It highlights a number of factors which may distinguish the social partnership model in NHS Scotland from others. The chapter then reviews the polarised debates between advocates and critics on Britain partnership as well as in the empirical evidence. This is followed by summarising a list of features that are associated with ‘robust’ and ‘shallow’ partnership arrangements, including factors in the dimensions of context, process and outcomes. Finally, research questions are developed from the pertinent literature.

Chapter 3 expands the research strategy outlined in the preceding section to address the research question, provides a full account of the methods used to collect data, and presents the analytic framework to analyse the data.

Chapter 4 presents the context for the case studies which is followed by an overview of the development of the Scottish health services sector. On the macro level, key changes in the last decade including political devolution, financial environment, organisational restructuring and NHS reforming will be discussed. Such changes had significant human resource implications for pay, staffing, work organisation and industrial relations. On the micro level, this chapter also provides the context for the specific case organisation, including geography, organisational and workforce size, organisational performance and the culture of industrial relations.

Chapter 5 analyses and compares the operation of partnership in the three cases. The chapter begins by describing the partnership structures at the national, regional/board and local/CHP levels in NHS Scotland. This is followed by an examination of the composition of partnership forums at regional/board levels within the case organisations. It then goes on to explore the scope of the partnership agenda by dividing all issues into nine broad categories. Different groups of participant comments in the partnership consultation meetings are examined. After that, it analyses the behaviours of different groups of participants in the forums by utilising the analytic framework drawn from Bacon and Samuel (2009). The final section concludes the main findings of the present study.

Chapter 6 examines and compares the evolution of partnership in the three cases. Some of the key changes in relation to the partnership arrangements within the three cases include partnership structure, composition of the joint consultation forum, consultation agendas, and participants' voice and behaviours.

Chapter 7 assesses and compares the outcomes of partnership working in these cases. Firstly, it analyses the outcomes of partnership meetings by classifying the decisions into five main categories. This is followed by an analysis of some critical issues that were selected from the common agendas of the three partnership forums. To complement the existing analysis, a study of the critical issues can help explain how problems were generated, discussed and resolved through partnership arrangements.

Finally, Chapter 8 presents a summary of findings and provides a discussion of their implications for NHS Scotland in particular, and public sector industrial relations in general.

In conclusion, this thesis contributes to the partnership debate by providing a review of the experience of partnership working in NHS Scotland which is distinct from partnership in other sectors. A key finding of this study is that it supports the point of view that mutual gains can be successfully secured through a partnership approach. However, the extent to which mutual gains can be delivered to both management and trade unions is greatly shaped by the external and internal contexts surrounding the organisation and the way partnership is implemented.

The thesis has several important implications for both academics and industrial practitioners. For academics, it stresses the need to conduct more longitudinal studies, as such methods can trace the changes of the contexts surrounding partnership arrangements, different participants' experience, attitudes and behaviours over time. It also emphasises the need for more comparative case studies, as such studies would enable comparison to be made more appropriately between organisations operating between similar external constraints. Furthermore, it also suggests that for future studies to understand more about the linkage between the context, operation, evolution

and outcomes of partnership and to develop a benchmark or a common acceptable model to define a positive or negative partnership arrangement.

The study also generates several implications for industrial practitioners. It suggested that important features associated with a robust partnership arrangement include a good tradition of cooperative industrial relations, well embedded partnership structures, frequent partnership meetings, early involvement of trade unions in a broad range of issues, strong commitment and regular involvement of senior managers, as well as mutual respect and cooperative behaviours of both managers and union representatives. In contrast, a shallow partnership arrangement is more likely to associate with a history of conflict industrial relations, the lack of senior managers' commitment to partnership working, infrequent partnership meetings, and managers' reluctant to release staff representatives to join partnership meetings, and conflict behaviours.

## **Chapter 2. Partnership in the Private and Public Sectors**

### **2.1 Introduction**

The overall aim of this thesis is to examine the labour-management partnership in NHS Scotland. In order to develop the specific research questions, the purpose of this chapter is to review the literature on labour-management partnership to date, to explore the key debates and controversies in Britain, and to clarify the contribution of this study.

The chapter begins by conceptualising the meaning of partnership. It highlights a number of factors which may distinguish the social partnership model in NHS Scotland with partnership in other sectors. It then goes on to review the current debate between advocates and critics on British partnership. This is followed by summarising a list of features that are associated with ‘robust’ and ‘shallow’ partnership arrangements, including factors such as context, process and outcomes. Finally, it draws the main research aims from the pertinent literature.

### **2.2 Conceptualising Partnership**

The promotion of partnership for management and union relations has attracted extensive research interest over the past decade. However, there is so far no agreed definition or conceptualization of partnership in either the academic or the policy literature. As Undy (1999: 318) suggested towards the start of this debate ‘What one party, or commentator, means by “partnership” is not however necessarily shared by others.’ In order to gain a holistic understanding of partnership, this section will start by reviewing the fundamental elements of partnership. The definitions of partnership of the main practitioners and academic researchers in Britain will be considered and

potential factors that may make partnership in NHS Scotland distinct from others will be highlighted.

### **2.2.1 Different Partnership Approaches**

As summarised by Guest and Peccei (2001), the meaning of partnership can be understood by considering three approaches upon which partnership was created. These three approaches are labelled as unitary, pluralist and hybrid.

The unitary approach seeks to integrate employer and employee interests, while at the same time maximizing employee involvement and commitment to the organization. An important feature of the unitary approach is the utilisation of various forms of direct employee participation and involvement in day-to-day work activities. It has been argued that under the circumstances in which employers pursue a unitary approach, partnership can be used as a veneer for a human resource management approach designed to weaken the unions (Taylor and Ramsay, 1998).

The pluralist approach accepts that employers and employees have overlapping and different interests, and a key feature of this approach is the use of representative systems, albeit not necessarily involving trade union representatives. In Britain, it was expected that the pluralist approach to partnership can be used by unions as a device to strengthen their organisational capacities (Ackers and Payne, 1998).

Operating within the competing industrial relations frameworks of pluralism and unitary, Guest and Peccei (2001) construct a hybrid approach to partnership, which combines elements of the two previous approaches. Unlike traditional pluralist approach, the hybrid approach recognizes the importance of direct forms of employee involvement and participation. It promotes the benefits of employers and of employees working together to ensure gains for all the parties concerned. In the hybrid approach, the idea of a formal joint governance system and formalised representative

arrangements is regarded as essential for ensuring the longer-term viability of employee involvement and so-called 'progressive' human resource management practices (Cutcher-Gershenfeld and Verma, 1994).

Influential on this hybrid approach to partnership has been the work of Kochan and Osterman in 1994. For Kochan and Osterman (1994), underpinning the practice of partnership in this view is a mutual gains strategy. They used the term 'mutual gains' in place of 'high commitment', 'high performance' and 'best practice' to describe firms that treat human resources as a source of competitive advantage, because it conveys a key message: to achieve and sustain competitive advantage from human resources requires the strong support of multiple stakeholders in an organisation. On one side employees must commit their energies to meeting the economic objectives of the enterprise. In return, employers share the economic returns with employees, and invest those returns in ways that promote the long-term economic security of the workforce. In practice, in order to make partnership effective, employee involvement is required at the strategy, functional and workplace levels through a mix of direct participation and representative participation. Kochan et al. (2008: 36) offered an operationally useful definition of the concept in the context of partnership: 'a form of labour-management relationship that affords workers and unions' strong participation in a broad range of decisions from the top to the bottom of the organization'. It is felt that this definition is more suitable for the purpose of this study, as the partnership agreement in NHS Scotland has particularly stressed on the engagement of staff through a trade union channel and a consensus to decisions through joint problem solving (Scottish Executive, 2006). Thus, throughout this thesis the object of study is explicitly upon partnership agreement as a specific form of joint problem solving

approach that engaging staff and their representatives at all levels in the early stage of the decision-making process.

### **2.2.2 Definitions from the TUC and the IPA**

The Trades Union Congress (TUC, 1999) and the Involvement and Participation Association (IPA, 1997) each devised a set of ‘partnership principles’, attempting to define partnership in Britain.

The TUC’s interest in partnership rose from the potential it saw to renew and extend trade union influence in the workplace by working with government. Six partnership principles were presented by the TUC as ‘vital preconditions for a new accord between unions and employers’ (Stuart and Martinez-Lucio, 2005: 10-11). These include (TUC, 1997; 2002):

- i) A commitment to the success of the organisation
- ii) A focus on the quality of working life
- iii) A recognition of and respect for the legitimate roles of employers and the trade union
- iv) A commitment to employee security
- v) Openness and transparency
- vi) Adding value to all concerned

According to the IPA (1997), three commitments are essential for partnership. These are:

- i) The success of the enterprise
- ii) Building trust through greater involvement
- iii) Respect for the legitimacy of other partners

The four key building blocks of the IPA partnership principle are (IPA, 1997):

- i) Recognition of the employees' desire for security and the employers' need to maximize flexibility
- ii) Sharing success within the enterprise
- iii) Informing and consulting staff about issues at workplace and enterprise level
- iv) The effective representation of people's views within the organisation

In general, some elements of these two models appear to be similar to the mutual gains approach (Guest and Peccei, 2001), for example, the mutual recognition of interests of different participants and the emphasis on employee involvement. However, the two models emphasise different ways to secure employee involvement. The IPA definition is open enough to allow for the possibility of partnership in a non-union context, while the TUC believe trade union presence is essential to partnership. Aside from this difference, both of the models include outcomes as part of their definition of partnership and agree on the need to balance flexibility with employment security, and the desirability of positive employee outcomes (although these are defined slightly differently, with the IPA focusing on 'sharing success' and the TUC preferring the broader notion of 'improving the quality of working life').

Although the TUC and IPA principles provide a useful focus to guide the establishment of partnership, they leave uncertain the precise content of partnership agreement and the practices that must be in place for an organisation to be described as a partnership organisation (Guest and Peccei, 2001). As a result, in the research conducted by Samuel and Bacon (2010) in analysing 126 British partnership agreements it was found that many of these partnership agreements do not fully reflect key IPA or TUC principles. On average, partnership agreements contained two or three principles that had been proposed by the IPA, but TUC principles were rarely

applied. Interestingly, the partnership agreements that did contain most or all of the IPA and TUC principles were held in the public sector.

### **2.2.3 Various forms of Partnership**

Given the decentralised structure of industrial relations in Britain, particularly in private sector, discussions of partnership have been largely focused at the enterprise level. Academic definitions centre around the idea of 'co-operation' and 'mutuality/reciprocity' (Martinez-Lucio and Stuart, 2002). For example, Guest and Peccei (2001) suggest that trust and mutuality are the key components of a genuine partnership agreement. For Heery (2002), the purpose of partnership is to promote a new and more co-operative set of relations within the enterprise.

However, even though most commentators agree on these two elements, various distinctions have traditionally been drawn between different forms of partnership arrangements. For instance formal versus informal, union versus non-union, public sector versus private sector, as well as between the varieties of routes to partnership. This has led to various classifications of partnership emerging in recent studies in Britain (Deakin et al., 2005; Martinez-Lucio and Stuart, 2004; Oxenbridge and Brown, 2004; Samuel, 2007; Wray, 2005). For example, Samuel (2007) differentiated between 'defensive' partnership which occurs against a background of crisis, and 'offensive' partnership which reflects a consensual approach to modernisation. Oxenbridge and Brown (2002; 2004) identified a 'nurturing' type of partnership in unionised manufacturing firms in which the relationships are characterized by negotiation over rights to bargain over pay and conditions, high union density and active workplace representatives; and a 'containing' partnership in service organisations in which employers have tended towards relationships that seek to contain unions by giving them minimal or reduced rights. Wray (2005) argues that it is

not possible to predict the potential outcomes of partnership from the signature of an agreement, suggesting a distinction between ‘genuine’ and ‘counterfeit’ partnership. Kelly (2004) categorised partnership agreements based on the balance of power between the parties. At one end of a continuum, ‘employer-dominant’ agreements offer employers an agenda that primarily reflects the employers’ interest and labour compliance rather than cooperation. At the other end of the continuum, ‘labour-parity’ agreements feature a more even balance of power, and as a result are more likely to meet the interests of both parties.

These different classifications implied that there must be specific conditions under which mutuality is likely to emerge, and it is important to systematically analysis these certain conditions before we start to explore partnership arrangements. (Heery, 2002; Samuel, 2005; Wills, 2004).

#### **2.2.4 National-level Partnership Agreements in Britain**

An additional dimension to the content and definition of partnership arrangements is the design of partnership structures on different levels, for instance enterprise, economy and sectoral, or national and supra-national levels. In Britain, a crucial distinction must be mentioned between partnerships formed at the national level (especially in the public sector) and partnerships at enterprise level. An example of partnership at the national level is the recent partnership agreements signed by NHS England (Department of Health, 2007: 11). In this, partnership is defined as a ‘tri- or multi-partite arrangement involving employers, trade unions, public authorities and/or others e.g., voluntary sector’. The concept of ‘social partnership’ is then broader than in partnerships established at enterprise level, as a broader range of interests must be considered. The term ‘social partnership’ used in some recent public sector agreements in Britain suggests that the agreements are concerned primarily with areas

of economic and social policy. At the heart of social partnership is a decision-making framework where several social partners are included. This broader conceptualisation of partnership may have little explicit connection with matters of employment and workplace practice, whereas partnerships signed at the enterprise level may primarily focus on these issues.

It is worth noting that the term 'social partnership' used in Britain is quite different from traditional continental notions of 'social partnership' associated with the more regulatory European social model. In the wider European context, the term social partnership is recognised as trilateral relationships between employers, trade unions and public authorities (the state, local and/or regional authorities), and 'social partners' is the term then used to designate the representative organisations of trade unions and employers (The Copenhagen Centre for Partnership Studies, 2002). In some European countries (e.g. Germany and the Netherlands), the idea of social partnership has obtained strong institutional and legal support. Unions acting as a social partner were granted access to discuss issues with other social partners on economic and social policies in national forums, in industry-wide collective bargaining, and in works councils at workplace level (Tailby and Winchester, 2005).

In the British context, partnership at the enterprise level is often seen as a bilateral agreement between unions and management, rather than wider conceptions of social partnership, because of the lack of government support. Previous moves towards allowing the social partners a greater say in policy making have tended to be labelled as 'corporatism', a form of social organization in which the key political and social decisions are made by trade unions and employers in conjunction with the government (Boyd, 2002). Therefore, it is important to be aware that, in Britain, partnership in the public sector, particularly at the national level, might be very different to partnership

in the private sector, at the workplace and enterprise level. In addition, devolved regions in Britain, like Scotland, are pursuing a distinct approach to policy-making and partnership with employers and unions. In Scotland, the term ‘Social and Economic Partnership’ was used by the Scottish Executive to refer to a particular type of governance model common to several European countries, with the devolved government, trade unions and employers involved as the ‘social partners’. Therefore, it is appropriate to use the term ‘social partnership’ to study the national partnership in NHS Scotland, as the devolved Scottish Government tends to be a key player.

Through the review so far, a number of potential influences and perspectives on partnership have been identified. The diversity of interpretation and specification of partnership is not surprising, as with many industrial relations concepts these are developed through practice, and different stakeholders attempt to shape the meaning and practice of partnership within different contexts. Therefore, to understand partnership in NHS Scotland, there is a need to bear in mind: the circumstances surrounding it including the legal, social, economic situation and politics of devolution; the structure of partnership established at both national and local levels and what sort of interests are involved at different levels; and how these different interests are represented within the partnership arrangement.

### **2.3 Prospects for Partnerships in Britain**

Over the past decade fierce debates have arisen in academic literature and among policy makers on many aspects concerning partnership arrangements as growing numbers of unions and employers entered into formal partnership agreements (Bacon and Samuel, 2009). In order to gain an overall picture of academic research on the topic of labour-management partnership, this section reviews recent studies on partnership in Britain.

Three main streams of academic research on partnership are identified. The first stream starts from the very early stage of partnership, the primary dispute issue has focused on partnership as a trade union renewal strategy or as a union marginalisation strategy facilitated by employers. The second phase saw many empirical studies concerning on the extent to which mutual gains have been delivered to all stakeholders. Lately, more recent studies emphasized the importance of understanding the process of partnership in practice rather than only focusing on the outcome of partnership.

### **2.3.1 Debates**

The early debate on partnership in Britain was starkly polarised between the optimists and the pessimists. It is noted that the emergency of such agreements was located in a specific context of trade union membership decline due to profound changes in workforce composition, macroeconomic conditions, the strategies and structures of unions themselves, and the Conservative governments' hostile policies to collectivism (Gall and McKay, 1999; Metcalf, 2004; Millward et al., 2000; Tailby and Winchester, 2005). Alongside with the decline of trade union membership, the influence of trade unions has fallen due to the privatisation, increased international exposure and employer de-recognition (Millward et al., 2000; Oxenbride and Brown, 2004a). The 1998 survey found that the proportion of employees covered by collective bargaining has fallen from 71 per cent in 1984 to 40 per cent (Millward et al., 2000: 197), and empirical studies have revealed that the role of trade unions has faded over both wage and non-wage issues (Brown, 2000).

Therefore, for supporters, partnership agreement was perceived to offer a great opportunity for reversing the decline of British trade unions (Terry, 2003). Ackers and Payne (1998), presenting the most optimistic set of arguments, emphasize that partnership offers British trade unions a strategy that is not only capable of moving

with the times and accommodating new political developments, but also provides an opportunity for unions to return from political and economic exile (Ackers and Payne, 1998). Partnership can also be considered to provide a vital means for unions to extend their representative capacity, thus enhancing union influence on their historic concerns to ensure that the rights of workers in terms of the working environment, such issues as health and safety, and the extension of learning and training in work and non-work related matters, are supported and enacted upon by employers (Stuart and Martinez-Lucio, 2004a). In this aspect, many advocates of partnership have noted a number of potential specific benefits to union members and to the institutional interests of unions. These include improved rewards and working conditions, more positive relations with supervisors, enhanced employee consultation and involvement and greater job security (Haynes and Allen, 2000; Guest and Peccei, 2001; Stuart and Martinez Lucio, 2005).

Advocates also argue that partnership offers union representation a more acceptable face, given the fact that traditional adversarial postures and forms of union leverage (especially strike action) are more difficult for unions to deploy and sustain. As stressed by Oxenbridge and Brown (2004: 400), the retention of traditional bargaining postures may no longer represent a credible union strategy: 'given the realities of contemporary power relationships, it is wholly misleading to pose robust, traditional negotiation as a viable hypothetical alternative for most contemporary cooperative relationships.'

Critics of partnership, on the other hand, argue that a partnership arrangement may represent a trade union marginalisation strategy that employers attempt to exploit in order to weaken trade union influence at the workplace level (Kelly, 1996; 2004; Terry, 1999; 2003). The primary concern appears to be the extent to which partnership

incorporates trade unions, which could lead to compliant unions, thus limiting the ability of unions to attract members (Kelly, 1996; Taylor and Ramsey, 1998). Trade union representatives were concerned that appearing to be too involved in management, being party to unpopular decisions, or having only limited influence over management decision-making could damage their appeal (Marchington, 1998). Danford et al. (2002) and Tailby et al. (2004) took this argument further. They argue that the emphasis on partnership as a strategy may lead unions to downgrade their development of membership-led and resistance strategies, and partnership may also lead to an undermining of workplace activism, which can in turn lead to a long-term weakening of union structures. In addition, there were arguments put forward which suggest that partnership arrangements may draw trade unions into a management strategy of enhancing surveillance and work intensification (Taylor and Ramsay, 1998). The expectation that the involvement of unions in partnership would protect jobs and increase employees' benefits was criticised as being unrealistic, and employers suspected of using it as a change legitimising strategy or a short term necessity to achieve long term de-collectivisation (Oxenbridge and Brown, 2002; Roche and Geary, 2002). In short, the early debate on partnership is starkly polarised between the optimists and the pessimists. These competing perspectives are well summarised by Johnstone et al., (2009) in Table 2-1.

**Table 2-1. Polarised Perspectives on Partnership**

<b>Optimistic</b>	<b>Pessimistic</b>
Union renewal, legitimacy, renaissance, organisation	Union incorporation, emasculation
Organisational success, competitiveness, productivity	Work intensification
Employee involvement, quality of working life	Surveillance
Win-win	Co-option
Greater job security	Employee Disillusionment
Better working conditions	Zero-sum
Higher productivity	

Source: drawn from Johnstone, S. Ackers, P. And Wilkinson, A. (2009), “The partnership phenomenon in Britain: a ten year review”, Human Resource Management Journal, Vol 19(3).

### **2.3.2 Empirical Evidence**

The past decade has also seen a large quantity of empirical studies on partnership. A central theme of these empirical studies was the outcomes of partnership to employers, trade unions and employees, or in other words, the extent to which mutual gains have been delivered (Badigannavar and Kelly, 2005; Danford et al., 2004; 2005; Johnstone et al., 2004; Kelly, 2004; Oxenbridge and Brown, 2002; 2004; Richardson, 2005a).

Positive studies have revealed stronger workplace union organisation, more effective consultation, improved management-union relationships, access to senior decision makers in the organisation, and greater employer and employee support for trade unions (Haynes and Allen, 2001; Oxenbridge and Brown, 2004; Wills, 2004; Samuel, 2005). For example, Guest and Peccei (2001) examined 54 IPA member organizations. It was indicated that, although unevenly, partnership creates mutual gains for employees and their employers. For employers benefits include higher employee contribution, better employment relations outcomes and superior performance; for employees, there is a better psychological contract and greater voice, including scope

to contribute; and for employee representatives the process engages them more fully in decision-making over a wider range of issues.

Knell's (1999) case studies of 15 British companies concluded that mutual gains had been realized through the introduction of partnership arrangements. These included higher turnover and profits, lower levels of labour turnover and lower absenteeism, higher levels of work satisfaction, higher levels of identification with firms' objectives and values, confidence on the part of employees in the development potential of their jobs, and higher levels of employment security (Knell 1999:28–30). A series of positive outcomes for unions was also catalogued in unionized partnership companies. These included union involvement in business planning and decision-making, more efficient collective bargaining and the extension of union representation to previously unorganized grades (Knell, 1999).

Wills' (2004) case study on Barclays Bank indicates that partnership had real benefits for the trade union, which included: integrating itself into managerial decision-making at the top of the bank and providing the opportunity to influence decisions at an early stage; developing a new workplace representation system; securing greater employer support for the trade union and so legitimating the process of staff joining and getting involved; and changing managerial attitudes on the shop-floor.

Oxenbridge and Brown (2004) outlined potential gains for both unions and management in their case studies. For unions, it includes increased contact between union representatives and the enterprise, greater union access to senior managers, and greater union involvement in and influence over decision-making than in the past; increased enterprise support for trade union recruitment and representation; a strengthened role for workplace representatives within the organization; improvement

in the quality of working life and job security. For management, it includes: less conflict than other workplaces; union facilitation of workplace change; limiting the extent to which unions may prevent managers from introducing effective change; raising the enterprise's public profile and bringing political gains from local and central government. According to these studies union management relationships had become more open and honest, in terms of each side sharing information, plans and problems. The TUC (2002) has also reported that partnership-based workplaces are one-third more likely to produce above-average performance, have lower labour turnover and absenteeism, and report higher sales and profits.

Despite these positive outcomes, critical studies suggest difficulties demonstrating union effectiveness, greater distance between unions and their members, work intensification, job insecurity, and labour outcomes no better than non-partnership firms (Kelly, 2004; Richardson et al., 2005; Tailby et al., 2004). For example, by comparing the employment and wage outcomes in partnership and non-partnership organizations, Kelly (2004) argues that partnership firms generally had a poorer employment record than their non-partnership counterparts, at least in the industries that were retrenching, and that there is no discernible impact of partnership on either wage settlements or union density. Based on this evidence, Kelly argues that management-union partnerships are a reflection of heightened employer dominance in workplace employment relations. Martinez Lucio and Stuart's (2002) study with MSF union representatives also found that despite ideological support, there was little evidence of proposed benefits such as transparency and involvement or job security proposed by the TUC. Danford et al. (2003) reported that rather than the much-vaunted mutual gains being delivered, employees were actually experiencing work intensification, task accretion and decreased job security.

In summary, albeit benefits of partnership to employers, unions and employees were reported in many empirical studies, it also suggests that the balance of advantage was far from a situation of mutual gains, only marginal gains have been won for employees compared to significant gains for management (Guest and Peccei, 2001; Wray, 2005). Empirical studies have also pointed out that the outcomes of partnership can be mixed, depending upon various conditions such as the political and regulatory context; the specific economic and organizational factors; sectoral differences; the underlying management and union strategies; the rationale for partnership; and the way in which it has been implemented (Heery, 2002; Heery et al., 2005; Stuart and Martinez-Luico, 2005a; Wills, 2004; Samuel, 2007). This suggests a need to understand more about contextual factors that facilitate the initiation of partnership, generate positive or negative consequences, and sustain a partnership.

### **2.3.3 Understanding Partnership as a Process**

More recent literature suggests standing on a wide range of intermediary positions rather than attempting to predict the outcome of partnerships deterministically. There is a consensus among most researchers that partnership is not only about outcomes, but also about the handling of issues in a more cooperative way. Thus, it is essential to examine the process of partnership in addition to the outcomes (Dietz, 2004; Stuart and Martinez-Lucio, 2004a; Wray, 2005). Many commentators have emphasized this point of view in their studies, as the following array of quotes illustrate:

*'The study of partnership requires an approach that is sensitive to the internal process of decision-making, and the rationales that underpin the elaboration of strategies regarding work.'* (Martinez-Lucio and Stuart, 2004a: 421)

*'Although there exists a wealth of published material governing the breadth and depth of participatory practices in British workplaces, we have much less understanding of participation as a process.'* (Danford et al., 2005: 613)

*'Need to understand more about the substance of the relationships forged as a measure of robustness as opposed to the formality of the agreement.'*

(Oxenbridge and Brown, 2004: 143)

However, despite acknowledgement that process is important, few British studies have explicitly focused on understanding the particular aspects of partnership, such as structure, agenda and behaviour. On this point, academic studies on the dynamics and processes of partnership from Ireland and the United States can provide inspiration for future research in Britain. Such studies attempt to understand more about the preconditions for effective partnership and the particular circumstances in which 'mutual gains' may be realised (O'Dowd and Roche, 2009; Roche and Geary, 2002; Kochan et al., 2008). In terms of partnership structure and agenda, for example, based on assessments of stakeholder outcomes from managers in Ireland, O'Dowd and Roche (2009) indicate that 'integrated business partnership', in which partnership structure combining strategic and operational arrangements and addressing substantively significant agendas of broad scope, act more positively to deliver a range of current and expected outcomes of significance for each stakeholder group than the 'exploratory partnerships' which are characterised by operational or strategic structures only and relatively narrow agendas. Kochan and Osterman suggested in 1994, the importance of the integration of partnership structure at a strategic, functional/HR policy level, and at a workplace level (Kochan and Osterman, 1994). Kochan et al.'s (2008) more recent case study on Kaiser Permanente again emphasised the importance of propagation of new structures across the organisation.

Besides the partnership structure and agenda, commentators have also pointed out that sensitivity must be paid to the presence or absence of partnership ‘behaviours’ in the employer-union relationship (Dietz, 2004; Walton and McKersie, 1965; 1991). Essentially, partnership implies a new cooperative relationship that requires fundamental changes of all participants’ behaviour. However, subtle changes in attitudes and behaviours under partnership arrangements were largely overlooked by researchers who have taken a narrow research focus on partnership outcomes. Therefore, this thesis will primarily focus on these issues in the following chapters.

## **2.4 The Context, Operation and Outcomes of Partnership**

The previous section reviews the debates, empirical evidence and prospects for the study of partnership, and stresses the necessity of examining context and process in addition to outcomes. This thesis therefore intends to contribute in these aspects, which is to explore the context, operation, evolution and outcome of partnership in NHS Scotland.

The following section will go through the specific context factors which can impact on the partnership arrangements. It highlights four dimensions which comprise the main content of the operation of partnership and assesses the impact of these factors on the outcomes. Finally, it proposes the specific research questions of this thesis.

### **2.4.1 Context Issues**

Dunlop (1958) identifies three key factors to be considered in conducting an analysis of the labour-management relationship. One of these factors is to analyse the environmental issues in which the relationship was embedded. The underlying logic is that the environment is particularly influential through the effects it exerts on the

balance of power held by labour and management, which determines the distribution of benefits.

The external characteristics, as listed in table 2-2, include the economic context, the technological context, the legal and public policy context, the demographic context and the social context. While the internal characteristics, include the enterprise ownership and structure, size and growth, union organisation and strength, function of HR and industrial relation traditions. Some of these factors are primarily determining the total profit that are available to labour and management. The impact of these factors on industrial relations is obvious. For example, a firm's performance is deeply affected by the degree of domestic and international competition faced by the firm. The greater the competition is, the more willingness that the firm cut expenditures in order to gain cost advantage, which will leave limited space for improving employment relations. Furthermore, the greater the competitiveness of a firm, or the larger the size of a firm, the greater will be the profits earned by the firm, that allows more resources for the parties to divide based on the balance of power (Dunlop, 1958; Kochan and Osterman, 1994). Other factors appear to have more influence on the relative strength of labour and management, which determines the ability of either side to gain a larger share of a given amount of profit. For example, the law and public policy can influence the legal standing of trade unions, trade union's bargaining power and employment conditions (Katz et al., 2008). The changing nature of labour force can influence the needs and expectations of workers. These, in turn may affect the individuals interest in union memberships, which ultimately influence the balance of power between unions and management (Katz et al., 2008). Industrial actions with well-organised unions involved are more likely to deliver mutual gains for both parties (Kelly, 1996; 2004). A cooperative industrial relations culture can also help to secure

trade union's involvement in the decision-making process and gain management support for union development (Samuel, 2007).

**Table 2-2. External and Internal Contexts when analysing innovations in industrial relations**

<b>External</b>	<b>Internal</b>
Economic context	Enterprise ownership and structure
Technological context	Size and growth
The legal and public policy context	Union organisation and strength
Demographic context	Functions of HR
Social context	Industrial relations tradition

Source: drawn from John T. Dunlop, *Industrial Relations Systems*. New York: Holt and Company, 1958.

Harry C. Katz, Thomas A. Kochan, and Alexander J.S. Colvin, *An Introduction to Collective Bargaining and Industrial Relations*, International Edition 2008.

Besides the general contexts outlined above, some specific context issues related to this study are also needed to be highlighted here. To explore the labour management partnership in NHS Scotland, a distinction must be made between partnership in the public sector and private sector.

A recent study conducted by Bacon and Samuel (2009) revealed that an important feature of industrial relations in Britain was found to be an increasing interest in the adoption of partnership arrangements in the public sector. Although private sector employers led the way by signing more partnership arrangements than the public sector before 2001, the balance thereafter changed, with most agreements signed since 2001 being in the public sector. At the end of 2007 public sector agreements accounted for 57% and private sector agreements for 43% of all those signed. In addition to the rapid growth of partnership agreements in the public sector, such agreements also seem to be more likely to survive than those agreements in the private

sector. Bacon and Samuel (2009) further conclude that partnership in the public sector is distinguished from partnership in the private sector in two respects: the previous Labour government's support (1997-2010) and stronger union organisation.

The election of a Labour government between 1997 and 2010 caused a rapid growth of partnerships agreements in the public sector (Bacon and Samuel, 2009; Terry, 2003). The Labour government wished to change the tradition of adversarial industrial relations to a new cooperative relationship through encouraging partnership arrangements. Relying upon a non-statutory approach, the Labour government offered advice and funding for partnerships combined with institutional support from organisations like the Arbitration and Conciliation and Advisory Service (ACAS), the Department of Trade and Industry (DTI), the Trades Union Congress (TUC) and the Involvement and Participation Association (IPA). For example the Partnership at Work Fund, which was established by the DTI in 1999, committed over £12.5 million to promote the best of modern partnership policies in order to stimulate more innovative partnerships at work before it was closed in 2004 (Terry and Smith, 2003). Although great effort was devoted to the promotion of partnership, fewer private sector employers have signed partnership agreements with trade unions (Kelly, 2004), especially since union membership has been declining in the private sector. At the same time partnership agreements appear robust in the public sector. The increase in public sector partnership agreements originated from political pressure on New Labour to improve the quality of public services, which was an important indicator to assess the Labour government's record in both the 2001 and 2005 general election campaigns (Bach et al., 2005; Bacon and Samuel, 2009). Aiming to modernise public services, the Cabinet Office actively promoted partnership agreements to secure union cooperation on the reorganisation of the delivery of public services (Bach et al., 2005).

In 2003, chaired by a cabinet office minister, a tripartite Public Service Forum was established in order to enable dialogue between government, public service employers and trade unions on public service and workforce reform. Further action was taken in 2004, the Warwick Agreement was signed between trade unions and the Labour Party. This secured union support for the 2005 election campaign, which in turn committed the government to continuing to engage unions in a range of legal and policy reforms. These agreements guaranteed trade union's involvement in public services and underpinned partnership in the public sector (Bacon and Samuel, 2009).

A strong, well-established union with high density is another factor that distinguishes the industrial relations climate between public and private sectors. It was also perceived to be a necessary condition for the development and successful operation of partnership (Oxenbridge and Brown, 2004; Kochan et al., 2008). In Britain, union membership and influence fell precipitately throughout the 1980s and 1990s, especially in the private sector (Ackers et al., 2005) and so in some areas only weak unions exist. For these weak unions, outcomes may be worse institutionally and economically if they do not buy into the process of partnership. Under such circumstance, union interest in partnership is not solely driven by an assessment of economic gains and losses: trade unionists were concerned about being co-opted by management, being party to unpopular decisions and having only limited influence over management decision-making (Marchington, 1998). These kinds of partnership agreements are labelled by Kelly (2004) as 'employer-dominant agreements', in which union voice is likely to be contained, with managers acting unilaterally, and unions having very limited influence over management decision-making (Kelly, 2004; Tailby et al., 2004; Munro, 2002). In contrast, in the case where unions are strongly organised, unions are expected to be able to express their voice on a range of substantial

employment matters, and unions with high degrees of influence could challenge, change or possibly even veto management proposals under certain circumstances (Oxenbridge and Brown, 2004; Wills, 2004). Furthermore, their influence can be reinforced if strong commitment from senior management is given to the partnership arrangements (Wills, 2004; Samuel, 2007). In a situation where combines the commitment from senior managers and strong union organisations, unions may be able to raise their own issues and place these onto the partnership consultation agenda, be involved in the early stage of management decision-making, and ultimately extend their influence on a range of substantial issues (Oxenbridge and Brown, 2004; Samuel, 2007).

In summary, one might argue that public sector unions may be more capable of addressing a range of employee concerns and of forcing employers to share at least some of the gains from any performance improvements resulting from partnership at work. Centralised collective bargaining, job security and higher employer spending on training are some of the conditions under which public sector employees may benefit from a partnership approach to change (Bacon and Samuel, 2009). Combining all of these factors together, it suggests that the operation, evolution and outcomes of partnership in the public sector may be different to the private sector. The public sector unions are more likely to influence management decision-making in an early stage, and eventually gain more benefits for their members than the private sector partnerships provide.

#### **2.4.2 The Operation of Partnership**

The previous literature suggests that four dimensions appear keys to define the operation of partnership, which includes structures, scope of agendas, voice, and

behaviours (Bacon and Samuel, 2011; Kochan and Osterman, 1994; Oxenbridge and Brown, 2004; Samuel, 2007).

### **Partnership Structures**

A central feature of changes to organisational structure facilitated by partnership arrangements is the establishment of joint consultation committees. Such committees are perceived to provide trade unions with access to strategic management decision-making. They also provide a problem solving approach which aims to deal with issues or concerns within the organisation, usually involving senior managers, trade union representatives, non-union employees and middle managers (Oxenbridge and Brown, 2004, Munro, 2002). The benefits of such arrangements have been described as the provision of a framework for common practice, and a route to better outcomes.

The relevance of structures has received great attention in the theoretic literature. The most rigorous study on the structure of partnership is probably originated from the 'vertical integration model' of Cutcher-Gershenfeld and Verma (1994). For Cutcher-Gershenfeld and Verma (1994), partnership arrangements at the strategic level are more likely than those at the operational level to involve senior managers and senior full-time union officials capable of dealing with significant change agendas, and well positioned to generate support for partnership among those engaging with issues at a more operational level (O'Dowd and Roche, 2009). In addition, strategic partnership arrangements may also integrate partnership activities with strategic decision making, thus providing focus and cohesion for partnership initiatives (Kochan and Osterman, 1994). Meanwhile partnership arrangements at the operational level provides an important way to handle workplace grievances, establishing a climate of cooperation and trust between employees and managers in the day-to-day interaction, which ultimately leads to an increase in productivity (Kochan and Osterman, 1994). In

addition, it also provides leverage over workplace practices and organisational process that can enhance organisational performance and thereby provides a basis for more secure jobs and better pays and conditions for employees (Cutcher-Gershenfeld and Verma, 1994). Combing the advantages of these two structures, the vertical integration model assumes that partnership structure at both strategic and operational levels address issues or agendas of significance, such that they are capable of impacting positively on outcomes relevant to the main stakeholders. This point is positively echoed by other researchers. For example, as suggested by Kochan and Osterman in 1994, for partnership to deliver effective mutual gains, a voice mechanism must be established at a strategic level, a functional/HR policy level, and also a workplace level (Kochan and Osterman, 1994).

Empirically, the underlying theory behind this hypothesis has been systematically examined by O'Dowd and Roche (2009). Based on data from a survey of managers involved in all known partnerships in unionised companies in the Republic of Ireland, O'Dowd and Roche (2009) demonstrated that having in place structures which involve management-union cooperation at both operational and strategic levels and which address dense agendas of broad scope is associated by managers with more positive outcomes. They further explained that this type of vertically integrated structure involves a series of features that should affect issues of importance for multiple stakeholders. These include attention at both a strategic and operational level to areas capable of leveraging higher performance, as well as better outcomes for employees, added legitimacy for partnership initiatives in the eyes of union representatives, union members, middle managers and supervisors, and commensurately a higher level of 'buy in' by all stakeholders. When these 'structural advantages' are combined with a joint focus on dense agendas covering many respects of workplace organisation and

functioning, the likelihood of positive outcomes is further enhanced (O'Dowd and Roche, 2009: 34).

In the literature on partnership structure from Britain, however, many writers have mentioned that a well-formed organised partnership structure is important but not necessarily vital for partnership arrangement to work effectively and deliver benefits for all participants (Dietz, 2004; Oxenbridge and Brown, 2002; 2004). Other factor, for example, the degree of involvement and commitment from senior managers in the partnership structure has also been identified as a crucial factor that can influence the effectiveness of partnerships (Samuel, 2007). With strong commitment from senior managers the legitimacy of partnership initiatives are profoundly enhanced. This provides a more strategic focus for trade union activists, and middle level managers are also more likely to be actively engaged in the partnership arrangement. If senior managers are not committed to, partnership initiatives, resistance from middle managers may be encountered when these are implemented at the workplace level (Munro, 2002; Marchington and Wilkinson, 2000). In addition, there is also evidence from British literature suggesting that positive outcomes may be more associated with informal than formal arrangements if there is already a history of cooperative relationships between senior managers and union stewards (Dietz, 2004; Oxenbridge and Brown, 2004; Samuel, 2007).

Indeed, it is inappropriate to compare these conclusions, given the specific firm-based context of these case studies. It is also difficult to isolate the effects of structures from the holistic process of partnership, as they are fundamentally connected to each other. All of these factors reflect the challenges of organizing comparable case studies to examine the effects of partnership structure. This research overcame these limitations by selecting cases from a same sector with similar structures established in

all of the three cases. It therefore provides an unique opportunity to eliminate the differences of the context and provides an insight to how partnership structure is connected to other processes.

### **Partnership Agendas**

A precondition for partnership to generate tangible, valued and substantive results is the extent to which partnership agendas actually cover the strategic and workplace issues that employees are more likely to concern with (Kochan et al., 2008). The range of substantial issues discussed in joint consultation committee are key in assessing how far a partnership arrangement represents a more profound change to decision-making, or is merely a more sophisticated route for management to achieve change (Munro, 2002). Various researchers have suggested that in circumstances where management sets the partnership agenda and the parameters of discussion, and senior steward activity focus solely on reactive bargaining and consultation without linking this to the needs and discontents of members, these forms of partnership arrangements may eventually result in union weakness and membership decline (Danford et al., 2000).

A number of empirical studies in Britain reinforced this point, for example Tailby et al. (2004) indicated in their case study of a NHS Trust that the agenda of the Joint, Cross-site, Negotiating and Consultation Committee (JCNC), which is the centre of gravity of the union-management partnership at trust level, was shaped mainly by the concerns of the HR department and of the senior executives who sat in when they had a particular issue to present. Employees had a wide range of concerns, but these did not neatly coincide with the issues that occupied the trust-level partnership. As a consequence, partnership agreement was used as an instrument to achieve formal policy and procedural change. The outcomes of problem solving on large issue were

management-led. Oxenbridge and Brown (2004) found that unions had fewer consultation rights in the cases which they labelled 'shallow partnership relations'. In the cases where partnership arrangements appeared 'robust', unions were actively involved in the early stage of strategic decision making and exerted influence over a broader range of workplace issues. It is thus proposed that in order for partnership arrangements to be able to deliver positive outcomes for all stakeholders, the partnership agendas must focus on a broader range of issues that encompass the main issues of concern for all stakeholder groups (Munro, 2002; O'Dowd and Roche, 2009; Oxenbridge and Brown, 2004).

Even though a number of case studies of partnership in Britain have pointed to the emergence of partnership agendas that are focused on a diverse mix of issues, like pay bargaining, changes in conditions of employment, organizational restructuring industrial relations reform, flexibility, product quality, productivity, commercial strategy and business challenges (Bach, 2004; Deakin et al., 2005; Heaton et al., 2002; Kelly, 1996; 2004; Marchington and Wilkinson, 2000; Munro, 2002; Oxenbridge and Brown, 2002; 2004; Samuel, 2007), there is no systematic study on how partnership agenda is set up and associated with other processes to impact on the operation and outcomes of partnership. There is also a lack of longitudinal research on how would the scope of partnership agenda evolve over time, and what kind of factors are influencing the change of partnership agendas. This research therefore will provide an insight in these respects.

## **Voice**

The term of 'voice' has been widely used in the practitioner and academic literature on industrial relations. However, its meaning has been interpreted differently by scholars as well as practitioners, ranging from a key ingredient in the creation of

organisational commitment (Pfeffer, 1998) to a symbolism of industrial citizenship right (Freeman and Medoff, 1984; Marchington et al., 1994; 2001).

Wilkinson et al., (2004) developed a framework for analysing voice suggesting that voice can be differentiated along two main dimensions. Those are (i) direct and indirect, and (ii) shared and contested agendas. Based on this framework, it provides four ideal types of voice mechanism: upward problem-solving, grievance processes, partnerships and collective bargaining. Such framework partially tells the differences of voice mechanism between partnership and other forms of industrial relations innovative, like collective bargaining. However, it overlooked a key dimension that comprises an essence of partnership arrangement, which is the extent and degree of engagement between the parties (Kochan and Osterman, 1994).

In Britain, collective bargaining and other forms of collective consultation have traditionally been the dominant forms of representation (Bach, 2004). Traditional collective bargaining usually involves lead negotiators stating an agreed position and discipline among a negotiating team to enforce and back this position. As a result, agreement is generated through a series of concessions from each side rather than an open search for 'win-win' solutions. Such workable compromises may result in sub-optimal outcomes for the parties (Bacon and Samuel, 2011). However, the aim of partnership working is to facilitate the wider involvement of a broad range of views to develop a variety of potential solutions from which the best option may be selected or policies refined. It perceived to be an employee-voice-rich organisational approach that provides 'multi voice channel' which, if sufficiently well integrated, achieves benefits for the organisation and its members (Boxall and Purcell, 2003).

Many empirical studies echoed this point of view by reporting that genuine partnership agreements that allow trade union involvement in an early stage of

strategic management decision-making process covering a broader range of issues are more likely to deliver substantial benefits for both parties (Oxenbridge and Brown, 2004; Wills, 2004). In contrast, if management use communication techniques to keep trade unions informed, rather than to involve them in decisions, or limits union involvement on selected issues, the outcomes of partnership are more likely to be skewed towards management's favour (Tailby et al., 2004; Bach, 2004).

### **Behaviours**

Another important dimension to describe the operation of partnership is the bargaining behaviours during the process of partnership consultation. In the literature on bargaining theory, three types of behaviours have been identified: competitive/conflictual behaviour; problem-solving/cooperative behaviour; and a mixture of both types (Carnevale and Keenan, 1992). The existing theory has been well developed by Walton and McKersie (1965). Perceiving labour-management negotiation as a potential mix of cooperative and conflictual behaviour, Walton and McKersie's (1965) *Behaviour Theory of Labor Negotiations* provides a useful analytical framework to organize the study of bargaining (Kochan, 1992; Kochan and Lipsky, 2003). At its core is the distinction between the four sub-processes of bargaining: distributive bargaining; integrative bargaining; attitudinal structuring and intra-organisational bargaining.

Adapted from Walton and McKersie (1965)'s bargaining theory, Bacon and Blyton (2007) studied the potential impact of different bargaining tactics on the outcomes of workplace change. The result reveals that bargaining strategies play an important part in influencing the extent to which employees benefit from the change of work practices. No direct evidence shows that cooperation delivered greater mutual gains. Furthermore, in departments where managers and unions cooperated throughout the

process, compared to where they were in conflict, employees were more dissatisfied with aspects of team working, and productivity gains were no higher. Unions had to adopt conflict strategies in bargaining to achieve mutual gains (Bacon and Blyton, 2007: 831). The analytic framework and findings of their study have remarkable implications for the research of labour-management relationships under the partnership arrangement. It not only demonstrates the rationality of conflict, if not militancy, as a strategy of worker representation, but also provides an analytic framework to examine labour-management relationships under partnership arrangements.

In the literature on bargaining behaviours under partnership, polarized views have been expressed that, for the advocates of partnership, as the infrastructure and precondition to obtain mutual gains, employers and unions should cooperate with one another and work more closely together (Kochan and Osterman, 1994). In contrast, critics of partnership argue that managers could use partnership as an instrument to exploit trade unions cooperation by limiting union rights and curbing union power, bypassing and choosing a more cooperative union representative and controlling over communication and consultative structures (Oxenbridge and Brown, 2002). Therefore, it was suggested that rather than cooperating with managers, unions should reserve militant actions in order to preserve their position and protect the interests of members (Kelly, 1996).

Although these writers were aware that subtle changes in the behaviours of participants under partnership arrangement is a critical parameter to assess the success of partnership, there is a lack of systematic research on the mechanism by which bargaining behaviours influence the decision-making process (Jonestone et al., 2009). Researchers have also overlooked the potential value of *Behaviour Theory* in recent

debates over the operation of partnership consultation. Thus, a further aim of this study is to describe the behaviours in the process of partnership consultation and examine the importance of different behaviours on the operation and outcome of partnership.

### **2.4.3 Outcomes**

Two key issues need to be articulated when assessing the outcome of partnership. The first issue concerns different ways to define the meaning of “outcome” and various methods employed by researchers to measure such outcomes. The British academic studies have identified three main strands of methods to measure the outcome of partnerships. The first strand was for those researchers who pursue quantitative research methods. Most of these researchers attempted to use labour outcomes or organisational outcomes to measure the success of partnership (Kelly, 2004). The advantage of such method is that it explicitly indicates how benefits were being distributed between employers, trade unions and employees. However, it overlooked the subtle changes in attitudes and behaviours, or improvements with management-union relations, which may not always be apparent if a narrow outcome focus is taken (Dietz, 2004; Johnstone et al., 2009). It also overlooked the impact of contextual conditions associated with every single case. The second strand refers to researchers who conducted surveys of managers, trade union representatives or employee to represent the outcome of partnership (Guest and Peccei, 2001; O’Dowd and Roche, 2009). Such methods have the advantages to describe internal relationships between different parties and it also provides a possibility to compare different parties’ attitudes on partnership. However, the problem of this method is that participants’ attitudes can easily be influenced by a particular issue of the day. Positive or negative attitudes towards partnership could be symptomatic of a feel-good factor or bad news

within the organisation. In addition, the accuracy of using employee survey data is still questionable, as many researchers have reported employee apathy in their studies (Oxenbridge and Brown, 2004; Wills, 2004). The third strand refers to researchers who generate case study, selecting critical incidences for tracing the thinking process, feelings about an incident and key actor's judgement on outcomes (Johnstone et al., 2009). Although this method succeed to link the context, process and outcomes together by tracing the origins, development and final results of a particular issue, it can only tell partial of the operation of partnership. Furthermore, the selection bias of critical incidents also appears to be a problem here.

The second issue concerns valuing the importance of contextual conditions as well as the operation of partnership when assessing outcomes. As discussed in previous section 2.2.3, empirical studies have suggested that the outcomes of partnership are depended upon various conditions such as the political and regulatory context; the specific economic and organizational factors; sectoral differences; the underlying management and union strategies; the rationale for partnership; and the way in which it has been implemented (Heery, 2002; Heery et al., 2005; Stuart and Martinez-Luico, 2005a; Wills, 2004; Samuel, 2005).

Oxenbridge and Brown (2004) categorised two distinct types of cooperative relationships in their case studies of nine firms in which formal or informal partnership arrangements were set up. 'Robust' relationships are characterised as conferring a range of benefits to both parties, while 'shallow' relationships provided substantially fewer benefits for the union. Based on this conceptual framework, table 2-3 extracts evidence from empirical studies indicating how these features come into play in identifying robust and shallow partnerships.

Albeit many commentators acknowledged that the assessment of outcomes cannot be isolated from a full understanding of contextual conditions and processes of partnership, few British studies have explicitly focused on examining the impact of contextual conditions and the mechanisms by which partnership is supposed to produce its effects, as well as the outcomes, in order to achieve a more holistic understanding (Guest and Peccei, 2001; Johnstone et al., 2009; Kelly, 2004; Oxenbridge and Brown, 2004).

**Table 2-3. Features of organisations associated with ‘robust’ and ‘shallow’ partnership arrangements**

<b>Feature</b>	<b>Robust partnership arrangements</b>	<b>Shallow partnership arrangements</b>
<b>Contexts</b>	<ul style="list-style-type: none"> <li>• Managers’ willingness to maintain an independent employee voice (Oxenbridge and Brown, 2004)</li> <li>• Managers actively support trade union recruitment (Oxenbridge and Brown, 2004)</li> <li>• Replace HR managers who act against partnership (Oxenbridge and Brown, 2002)</li> <li>• High union density (Oxenbridge and Brown, 2004)</li> <li>• Strong workplace organisation (Guest and Peccei, 2001)</li> <li>• Active workplace representatives (Oxenbridge and Brown, 2004)</li> <li>• Union representatives have a strong, legitimate position in the organisation (Oxenbridge and Brown, 2004)</li> <li>• A history of mature industrial relations (Samuel, 2007)</li> </ul>	<ul style="list-style-type: none"> <li>• Managers prevent unions from extending their influence by placing restrictions on union recruitment (Oxenbridge and Brown, 2004)</li> <li>• Low union density (Kelly, 2004; Oxenbridge and Brown, 2004)</li> <li>• Weak union organisation (Kelly, 2004)</li> <li>• Union representatives are selected by and compliant to management (Oxenbridge and Brown, 2002)</li> <li>• Inter and intra-union tensions (Heaton et al., 2002)</li> <li>• The exhaustion of union energies and resources in servicing the central institutions (Tailby et al., 2004)</li> <li>• A history of industrial relations conflict (Samuel, 2007)</li> </ul>
<b>Partnership structure</b>	<ul style="list-style-type: none"> <li>• Integrated participative (e.g. team-working at the operational level) and representative (e.g. joint consultation committee at the organisational level) partnership structures (Cutcher-Gershenfeld and Verma, 1994; Kochan and Osterman, 1994; Oxenbridge and Brown, 2004)</li> <li>• Regular and high frequency of consultation meeting</li> </ul>	<ul style="list-style-type: none"> <li>• Management control over the consultative committee (Kelly, 2004)</li> <li>• The absence of senior managers in partnership consultation (Samuel, 2007)</li> </ul>

	(Oxenbridge and Brown, 2004)	
<b>Partnership agenda</b>	<ul style="list-style-type: none"> <li>• Negotiating rights over pay and conditions (Oxenbridge and Brown, 2004)</li> <li>• Agenda covers a broader range of workplace issues (O’Dowd and Roche, 2009; Oxenbridge and Brown, 2004)</li> <li>• Strategic in orientation (Samuel, 2007)</li> </ul>	<ul style="list-style-type: none"> <li>• Sparse scope of partnership agenda (Oxenbridge and Brown, 2004)</li> <li>• Substantive decisions handed down by parent group headquarters or national-level senior managers (Oxenbridge and Brown, 2004)</li> <li>• Agenda was shaped mainly by the concerns of management (Tailby et al., 2004; Samuel, 2007)</li> </ul>
<b>Participation and Voice</b>	<ul style="list-style-type: none"> <li>• Senior managers’ commitment and active involvement in the consultation meeting (Wills, 2004; Samuel, 2007)</li> <li>• Early union involvement in the management decision-making process (Oxenbridge and Brown, 2004)</li> <li>• Union involvement and influence on strategic decision-making process (Samuel, 2007)</li> </ul>	<ul style="list-style-type: none"> <li>• Managers actively constrain union involvement at an early stage of decision making (Munro, 2002)</li> <li>• Limited union involvement in workplace affairs (Oxenbridge and Brown, 2004)</li> <li>• Implementation of ready-made management decisions (Oxenbridge and Brown, 2004)</li> <li>• Managers used communications to keep employees informed, rather than involve them in decisions (Tailby et al., 2004)</li> </ul>
<b>Behaviours</b>	<ul style="list-style-type: none"> <li>• Managers value union representatives candid and critical views (Oxenbridge and Brown, 2004)</li> <li>• More open and honest, high level of trust (Tailby et al., 2004)</li> <li>• Share information, plans and problems to a greater degree (Bacon and Samuel, 2010)</li> <li>• Outbreaks of conflict and disputes occasionally occur, but are resolved in cooperative ways (Oxenbridge and Brown, 2002)</li> </ul>	<ul style="list-style-type: none"> <li>• Confrontation largely defused or suppressed by selecting more cooperative union officials (Oxenbridge and Brown, 2002)</li> <li>• Resistant from middle and line managers (Tailby et al., 2004)</li> <li>• A lack of cooperation between workgroups (Heaton et al., 2002)</li> </ul>

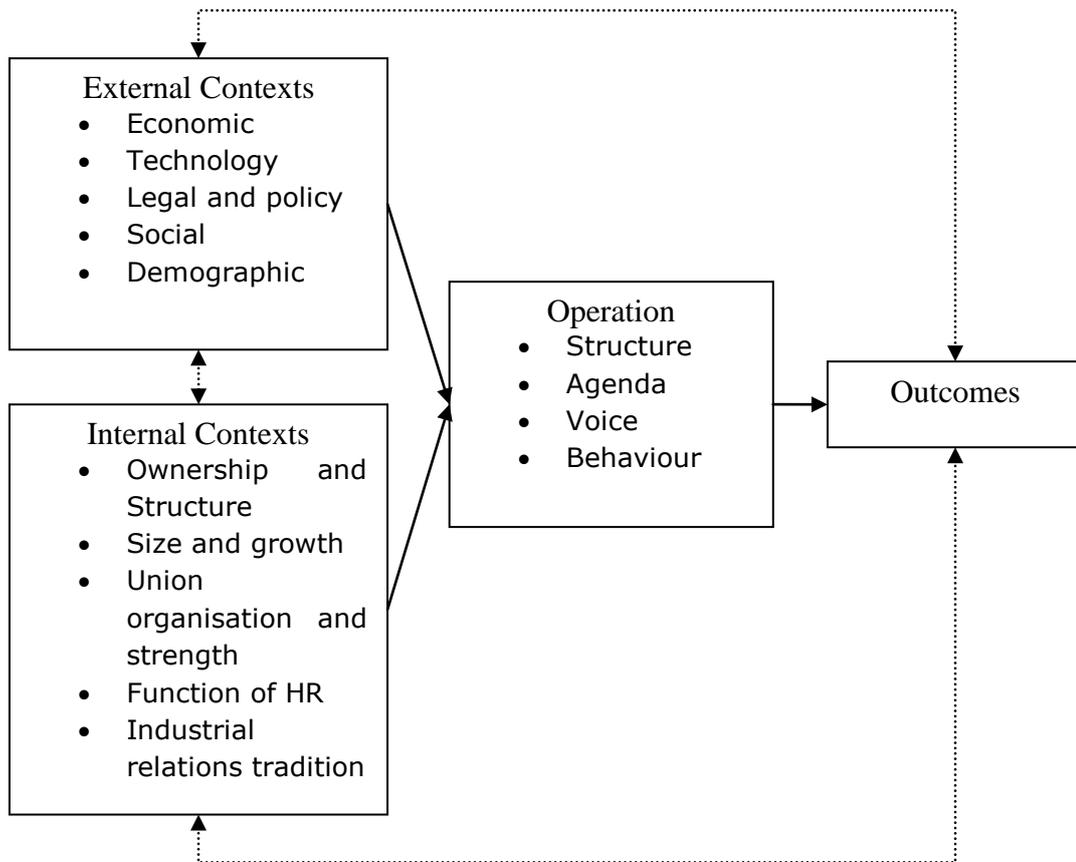
## **2.5 Conclusion and Research Questions**

This chapter has provided an overview of current literature on partnership, including the different ways to define it; the specificity of national-level partnership agreement in NHS Scotland; the key issues in dispute; the distinctions between public sector and private sector; the importance of analysing the operation of partnership in practice; and the key features associated with robust or shallow partnership arrangements.

There are three main implications from this review. Firstly, it is important to examine the impact of contextual conditions on the operation of partnership as well as outcomes. In addition to specific organisational contexts, attention must also be paid to the broader external contexts, such as economic and public policy contexts listed in Fig 2-1 below.

Secondly, there is a need to be more sensitive to the operation of partnership in terms of structure, agenda, voice and behaviours. Attention must also be paid to how these factors interacted with each other and how would these factors change in response to changes occurred in context issues.

Thirdly, it is important to clarify the meaning and expectations of partnership and adopt the right method to measure the outcomes. Particularly, it emphasised the importance to explain partnership outcomes in context as well as the operation practices associated with it.



**Fig 2-1. Conceptual Framework for this Research**

**Research Questions**

The main research aim of this study is to explore the labour-management partnership in NHS Scotland. In order to address this issue, the context issues, the operation of partnership, the evolution of partnership and outcome of partnership will be analysed in depth. Based on a longitudinal study, four specific research questions need to be answered.

The first aim of this research is to describe the social partnership model in the context of political devolution in NHS Scotland and examine the impact of specific context on the operation and evolution of partnership.

The second aim of this research is to explore the operation of partnership in NHS Scotland. In order to address this issue, four dimensions need to be considered separately, which are: the structure and composition of the partnership forums; the scope of partnership agenda and interests represented by different participants; the degree of trade union involvement and participation; and the bargain behaviours in the process of partnership consultation and its impact on the delivery of mutual gains.

The third aim of the research is to explore the evolution of partnership in NHS Scotland. In order to address this issue, it analyses the changes that occurred to the external and internal environment and examines how these changes would impact on the operation of partnership.

The final research aim is to examine the outcome of partnership in the three cases. It explains how is the outcome linked to the specific context and processes associated with each case. Similarities and variations between different cases with regard to partnership context, process and outcomes will be identified and explained.

## **Chapter 3. Research Methods and Analytic framework**

### **3.1 Introduction**

The overall purpose of this study is to explore the context, operation, evolution and outcome of labour-management partnership in NHS Scotland. The range of research topics implied that appropriate research strategies should be pursued in order to sketch a holistic picture of partnership relationship. For instance, in order to examine the partnership arrangements over time, this study adopts a longitudinal research method to trace changes in terms of the contextual factors, the partnership processes and the outcomes. Furthermore, in order to assess the impact of external and internal contexts on the operation and outcome of partnership, this study adopts comparative case studies by selecting three cases all from the healthcare sector, that enable comparisons to be made between organisations operating with similar external environment, such as political and policy contexts and national strategies for modernisation.

A variety of data collection methods are used to develop a rich body of evidence with which to evaluate particular features of the partnership arrangements. Documentary analysis including minutes of partnership consultation meetings, board annual reports and audit reports helps to obtain details of partnership practices and evaluate the outcomes of partnership arrangements. Non-participant direct observations of partnership meetings and interviews with managers, employee directors and trade union representatives allow rich and detailed contextual issues to be obtained. It is also useful for gaining different participants experience, attitudes and judgements on pivotal issues. In addition, several data analytic instruments are employed in this study, including methods to group different participants, categorise

partnership agendas, cloud participants' behaviours and clarify different types of outcomes.

### **3.2 Case Selection**

While most British case study research offers only a snapshot of partnership at a particular point in time in the organisations studied (Johnstone et al., 2009), this thesis pursues a longitudinal study to explore the partnership relationships in NHS Scotland. Such data can be collected either through surveys, or through linkage of administrative data. Compared to surveys, the greatest advantage of the longitudinal study stems from its ability to provide useful data about individual or organisation change over time (Guest and Peccei, 2001; Kelly, 2004; Johnstone et al., 2009). The endorsement of partnership agreement not only reflects management and union motives and strategies at one point in time, but also implies the necessity of fundamental changes in what they believe and how they behave in the long term. It therefore indicates a need for more longitudinal study in this area, as such a study provides an understanding of social change over time, of the trajectories of organisational histories and of the dynamic processes that underlie social and economic circles. Furthermore, a longitudinal study also has the potential to follow individuals through time and examine how experiences and behaviour are influenced by the wider social and economic contexts. In terms of research on partnership arrangements, it implies the ability to trace different participants' experience, attitudes and behaviours over time, which generates a unique data source to describe the dynamic partnership process and to explain the outcome of partnership (Geary and Trif, 2011; Johnstone et al., 2009).

Perhaps one of the biggest disadvantages to using longitudinal studies is the time factor. This type of study is time consuming, which affects cohort retention and the ability to maintain a committed research team. Another difficulty concerns the

appropriate access to observe organisations over an extended period of time. These constraints were successfully addressed in this study, as this study was accompanied with my two supervisors' research project which was granted by the Economic and Social research Council in June 2009<sup>1</sup>. Privileged access to all archives and committees were granted, and we are also indebted to a host of Scottish Government officials, employers and staff-side representatives for permitting wide-ranging access.

In terms of case selection, this study sets four main standards for choosing appropriate case. Firstly, all of the cases must have partnership agreement signed in place. Secondly, all of the cases must have established the basic partnership structures and operated for a period which allow for conducting a longitudinal study. Thirdly, all of the case organisations must can provide historical archive data for a period and grant access for the researcher to observe the partnership forums and organise interviews with different participants. Fourthly, the three cases would better diverse in term of organisational contexts.

Based on these standards, three cases were selected from the 14 health boards in NHS Scotland, which are NHS Highland, NHS Greater Glasgow and Clyde (NHS GG&C) and NHS Borders. It is noted that, all three cases have formal partnership agreements and structures in place since 1999. Furthermore, the three health boards have provided full archive documents and minutes and offered great accesses for researchers to get a deep insight of partnership arrangements in NHS Scotland. More importantly, the three cases have distinct internal organisation contexts from each other, with NHS GG&C has the most complicated organisation structure and a tradition of union-management conflict, NHS Highland covers the largest area in NHS

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<sup>1</sup> The two-year in-depth research project was conducted by Professor Nicolas Bacon and Dr Peter Samuel starting from June 2009. Research topic concerns "Evaluating Labour-Management Partnership in NHS Scotland".

Scotland and union-management relations were described as ‘cooperative’, while NHS Borders was located in the rural area and was the smallest board among the three. As all of the cases were selected in the same sector, the diversity in terms of organisational contexts could allow evaluating the impact of particular organisational contexts on the operation and outcomes of partnership.

### **3.3 Data Collection Methods**

The field research was conducted between 2009- 2011 and involved documentary analysis, non-participant direct observation of partnership meetings and interviews with senior managers, employee directors, trade union representatives and human resource managers.

The primary advantage of using documentary analysis in this research is that it allows the researcher to gather data from the minutes of the partnership meetings which usually across a long period. It therefore allows for the research to conduct a longitudinal study that observes the partnership arrangements in the three cases over time. Secondly, it contains facts that may not be readily available and it can provide access to information and may be difficult to gain via interview. And thirdly, it can use electronic tools to store and analyse data which provides ease of use for research (Briggs and Coleman, 2007; Ellem, 1999). In the meantime, it is well acknowledged by the researcher that the limitation of choosing this method is that documents can be subjective, unavailable for use or not catalogued correctly. It could also be inaccurate and have been created to present a particular view of events, activities or individuals (Briggs and Coleman, 2007; Ellem, 1999). To overcome these limitations, the researcher therefore has added interviews and non-participant observations to help interpreting events and actions, and to check the validity and reliability of the minutes.

Analysis of the full archive of confidential board minutes monitored the composition of the Area Partnership Forum (APF) which is the main organisation body for operating partnership practices and tracked the remit of consultation by substantive issue over time. A wide range of primary board documents and APF minutes were obtained from the three cases and are listed in Table 3-1 below. The APF minutes were taken by the Support Manager and were approved by the forum. They provide an invaluable and rich account detailing individual contributions to the forum over time. In total, this thesis has collected 114 minutes from the APF meetings, 60 minutes from the Staff Governance Committees' meetings, 21 Board Annual Reports and 14 Audit Reports. These minutes were coded according to nine broad categories of agenda, five groups of participants, three main sets of behaviours, and five different types of outcomes. In total, documentary analysis includes coding and analysing over 204,500 words of text in the minutes of APF meetings using Nvivo 9.0 software, studying comments from 418 individuals, on 180 different items, 22 different types of behaviour and 768 decisions.

**Table 3-1. List of documents in the three cases**

Items	NHS	NHS GG&C	NHS Borders
Board Audit Reports	2004-2009	2004-2009	2004-2009
Board Annual Reports	2002-2009	2002-2009	2003-2010
Board Annual Reviews	2005-2010	2004-2009	2008-2010
Minutes of APF meetings	2005-2010	2002-2009	2004-2009
Minutes of SGC meetings	2002-2010	2002-2010	2008-2010

Roughly 40 unstructured interviews have been conducted with senior managers, employee directors and human resource managers. The purpose of conducting interviews was to help identify the critical incidents and explore how issues were addressed, interpret events and explain actions, help assess the costs and benefits of

partnership, and seek opinions about the crucial factors to successful partnership working. In addition, non-participant director observations of the partnership meetings were conducted between 2010 and 2011, with the aiming to check the validity of the minutes.

### **3.4 Data analytic framework**

#### **3.4.1 Grouping Participants**

All the participants were categorised into three main groups, which are: *Senior Managers; Management-side; and Staff-side.*

The senior managers were observed as one group, because their behaviour in the APF can be regarded as reflecting the commitment to partnership from senior executive levels. The senior managers group consists the chairman, chief executive, executive and non-executive directors from the board, usually including: Chief Operating Officer; Chief Medical Director; Director of Finance; Chief Director of Nursing; Director of Public Health and Health Policy; Director of Human Resources; and CH(C)P directors. In addition, it also includes managers from the national forum, for example the Chief Executive of NHS Scotland. It is important to note that, in some boards, the employee director is appointed to the board as a non-executive member. As the role of employee directors are observed as a single group in this research, therefore, we will not count the employee director into the senior managers group.

Management-side includes managers from each executive position of area boards, but excludes the board senior managers. It contains the human resource managers and other management representatives. The human resource managers were separated from the management representatives group, because HR managers are under pressure from central government to achieve HRM targets, therefore, HR managers may attach

more importance to the relationship with trade unions than their managerial colleagues and are more likely to development partnership working with trade unions. In addition, a main issue discussed in the APFs are workforce issues and are part of the responsibility of human resource managers. Thus, it is expected that HR managers may behave differently to other managers in the forums.

The staff side includes full time trade union representatives from each union and employee directors of the three health boards. The employee director is separated from the trade union representatives group because the role of employee director is particular crucial to the APF and there is a possibility that the behaviour of the employee director could be different from that of other trade union representatives, as the position of employee director is more likely to bridge the union and management roles and have some managerial characteristics. Therefore, it is worth to observe the employee directors as a distinct group.

### **3.4.2 Categorising Partnership Agenda**

Drawing from Bacon and Samuel (2010; 2012), all the items discussed in the APFs were categorized into 9 broad headings, which are: *Modernisation; Pay; Equality and Training; Financial Issues; Partnership Working and the Forum; Workforce Planning and Development; Clinical Issues; Health, Safety and Wellbeing; and Staff Governance Process*. The content of the 9 board issues are detailed in table 3-2. The 9 headings of issues were then fell into three broader categories: strategic issues (including Modernisation; Financial Issues; and Workforce Planning and Development); policy issues (including Pay; Equality and Training; Partnership working and the forum; and Staff Governance Process); and workplace issues (including Clinical Issues; and Health, Safety and Wellbeing).

**Table 3-2. Content of the 9 broad Issues**

Issues	Content
<b>Modernisation</b>	Includes: 1) the implementation of strategies which aimed to improve health and social care services, for instance, <i>Better Health Better Care; Changing for the Better; Communications Strategy; Clinical Governance Strategy; Delivering for Health; E-health Strategy; National Shared Services; National Fraud Initiative; Local Delivery Plan</i> ; 2) discussions on service redesign and organizational structure change, for instance, <i>Change Matrix; Inpatient Redesign; NHS GG&amp;C Board Reorganization; Service Improvement Programme; Service Redesign; Rehabilitation Framework</i> ; 3) procedures on policy making, for instance, <i>PIN Guidelines; Policy Development; Policy harmonization</i> ; 4) reviews of performance and accountability, for instance, <i>Accountability Review; Acute Service Review; Benefits Delivery Plan; Clinical Services Strategy Review; Review on CHP; Review of AHP Service Model; Key Performance Indicators</i> .
<b>Pay</b>	Includes: 1) the implementation of Agenda for Change, for instance, <i>the assimilation, arrears and reviews process of Agenda for Change</i> ; 2) discussions on policies related to staff terms and conditions, for instance, <i>Annual Leave and Sickness Absence Policy; Christmas and New Year Pays; Consultant Contracts; Low Pay Agreement and Pay Concordat; On Call Allowance Rates; Holidays; Senior Manager Pay; Study Leave Policy; Fixed Term Contracts</i> ; 3) other issues related to pay, for instance, <i>Car Parking Issues; Pensions; Childcare Vouchers; Staff Travel; Staff Awards</i> .
<b>Equality and Training</b>	Includes: 1) the implementation of <i>Knowledge and Skills Framework</i> and other policies like <i>Dignity at Work Policy</i> ; 2) discussions on education and training issues, for instance, <i>At-Learning System; Leadership and Management Development Framework; Learning and Development Strategy; First Aid Training; Moving and Handling Training; Risk Management for Managers Training</i> ; 3) reports from sub-groups, for instance, <i>the Dignity at Work sup-group; Equality and Diversity sub-group; Learning and Development sub-group; Equal Opportunities Group</i> ;
<b>Financial Issues</b>	Includes: 1) the reports from finance directors or other staff from finance department; 2) discussions on corporate budget, deficit and savings, for instance, the <i>Cash Releasing Savings; Efficiency Savings; Energy Conversation; Financial Planning; Operational Savings</i> ; 3) other operational issues related to finance management, for instance, <i>Arbuthnott Formula; Icelandic Banks; Harmonisation of Catering Price Levels; Work of the Endowments Committee</i> .
<b>Partnership Working and the Forum</b>	Include 1) development of the forum, for instance, <i>Attendance Management; Restructure of the Forum; Board Partnership Forum; Review of Mediation Service; Staff-side Chair Election</i> ; 2) actions on partnership working, for instance, <i>Communication and Engagement Plan; Facilities Time; Partnership Agreement; Partnership Conference; Partnership for Care; Review of Partnership Working at Raigmore Hospital</i> ; 3) reports from sub-groups, for instance, <i>Joint Working sub-group; Joint Future Partnership Forum; CHP Raigmore Partnership Forum; CHP SSU Partnership Forum</i> ;

<b>Workforce Planning and Development</b>	Includes 1) development of workforce strategy, for instance, <i>Local Workforce Plan; Clinical Workforce Redesign Project; Modernising Medical Careers; Nursing in the Community; Support Workers Project; HEAT Target</i> ; 2) policy development related to staff grievance, careers, recruitment and rotation, for instance, the <i>Conduct and Capability Policy; Disciplinary Policy and Procedure; Grievance Policy; Induction Policy; Job Evaluation Policy; Maternity Policy; Staff Counselling; Pre-employment Checks; Regulation of Healthcare Support Workers; Voicing Concerns Policy; Volunteering Policy</i> ; 3) workforce planning, for instance, <i>Allied Health Professions Workload Measurement and Management; Managing Sickness Absence; Nursing and Midwifery; Refugee Doctors Programme; Workforce Reports</i> ; 4) reports from sub-groups, for instance, <i>Workforce Planning Group; HR sub-group; Workforce Development sub-group</i> ;
<b>Clinical Issues</b>	Includes issues related to clinical management, for instance, <i>Bed Utilisation; Pandemic Flu; On Call Management Arrangement; Patient Safety Programme; Hospital at Night; Staff Uniforms</i> .
<b>Health, Safety and Wellbeing</b>	Includes 1) actions on the management of staff health and safety, for instance, <i>Cycle to Work Scheme; Removal of Fizzy Drinks Machines in Healthcare Establishments; Working Well Challenge Fund; Flu Vaccine; Prevention and Management of Stress at Work</i> ; 2) development of policies related to staff health and safety, for instance, <i>Tobacco Policy; Gender based violence employee policy; Moving and Handling Policy; Protecting against Violence and Aggression at Work Policy; Health and Safety Policy</i> ; 3) reports from sub-groups, for instance, <i>Prevention of Violence and Aggression sub-group; Stress Management Steering Group; Health and Safety Forum; Health Working Lives sub-group; Occupational Health sub-group</i> .
<b>Staff Governance Process</b>	Includes the implementation processes of staff governance standard, which are <i>the Staff Survey; Annual Review; Executive Report; Action Plan; Facilities Budget; Planning and Prioritisation Process; SAAT</i> .

### **3.4.3 Participants' Behaviour Framework**

The coding frame of behaviours is drawn from Bacon and Samuel's (2009) work, which was developed from Walton & McKersie's (1965) 'A Behaviour Theory of Labour Negotiations'. 22 types of behaviour were classified and categorized into three broad sets, which are positive, neutral and negative (Table 3-3). It suggests that joint problem-solving requires positive behaviours as individuals engage in an open search for optimal solutions. Such behaviours should increase satisfaction with partnership and enhance commitment to partnership. Neutral behaviours include providing and seeking information. Such exchanges of information are required to provide information for the basis of a constructive discussion and encourage others to cooperate in searching for the best solutions to problems. If information is not freely exchanged this will likely reduce satisfaction with partnership. Exchanging information is not, however, sufficient to motivate partnership working, it must also lead to joint problem-solving. Excessive information exchange without joint problem-solving may create frustration as meetings resemble 'talking-shops' that never make progress towards resolving the major issues. This may reduce satisfaction with partnership and lead to declining levels of commitment to partnership. Negative behaviours will constrain partnership working and reduce both parties' commitment to partnership (Bacon and Samuel, 2010; 2012).

**Table 3-3. Behaviour Coding Frame**

Positive	Neutral	Negative
<p><i>Proposing</i> – tabling a suggestion or course of action                      Example: “Mr Ray Stewart felt there was a need to take a decision on this today for this year’s holidays, but that a discussion on consolidation and whether different areas could have different holidays should be deferred.”(APF minute, NHS Highland, 18<sup>th</sup>-Feb-05)</p>	<p><i>Seeking Information</i> – seeking facts, opinions or clarification on an issue                      Example: “Ray Stewart asked Anne Gent to clarify whether PIN Guidelines were part of terms and conditions.” (APF minute, NHS Highland, 22th - Jul – 05)</p>	<p><i>Blocking</i> – placing difficulties or hurdles in the path of a proposal                      Example: “On the point raised by Heather Sheerin, Philip Walker advised that it would be difficult to compare the financial cost of the service with that provided elsewhere given that provision was not on a like for like basis.” (APF minute, NHS Highland, 20th - Jan – 06)</p>
<p><i>Building</i> – extending or developing a proposal or innovation made by another individual                      Example: “The human resource director added that the APF may wish to consider, at their next meeting, how the existing APF Work Programme related to the Corporate Objectives.” (APF minute, NHS Highland, 13<sup>th</sup>-May-05)</p>	<p><i>Giving Information</i> – offering facts, opinions or clarification on an issue                      Example: “Caroline Parr gave a brief overview on progress of the implementation of NHS Highland PIN Policies in general. She advised that certain aspects of the Employee Friendly Policies for example Flexible Working (Flexitime, Compressed Working Week, Term Time Working, Self Rostering) were yet to be completed.” (APF minute, NHS Highland, 13th - May – 05)</p>	<p><i>Disagreeing</i> – a conscious and direct declaration of difference of opinion                      Example: “Philip Walker advised that he was not in favour of additional payments over and above the terms and conditions included in Agenda for Change and that this would affect 470 staff in New Craigs alone.” (APF minute, NHS Highland, 18th - Nov – 05)</p>
<p><i>Including</i> – seeking to draw other individuals into a discussion or to comment positive on their behalf                      Example: “Adam Palmer suggested that this was an opportunity to work with other agencies in respect of service delivery and consider radical new approaches.” (APF minute, NHS Highland, 13<sup>th</sup> - May - 05)</p>	<p><i>Deferring</i> – putting back an issue for consideration at a later date or sending the issue to another authority                      Example: “Roger Gibbins suggested that his presentation on the Kerr report should be deferred to the next meeting because of time constraints.” (APF minute, NHS Highland, 22th - Jul – 05)</p>	<p><i>Criticising</i> – a conscious and direct criticism of another individual’s concepts                      Example: “Adam Palmer reminded the Forum that the APF should be monitoring implementation of all PIN Guidelines, and did not currently carry this out as formally as expected.” (APF minute, NHS Highland, 22th - Jul – 05)</p>
<p><i>Solidifying</i> – summarising or otherwise restating in positive terms the content of a discussion or consideration                      Example: “Donald Shiach confirmed that the need to increase matching output arose because twice as many posts had been identified than originally anticipated. It was essential therefore to increase capacity in this</p>	<p><i>Empathising</i> – identifying with the views/positions of others while not necessarily agreeing                      Example: “Roger Gibbins stated that his understanding was that there would be designated areas provided for visitors.” (APF minute, NHS Highland, 20th - Jan – 06)</p>	<p><i>Attacking</i> – a conscious and direct verbal attack on another individual or his/her concepts involving value judgements and emotional overtones                      Example: “Jessie Farquhar advised that staff were unlikely to be pleased at the withdrawal of the Allowance especially as they had yet to see the options under consideration.” (APF minute, NHS Highland, 18th - Nov – 05)</p>

regard. "(APF minute, NHS Highland, 13 <sup>th</sup> -May-05)		
<i>Agreeing</i> – a conscious and direct declaration of support or agreement with another individual, position or action Example: "In addition it was agreed that the Action Plan should include an introduction that relates to the Corporate Objectives." (APF minute, NHS Highland, 13 <sup>th</sup> – May - 05)	<i>Defending</i> – attempts to uphold by argument Example: "He emphasised that NHS Highland should not assume these changes would not have an impact." (APF minute, NHS Highland, 22th - Jul – 05)	<i>Pre-conditions</i> – laying down conditions that must be fulfilled beforehand Example: "He noted that A&C staff -side representatives did not want to engage in the wider process until a decision on boundaries had been made." (APF minute, NHS Highland, 22th - Jul – 05)
<i>Open</i> – a conscious admission of error/inadequacy by an individual made in a non-defensive manner Example: "Chris McIntosh also commented that some staff had been confused by what they perceived to be an inconsistent approach to the provision of services on recognised public holidays." (APF minute, NHS Highland, 13 <sup>th</sup> – May - 05)	<i>Advance notice</i> – signposting issues for future consideration Example: "It was noted that the Group would be preparing a paper following its meeting on 27/11/06 for submission to the Board in February 2007." (APF minute, NHS Highland, 17th - Nov – 06)	<i>Shutting-out</i> – overt and continuous interruptions by individuals of another individual's proposals or reasoned statements of support/disagreement Example: "To approach the matter in any other way would raise the issue of equity among staff and could lead to equal pay claims, even amongst Mental Health staff." (APF minute, NHS Highland, 17th - Mar – 06)
<i>Trusting</i> – statements expressing confident expectations of an action or policy Example: "Ray Stewart advised that allocation of the Facilities Budget was being progressed as appropriate." (APF minute, NHS Highland, 20 <sup>th</sup> – Jan - 06)		<i>Apprehension</i> – fearful anticipation of the potential consequences of an action or policy Example: "George Andrews raised a staff concern that the clustering of jobs could lead to a discrepancy between jobs processed earlier and later. He noted that the matching process would lose all credibility if that were the case." (APF minute, NHS Highland, 22th - Jul – 05)
		<i>Threat</i> – declaration of intention to veto and/or retaliate Example: "Mr R Stewart stated that he was to write to the Chief Executive confirming this point, advising that there would be no participation in implementation." (APF minute, NHS Highland, 18th - May – 07)
		<i>Suspicion</i> – indicating or justifying suspicion of a proposal or plan Example: "Tony Cowan-Martin queried as to whether there was evidence that the closing of Assynt House and John Dewar had a negative effect on Clinical Services." (APF minute, NHS Highland, 18th - Nov – 05)

Source: Drawn from Bacon and Samuel's work in 2010 which was adapted from Walton & Mckersie (1965: Ch3, 5 and 6).

### 3.4.4 Types of Outcomes

The framework used to analyse outcomes of partnership meetings was drawn from Bacon and Samuel's work in 2010. After initially identifying 13 different types of decisions, these decisions were organised into 5 basic types of outcomes from discussions in the APFs (see table 3-4).

**Table 3-4. Types of Outcomes in the Partnership Meetings**

<b>Types of Outcomes</b>	<b>Examples</b>
<b>Refine</b> – refers to outcomes that refine the content of policies or change the way to implement policies as a result of discussion in the APF, producing tangible changes or improvements;	It includes: the Forum makes suggestions to a policy, and then transfers the issue to another committee/Forum for consideration; the forum responds to a national policy consultation, makes suggestions; the Forum changes the original action plans after discussion.
<b>Agree</b> – refers to outcomes that agree on proposed policies or planned actions.	It includes: endorsing a policy; agreeing a planned course of actions.
<b>Involve</b> – refers to outcomes that decide to involve other partners in the policy-making process.	It includes: the Forum sends representatives to another committee/Forum, jointly discussing a policy; policy has already been signed off by managers, but the Forum requires the issue to come back to the APF for further discussion; the forum agrees to hold a small working group meeting to discuss the issue, and then report back to the full group; the Forum invites representatives from other committee/Forum, jointly discuss an issue.
<b>Revisit</b> – refers to outcomes that decide to revisit an issue at a later date.	It includes: one party suggests refining the policy, but the other parties disagree in the meeting, defer the issue to the future; discussion on the issue is deferred because the Forum is inquorate or because of time pressure.
<b>Veto</b> – refers to outcomes that participants refuse to discuss an issue in the forum or veto a policy.	It includes: one party refuses to discuss the issue any more; one party rejects to sign off a policy.

It is suggested that refine the content of policies or the way to implement policies can increase satisfaction with partnership and commitment to partnership because the

meeting produced tangible impact. Reaching agreements based on early involvement of partners and fully consultation can also increase satisfaction of partnership working. It implies the effectiveness of partnership working. However, it needs to be noted that agreements without fully consultation with partners cannot increase satisfaction of partnership working, as it implies that the Forum is acting just as a rubber-stamped organisation. Involving partners in decisions is important but this will not increase satisfaction unless involvement also leads to impact. Revisiting is important but excessive revisiting may feel as though issues are never resolved. This may reduce satisfaction with partnership and commitment to partnership process. Vetoing a policy or refusing to discuss an issue in the Forum can be seen that no agreement is likely to be achieved in the future based on partnership working and this will cause damage to partnership relationships.

### **3.5 Conclusions**

This chapter has reviewed the advantage of pursuing longitudinal study in researching partnership phenomenon underlying broad social and economic changes. Three health Boards were selected under certain standards, including NHS Highland, NHS GG&C and NHS Borders. It also described the main approaches adopted by this study for data collection. The key features of the research methods in this study is that it has used a variety of methods to collect data and employed several instruments for coding the minutes into different categories of agenda, groups of participants, sets of behaviours and different types of outcomes. Based on these data analytic framework, the following chapters will start to explore the context, operation, evolution and outcome of partnership in the three health Boards.

# **Chapter 4. Social Partnership in NHS Scotland following Political Devolution**

## **4.1 Introduction**

The first aim of this research is to review the context in which social partnership was initiated and developed in NHS Scotland. The following discussion of the findings starts with details about the external social-economic and internal organisational contexts in which partnership arrangements were concluded. In terms of the external contexts, four main aspects will be analysed, including the political environment; the policy context; the financial environment; and the modernisation strategy in NHS Scotland. The internal contexts focus on the geographical and demographic backgrounds; organisation structure and size; the history of employment relations; and the trade union organisations and their strength.

## **4.2 External Contexts**

The external contexts embracing political, economic and social factors can profoundly influence the initiation and diffusion of a partnership agreement (Kochan and Osterman, 1994). It is argued that firms facing a moderate level of pressure and stress are more likely to establish joint initiatives than either the absence of pressure or extreme crises (Walton, 1987) and symbolic legitimacy provides political and policy foundations for the adoption and diffusion of innovations such as partnership (Scott, 1995). In NHS Scotland, political devolution appears to be a crucial factor in encouraging the adoption of the national-level partnership agreement, reflecting the ambition of the devolved governments to include trade unions in plans to improve public services (Bacon and Samuel, 2009). Government leaders, NHS employers and trade unions shared the vision that it is vital to modernise the NHS through partnership

working (Bacon and Samuel, 2012). Such commitment was frequently mentioned and reflected in the key strategy development documents in NHS Scotland. It is also crucial to note that partnership arrangements observed in this study was in a particular NHS modernisation context that managers seeking union cooperation in achieving the performance targets.

#### **4.2.1 Devolution**

The most profound step on political devolution in Scotland was made in 1997 when the Labour government was elected in Westminster with a manifesto of holding public referenda on devolving political power to Scotland. On 11 September 1997, the Scottish Referendum on Devolution was held which resulted in a turnout of 60.4% of the electorate supporting political devolution in Scotland. Following the referendum, the Scotland Act was passed on 19<sup>th</sup> November 1998 which provided Scotland the legislation to create a parliament and tax varying powers for this parliament (The Scotland Act, 1999). As a result, the Scottish Parliament was then established as a devolved legislature. The Act sets out how Members of the Scottish Parliament are to be elected and makes some provision about the internal operation of the Parliament (specified in section 1-18 of the Act). The Act also delineates the legislative competence of the Scottish Parliament, the subjects in which the Scottish Parliament can make primary and secondary legislation. However, these subjects are not specifically outlined in the Act. Instead, the Act provides a list that includes reserved matters for which British Parliament retains responsibility. Devolved subjects are those which do not fall under the reserved categories (specified in schedule 5 of the Act). Health is one of the most significant policy areas in which the Scotland Parliament has been granted power since devolution, except for professional regulation and abortion (The Scotland Act, 1999). Independent political structures

have been established under the governance of the Scottish Parliament, for instance, the Minister for Health and Community Care is accountable to the Scottish Parliament for the running of the NHS; the Parliament Committee can call to account the Scottish Executive Health Department’s Chief Executive and the Chairs of all the NHS boards (BMA, 2007).

By providing more political autonomy and financial flexibility, devolution has created huge opportunities for devolved nations to address local needs with greater determination and more focus than ever before. In terms of the political context, devolution has provided devolved nations with different voting systems which created different governments. In Scotland, for example, for the first two terms of the Scottish Parliament, the Executive was led by a Labour-Liberal Democrat Coalition. The third Scottish elections in 2007 saw significant changes as the SNP won more seats than the Labour Party and formed a minority government (Table 4-1). The new SNP Government then replaced the name “Scottish Executive” with “Scottish Government” instead.

**Table 4-1. The Composition of the Scottish Parliament in each Term**

<b>Year</b>	<b>The composition of Scottish parliament</b>
<b>1999 - the first election</b>	Seats - the Scottish Labour Party (56), the SNP (35), the Conservatives (18), the Liberal Democrats (17), the Scottish Green Party (1), the Scottish Socialist Party (1) and others (1). The Executive was led by a Labour-Liberal Democrat Coalition.
<b>2003 - the second election</b>	Seats - the Scottish Labour Party (50), the SNP (27), the Conservatives (18), the Liberal Democrats (17), the Scottish Green Party (7), the Scottish Socialist Party (6) and others (5). The Executive was led by a Labour-Liberal Democrat Coalition.
<b>2007 - the third election</b>	Seats - the SNP (47), the Scottish Labour Party (46), the Conservatives (17), the Liberal Democrats (16), the Scottish Green Party (2) and others (1). The SNP formed a minority government.

Different political parties within each nation are intending to employ entirely different levers and philosophies underpinning health policy (Greer, 2004). The establishment of new power and decision-making centres in Scotland has created the ability to address specific geographical needs and prioritise different issues. In addition, different political parties and stakeholder communities have shaped the health policy in different strategic directions. Alongside the Labour government's programme for NHS modernisation, the change of political environment has also been an important factor which caused great divergences in the process of Scottish NHS modernisation. Unlike the NHS in England where trust managers are empowered to determine their own terms and conditions and if partnership arrangement inside the organisations is to be established or not, the embedding of partnership structures to local level was mandated by the central power in Scotland, which in turn forms an important political impetus to facilitate union involvement in the public service process. It therefore creates a unique political environment which protects trade union presence in the stage and provides a solid foundation for a genuine partnership to emerge.

#### **4.2.2 Public Policies and Political Commitment**

Since devolution, Scottish Ministers have expressed a high commitment to partnership working (Scottish Executive, 2000; 2003; 2005) and a series of written agreements which seek to define the broad principles, shared priorities and terms of engagement with a range of partners have been introduced. In 2002, a Memorandum of Understanding (MoU) was signed between the Scottish Executive and the Scottish Trades Union Congress (STUC) aiming to establish effective co-cooperation, in particular, to provide a framework for developing genuine partnership in Scotland. In

November 2007, a new MoU was signed between the Scottish National Party (SNP) government and STUC to share a commitment to partnership working on strategic issues and areas of common interest based on a mutual understanding of the distinctive values and roles of each party.

As the biggest employer in the public sector, employers in NHS Scotland have taken the lead in developing and propagating partnership initiatives. The Scottish health ministers, NHS employers and trade union leaders have shared a vision that working in partnership is vital to build a world-class health service from the patient's viewpoint (Scottish Executive, 1997). At the same time, it was acknowledged that this vision could not be achieved without giving staff and their trade unions a greater say on how the NHS Scotland service were planned and managed. It is also recognised that greater staff involvement in decisions that affect their work allows for better quality of decision-making and a workforce that understands the local population in its demographic make-up is better able to develop responsive, inclusive services, and is directly related to delivery of high quality care and patient satisfaction (Staff Governance Standard, 2007). Therefore, the Scottish Executive has put forward a strong commitment to forge a spirit of partnership and cooperation within the NHS in Scotland since the start of NHS modernisation in Scotland. As the interviewees expressed:

*“Partnership in NHS Scotland is held together because we agree on why we are here. We are all here to deliver quality care for patients. The NHS has a head start in partnership because we agree on the product, we built it together. It is not affected by the profit motive although we must be efficient, you can't fight the class struggle in the NHS and those who try to do it, I tell*

*to go away, and it builds on the natural instinct of people not to live in conflict.” (Chair of SWAG in NHS Scotland, 2010)*

*“When I joined the NHS there was tension around partnership. There were questions raised about senior commitment from the top to partnership. I can assure you there is that commitment. We have made mistakes, there have been blips, but we remain committed to working in partnership.” (Interim Director for Health Workforce in NHS Scotland, 2010)*

Such commitments were also frequently been referred in many important strategic policy documents (see Table 4-2), for example:

*“The modernisation agenda is complex and demanding, but it is one which is now being tackled with greater vigour than ever before. At the heart of the approach is partnership. Everyone has a right, and a responsibility, to join together in a national effort for improvement and change. “*

*--- Our National Health, A Plan for Action, 2000: 9*

*“...partnership between staff and employers, involving Trade Unions and professional organisations, is essential to the continual improvement of public service. This partnership commitment will be driven forward at national level through the Scottish Partnership Forum and Human Resources Forum, launched earlier this year to make sure staff have a voice at the highest level.”*

*---Partnership for Care, 2003: 52*

*“The concept of a mutual NHS reinforces and extends this commitment to partnership working and we will work through the Scottish Partnership*

*Forum to continue the development of this concept at both a strategic and practical level.”*

*--- Better health, better care, 2007: 19*

**Table 4-2. Milestones in the Development of Social Partnership in NHS Scotland**

<b>Year</b>	<b>Key documents and activities</b>
1997	“Designed to Care” was launched. It proposed a vision of a world-class health service designed from the patient’s view. The importance of working in partnership with trade unions and professional organisations was recognised.
1998	“Towards a New Way of Working” was launched. The first Human Resources strategy made the point that a new employee relations framework based around partnership was necessary for the success of the modernisation of NHS Scotland.
1998	The Scottish Partnership Forum (SPF) was set up in order to support partnership working at the national level.
1999	The NHS MEL (1999) 59 was issued that set out the partnership arrangements with which NHS Scotland employers were required to comply.
2002	The Memorandum of Understanding (MoU) was signed between the Scottish Executive and the Scottish Trades Union Congress (STUC) that aimed to establish clearly defined processes and procedures for engaging with each other across a wide range of public policy issues.
2002	The Partnership Support Unit (PSU) was set up and located within SEHD. It acts as a dedicated resource to support further development and the implementation of partnership working at both national and local levels.
2003	The Human Resource Forum (HRF) was set up to ensure that NHS Scotland operated as an exemplary employer and consistency of HR practice and procedures could be maintained.
2005	“Partnership: Delivering the Future” was launched. It proposed a new structure of partnership which was carried out afterwards.
2007	The revised “Staff Governance Standard” was launched. The standard sets out what each NHS Scotland employer should achieve in order to maintain continuous improvement in fair and effective management of staff.
2007	A new MoU was signed between SNP Government and STUC which outlines a formal mechanism for on-going dialogue on shared priorities for economic development, public sector improvement and social partnership.

Given the strong political commitment to partnership working with trade unions, with substantial organisational support in place, it resembles a form of state-sponsored

social partnership and signifies the emergence of an embryonic, yet potentially distinctive, social democratic approach to industrial relations in Scotland. Albeit in a liberal market context, Scotland shared some features of social partnership in the coordinated market economies of some other European countries, given the factor that political parties are highly involved in the partnership arrangements (Bacon and Samuel, 2009).

#### **4.2.3 The Changing Financial Environment**

The financial arrangements for British NHS are determined by British Treasury. Funding was generated from general taxation and national insurance contributions. Currently, the devolved nations receive funding from British Treasury in an unconditional block grant and the size of the block grant is determined by the Barnett Formula<sup>2</sup>.

Although the financing mechanism of the four British health systems are quite similar, devolution has given the devolved nations significant autonomy and flexibility to allocate their resources in line with their own health policies and priorities. From 2000 to 2008, the health budget in NHS Scotland was allocated to the boards according to the Arbutnott weighted capitation formula devised in 2000. The Arbutnott formula distributed the NHS budget based on a weighted capitation approach that started with the number of residents in each NHS Board area, and then adjustments were made according to the age/sex of the NHS Board population, their needs based on mortality and life circumstances (including deprivation) and the additional costs of providing services in remote and rural areas. This formula was

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<sup>2</sup> The Barnett formula is a mechanism used by The Treasury in the United Kingdom to adjust the amounts of public expenditure allocated to Northern Ireland, Scotland and Wales automatically to reflect changes in spending levels allocated to public services in England, England and Wales or Great Britain, as appropriate.

created within the values of the NHS which seek to provide equal opportunity of access to free healthcare at the point of need. In 2005, the NHS Scotland Resource Allocation Committee (NRAC) was established aiming to improve the Arbutnott formula. The NRAC refined and extended the Arbutnott formula by evaluating new sources of evidence to determine the healthcare needs in different groups of people and using new information to identify items that might influence the costs of healthcare provision. It also considered how the formula could be extended to cover other areas of healthcare expenditure (such as primary care dentistry, eye and pharmacy services) and how NHS services changes (such as the Kerr report) may affect resource allocation in the future. As a result of the recommendations of the NRAC, the new NRAC formula replaced the Arbutnott formula in informing NHS Board allocations in 2009/10.

**Table 4-3. The overall NHS financial position in Scotland from 2004/05 to 2009/10**

NHS in Scotland outturn	2004/05 £ million	2005/06 £ million	2006/07 £ million	2007/08 £ million	2008/09 £ million	2009/10 £ million
Revenue budget	7,965	8,650	9,109	9,726	10,085	10,387
Capital budget	193	305	391	398	508	497
Total budget	8,158	8,955	9,500	10,124	10,593	10,884
Increased rate	-	9.7%	6.1%	6.5%	4.6%	2.7%

Source: Audit Scotland, "Financial Overview of the NHS in Scotland 2009/2010", 2010, Edinburgh.

In 2010, Audit Scotland reported that the Scottish public sector was under the greatest financial pressure since devolution. Between 2001/02 and 2009/2010, the NHS expenditure had increased by 38 per cent in real terms (Audit Scotland, 2010: 3). However, the level of year-on-year increase in NHS funding has slowed down since 2008/09 (Table 4-3). In 2010/11, the budget plans have only provided for 2.4% increase in cash terms for NHS Scotland.

Despite the slowing rate of funding increase, the NHS continues to face growing demand for its services. In the report of Audit Scotland 2009/2010, it identified a number of cost pressures in NHS Scotland including NHS salaries, increasing prescribing costs, existing commitments under Private Finance Initiative projects, health inequalities and the cost of treating obesity and the misuse of drugs and alcohol. Furthermore, coupled with the financial crisis in 2008, these pressures aggravated the financial environment. Therefore, it is important to note that boards in NHS Scotland are obliged to balance their finances in a way which should also ensure the quality of health delivery.

The tighter financial outlook means that NHS Scotland needs to do more to identify efficiencies, understand and improve levels of productivity, review how services are delivered and work more effectively with its partners and patients (Audit Scotland, 2009). In 2009, the SGHD established the NHS Efficiency and Productivity Programme which is expected to deliver efficiencies within support services, improve benchmarking information, support the uptake of improvement methodologies and reduce variation in service delivery through the redesign of core services (Scottish Executive, 2009). In line with this programme, the local boards have developed their own financial plans within the funding constraints and cost pressures they are facing. A number of steps have already been taken, including service redesign to deliver clinical and non-clinical services in new ways, better management of resources by acknowledging the need for unit costs and important efficiency indicators, improving procurement by reviewing and renegotiating supplier contracts, increasing income by reviewing the prices charged for services and workforce planning by considering the future requirements in relation to staffing complement and deployment.

These series of actions have a profound influence on the operation of NHS boards in terms of corporate strategy, governance structure change, and most importantly, workforce planning. It is recognised that the number of people employed in certain areas will inevitably be reduced as a result of increasing pressures on budget. Although NHS Scotland is committed to having a policy of no compulsory redundancies, NHS Scotland boards are taking necessary steps to address this challenge, including reviewing shift patterns and staff deployment which may cause contentious issues with staff who are affected by these actions.

The changing financial environment would also have important implications for both management and trade unions in partnership arrangements. As one HR manager described:

*“In moving forward, we are moving from comfortable financial circumstances previously into the unknown. Partnership with staff and unions will be pressurized by individuals who may find themselves in difficult circumstances. These will be interesting dynamics. It will be as tough for us to manage managers as it will be for unions to manage individuals in the current financial circumstances.” (Interim Acting Head of Workforce in NHS Scotland, 2010)*

However, there is no sign indicating that managers will drop off partnership in such a difficult time. In contrast, senior managers expressed a positive stance:

*“We are now going into difficult times with the election and pressure on public sector expenditure. This creates an environment in which we can use partnership to get through the financial situation.” (Interim Acting Head of Workforce in NHS Scotland, 2010)*

It is again emphasised that managers need to put in place effective consultation and engagement mechanisms to ensure that staff are kept informed about the need for the difficult decisions ahead, and partnership working arrangements are likely to become increasingly important in the process.

#### **4.2.4 Modernisation in NHS Scotland**

With its election in 1997, the Labour Government in Westminster put forward a modernisation strategy within the NHS. For the past decade, the NHS in Britain has undergone significant changes with the aim to improve the quality of health services. However, the modernisation agenda in NHS Scotland appears to be different from other nations in some aspects, as devolution has given the power for the Scottish Government to design a health service that fits Scottish needs.

NHS modernisation is a complex and dynamic process. Three aspects of the modernisation agenda appear to have a significant influence on the development of partnership, including strategic direction, the change of governance structure and performance management.

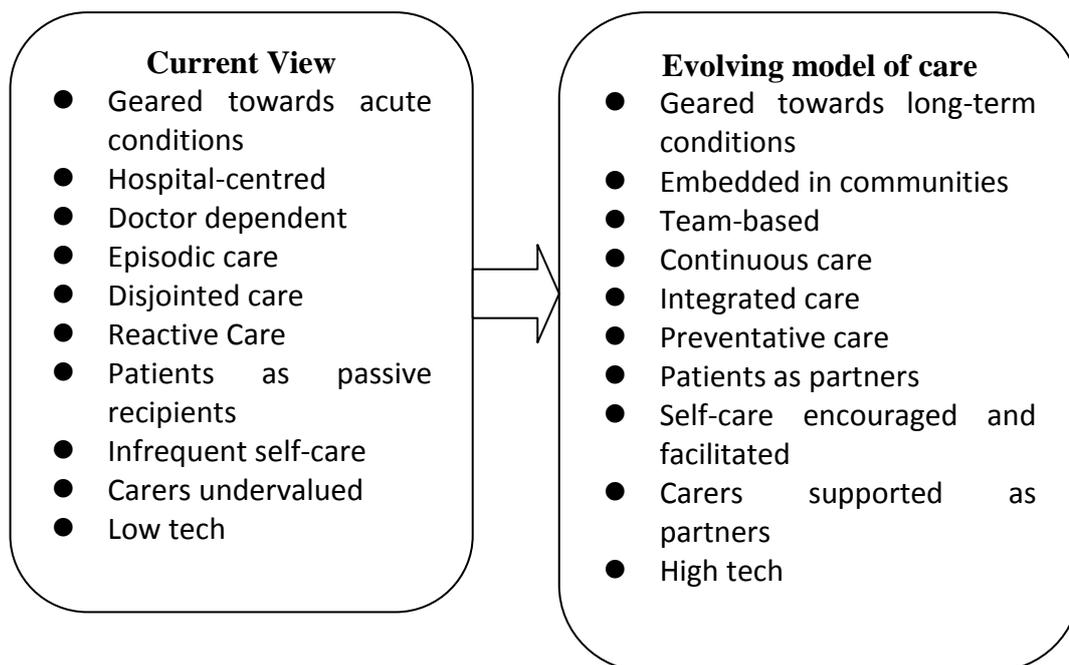
#### **Development Strategy in NHS Scotland**

During the past ten years, the strategic direction of health policy within NHS in Scotland has undergone significant changes alongside the dynamic process of devolution. Those key themes that reflect the influence of political dynamics on health service in Scotland include the integration strategy for healthcare, the changing role of the private sector and the influence of health communities on strategic decision-making.

In 2000, the NHS Scotland published 'Our National Health, A Plan for Action', which was perceived as an important milestone and signpost on the way to a healthier healthcare system in Scotland. The plan outlined the core aims, priorities and process

of modernisation in NHS Scotland, and the detailed programmes include rebuilding a truly NHS through changes to governance and accountability; increasing public and patient involvement in the NHS; and service change and modernisation (Scottish Executive, 2000). In 2005, the Kerr report 'Building a Health Service Fit for the Future' emphasised the need to provide more services outside hospitals and improve integration between primary and secondary care. It proposed to create an integrated health system with close connections between different components. It is anticipated that "the ageing of the population, the growth of long term conditions and the continuing pressures on emergency beds can and must be dealt with by an integrated, whole system response that moves the NHS in Scotland from an organisation reacting to illness often by doctors in hospitals to an organisation working in partnership with patients to anticipate ill health and deal with it in a continuous manner through the efforts of the whole health care team" (Kerr, 2005: 64).

In response, the Scottish Executive (2005) published 'Delivering for Health' which aimed to build an integrated approach to health and provide the majority of care for the local community (Scottish Executive, 2005). Based on the framework proposed in these two documents, the principle of joint working was set up between boards, and furthermore, the principle of establishing a local NHS governance system through the vehicle of Community Health Partnerships (CHPs) was reinforced (see Fig 4-1). In 2008, the new SNP Government published 'Better Health, Better Care: Action Plan' which was built on the direction set by the Kerr report (Scottish Government, 2008). In terms of governance, the SNP Government has reinforced the strategy of encouraging local decision-making and community involvement by legislating for directly elected health boards (Scottish Executive, 2007).



**Fig 4-1. Developing Strategy in NHS Scotland**

In terms of the role of the private sector, the Labour government in Westminster has given support to increased private sector involvement to create an internal market system in the NHS England. However, both the Scottish Labour Party and the SNP have pursued a different direction to England's market-based reforms. The Health Act, which came into effect in 1999, abolished the internal market in NHS Scotland. Instead, a new structure was put in place based on collaboration rather than competition. The SNP government has recently passed legislation to exclude commercial companies with shareholders from holding primary medical services contracts and ban private contracts for hospital cleaning and catering services (BMA, 2010).

Greer (2004) has referred to the Scottish NHS model as 'professionalism' which involves greater reliance on professionals to bring about quality improvement and to align healthcare structures with professional ways of working (Geer, 2004). Since

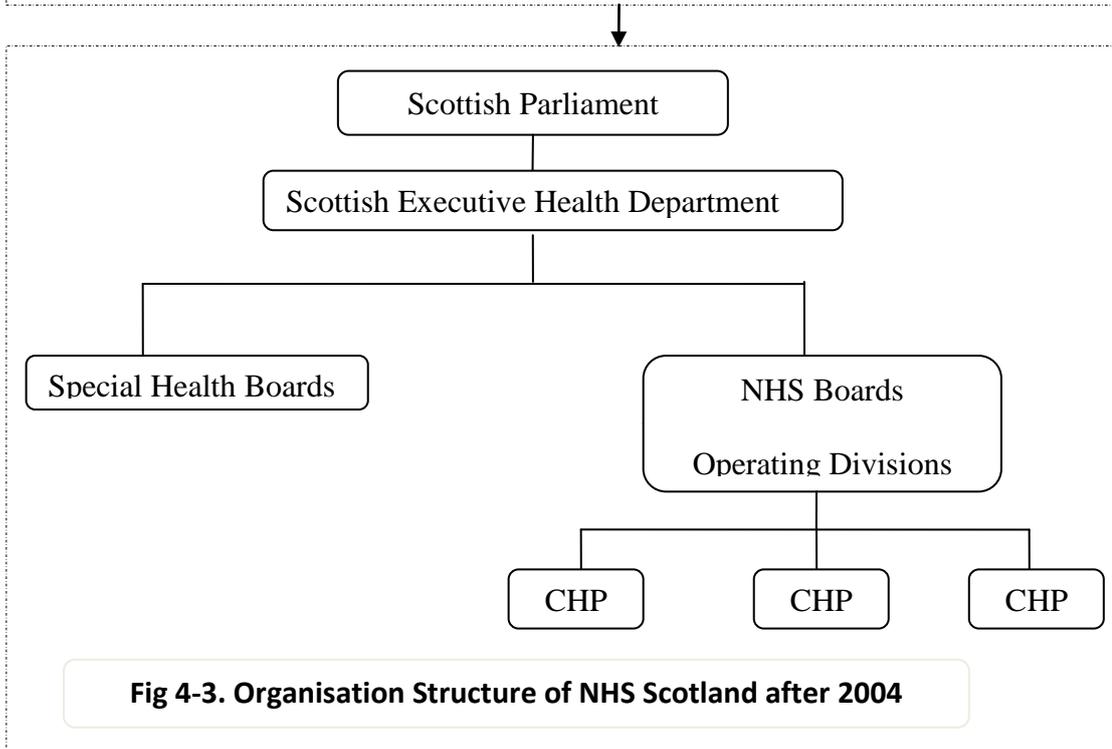
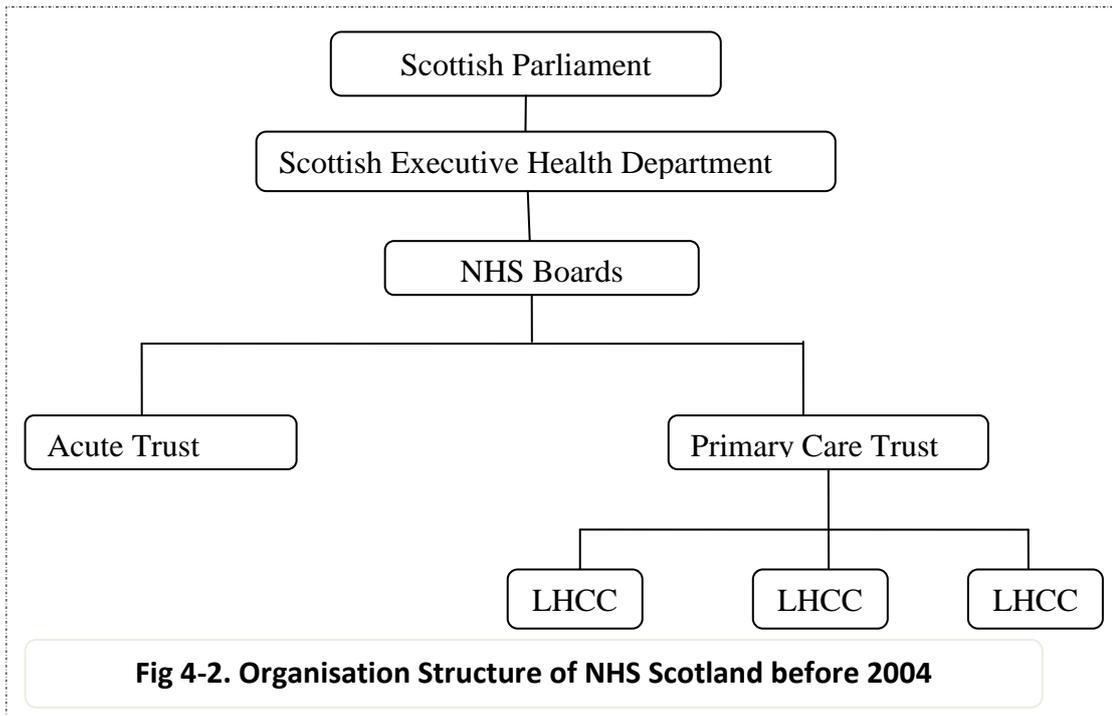
devolution, the policy making process has been largely influenced by its policy community that comprises of three Royal Colleges and five university medical centres (BMA, 2007). Policy-makers and healthcare professionals appear to show a closer professional relationship in the development of health policy which is often lacking elsewhere (BMA, 2007). However, the recent BMA (2010) report points out that the initial Scottish focus on ‘professionalism’ changed several years ago when the centralisation of health services became a significant public issue and the focus on listening to professionals changed as the Government began to give patients and the public a greater voice (BMA, 2010: 9).

### **Change of organisational structure**

Given that Scottish health policy has sought to create an integrated health system, significant structure changes have been introduced within NHS Scotland over the last ten years. The governance structure of NHS Scotland has largely focused on collaboration and integration. Before 2004, there were 15 NHS boards in Scotland. The overall purpose of the boards is to ensure efficient, effective and accountable governance of the local NHS system and to provide strategic leadership and direction for the local system. Basically there were 28 NHS trusts under the boards. The acute trusts delivered hospital-based services (including tertiary services such as specialist cancer services) and the Primary Care Trusts (PCTs) were responsible for the delivery of primary care services (including family, community and mental health services) (Arnison et al., 2003). The local health care co-operatives (LHCCs) were set up under the PCTs as voluntary groups of general practitioners working to support the delivery of care to their local communities (see Fig 4-2).

In February 2003, the Scottish White Paper ‘Partnership for Care’ was published, which proposed a new management structure for NHS Scotland (Scottish Executive,

2003). All acute and primary care trusts were all abolished. They were replaced with 14 Boards in an attempt to create a locally-focused, integrated health system with close connections between the different components (see Fig 4-3 and Table 4-4). Since then, the Boards are responsible for delivering community and primary care services. In addition, Community Health Partnerships (CHPs) were established in April 2005 to manage primary and community health services and replace the 79 health co-operatives. To date, there are close to 40 CHPs with every NHS Board having at least one CHP, while the largest board, Greater Glasgow and Clyde, has ten. It therefore established a closer working and planning relationship with local authorities and a direct report to NHS boards.



Source: Scottish Executive, 2003, "Partnership for Care", Edinburgh.

**Table 4-4. Organisational structure in NHS Scotland**

<b>Organisations</b>	<b>Roles and responsibilities</b>
Scottish Parliament	The Scottish Parliament has full legislative power for health in Scotland. It allocates funding from the Chancellor's budget to the NHS, which the Scottish Finance Minister divides up between central health services, NHS boards and the NHS at local level. The Parliamentary Committee can call to account the Scottish Government Health Directorate's Chief Executive and the Chairs of all the NHS Boards.
The Scottish Government Health Directorate (SGHD)	The SGHD is responsible both for NHS Scotland and for the development and implementation of health and community care policy. The Chief Executive of NHS Scotland leads the central management of the NHS, is accountable to ministers for the efficiency and performance of the service, and heads the Health Department which oversees the work of the 14 NHS Boards responsible for planning health services for people in their area.
Special Health Boards	The Special Health Boards in Scotland provide services across the country. They include NHS National Services Scotland, NHS 24, NHS Education for Scotland, NHS Health Scotland, NHS Quality Improvement Scotland, Scottish Ambulance Service, State Hospitals Board for Scotland, and National Waiting Times Centre Board.
NHS Boards	The NHS Boards provide strategic leadership and performance management for the entire local NHS system in their areas and ensure that services are delivered effectively and efficiently. They are responsible for the provision and management of the whole range of health services provided by hospitals and general practice. There are 14 regional health boards, including NHS Ayrshire and Arran, NHS Borders, NHS Dumfries and Galloway, NHS Fife, NHS Forth Valley, NHS Grampian, NHS Greater Glasgow and Clyde, NHS Highland, NHS Lanarkshire, NHS Lothian, NHS Orkney, NHS Shetland, NHS Tayside and NHS Western Isles.
Community Health Partnerships (CHPs)	The CHPs are joint organisations, comprising of local authorities, groups of GPs and other health professionals, in a defined geographic area. The CHPs are directly accountable to the NHS Boards, with a vital role in partnership, integration and service redesign. They provide opportunities for partners to work together to improve the lives of the local communities which they serve.

These changes brought about a simple and relatively flat organisational structure that implies fewer levels for the Scottish ministers to communicate with managers, and for managers to communicate with their staff. It also implies strong impetus for managers to seek union cooperation in facilitating the organisation change, which creates a

circumstance for closer working relationships between managers and union representatives.

### **Performance management and HR reforms**

Alongside the above-mentioned distinct development strategy and continuing structure change, NHS Scotland has also pursued a different performance management system with its counterparts in NHS England and NHS Wales. The performance management of NHS Scotland is currently measured by HEAT targets which are a core set of Ministerial objectives, targets and measures. The HEAT stands for Health, Efficiency, Access and Treatment. The key objectives are as follows: Health Improvements for the people of Scotland - improving life expectancy and healthy life expectancy; Efficiency and Governance Improvements - continually improve the efficiency and effectiveness of the NHS; Access to Services - recognising patients' need for quicker and easier use of NHS services; and Treatment Appropriate to Individuals - ensuring patients receive high quality services that meet their needs (Scottish Executive, 2005). A series of indicators are contained in each objective, covering a wide range of financial, patient service and HRM targets. The HEAT performance management system sets out the targets and measures against which NHS Boards are publicly monitored and evaluated. Every year a small number of HEAT targets are agreed with NHS Scotland and partners. These set out the accelerated improvements that will be delivered across Scotland in support of progress towards the Healthcare Quality Ambitions and Outcomes. Successful Local Delivery Plans and Annual Reviews are at the heart of performance management of NHS Scotland. NHS Boards continue to produce Local Delivery Plans based around the HEAT targets that set out their delivery trajectories, key risks, workforce challenges, and financial plans.

Under the HEAT performance management system, significant HR reforms have occurred, with key components including pay modernisation and staff governance. In 2004, the 'Agenda for Change' was launched that plans for far-reaching reforms of pay, conditions and working practices. The plan provides common terms and conditions for all staff and is supported by the NHS Job Evaluation Scheme and the NHS Knowledge and Skills Framework (KSF). It was designed to deliver: a fair pay system based on the principle of equal pay for work of equal value; improved links between pay and career progression; harmonised terms and conditions of service including annual leave, full-time hours of work, payment for unsocial hours working and levels of sick pay (Agenda for Change, 2004). At the core of these proposals is an emphasis on partnership working with trade unions to ensure that union representatives have adequate time and support to participate in the implementation of the Agenda for Change at the local level.

In 2007, the revised 'Staff Governance Standard' was legislated which makes up the third pillar of the NHS Scotland governance framework alongside clinical and financial governance. The standard is the key policy document and is enshrined in legislation as part of the NHS Reform (Scotland) Act 2004. It sets out what each NHS Scotland employer should achieve in order to maintain continuous improvement in relation to the fair and effective management of staff. The Standard focuses on five key principles to ensure that staff are appropriately trained; provided with a safe working environment; well-informed; involved in decisions which affect them; and treated fairly and consistently (Scottish Executive, 2007). The Staff Governance Standard is the overarching policy for partnership working, employment practice and employee relations. It proposed to establish local partnership arrangements aiming to advocate, broker and monitor staff-side involvement in all aspects of service planning,

strategy development and workforce planning. Under the instruction of this policy, a Staff Governance Committee is required to be established within each NHS board, which forms the full governance framework for NHS boards alongside the Clinical Governance Committee and Audit Committee.

In sum, the above discussions indicate that partnership arrangements are centrally driven by the government in NHS Scotland. The devolution has created a unique political environment in Scotland (Bacon and Samuel, 2012), bringing greater financial autonomy and a distinct modernisation strategy to the NHS. Most importantly, it promotes stronger political commitment to and involvement in the partnership working with trade unions, which may distinguish partnership arrangement in NHS Scotland from many other sectors.

### **4.3 Internal Contexts**

Besides the external contexts, it is also suggested that partnership arrangements are constrained by the nature of the organisation itself (Kochan et al., 1994). Deriving from existing literature, four main organisational features can shape the dynamics of partnership, including: the geographic and demographic backgrounds; the organisation structure and size; the history of employment relations; and trade union organisations and strength (Deakin et al, 2005; Haynes and Allen, 2001; Oxenbridge and Brown, 2002).

#### **4.3.1 Geographic and Demographic Backgrounds**

Geographically, NHS Highland is the largest health board in Scotland, covering an area of 32,512 km<sup>2</sup> from Kintyre in the south-west to Caithness in the north-east, serving a sparse population of 0.39 million residents within the Highland and Argyll and Bute Council areas.

NHS Greater Glasgow and Clyde covers an area of 1190.23 km<sup>2</sup>, with a population of 1.2 million, almost a quarter of the population of Scotland. It is located in west-central Scotland, created from the amalgamation of NHS Greater Glasgow and part of NHS Argyll and Clyde on April 1, 2006. It covers the unitary council areas of City of Glasgow, East Dunbartonshire, West Dunbartonshire, Renfrewshire, East Renfrewshire, Argyll and Bute and Inverclyde, together with the towns of Stepps, Moodiesburn, Muirhead, and Chryston in North Lanarkshire and Cambuslang and Rutherglen in South Lanarkshire. It also provides some services to the East Kilbride area in South Lanarkshire.

The NHS Borders cover a large rural area in Southern Scotland. The board is centred on Borders General Hospital, Roxburghshire, which employs over 1,000 people and serves as a community hospital for the central Borders, with a catchment of some 0.11 million residents in the Scottish Borders area, covering an area of 4,732 km<sup>2</sup>.

#### **4.3.2 Organisation Structure and Size**

NHS Highland employ over 11,000 staff, making it one of the largest employers in the region. It has 26 hospitals, over 110 community clinics and health centres operating under four Community Health Partnerships (CHPs) and Raigmore Hospital. The Mid Highland CHP, South East Highland CHP, and North Highland CHP were established in 2004, and Argyll and Bute became Highland's fourth CHP in April 2006. Each CHP is governed as a committee of the board (NHS Highland Annual Report, 2008).

NHS Greater Glasgow & Clyde (NHS GG&C) is the largest NHS organisation in Scotland with over 44,000 staff. It consists of more than 300 GP (General Practitioner) surgeries, 35 hospitals of different types, dental services in more than 270 locations, almost 180 optician practices, over 50 health centres and clinics and more than 300

pharmacies. There are ten CHPs in Greater Glasgow and Clyde including six Community Health and Care Partnerships (CHCPs) which are also responsible for delivering local social work services. The list of the CHPs/CHCPs are: East Glasgow CHCP, North Glasgow CHCP, South East Glasgow CHCP, South West Glasgow CHCP, West Glasgow CHCP, East Dunbartonshire CHP, West Dunbartonshire CHP, East Renfrewshire CHP, Renfrewshire CHP and Inverclyde CHP.

Within NHS Borders, clinical services are organised into four different clinical boards, which are Primary & Community Services, Borders General Hospital, Mental Health Service and the Learning Disabilities Service.

#### **4.3.3 History of Industrial Relations**

Previous research has suggested that a tradition of paternalism and mature working relationships between senior management and union officials is conducive to a partnership orientation and a good culture of union management cooperation is more likely to underpin partnership arrangement generating positive outcomes (Oxenbridge and Brown, 2002).

Historically, the overall industrial relations within NHS Scotland were described to be very confrontational prior to partnership. Individual employers did their own negotiation at the local level as the structure of NHS Scotland was decentralised and local managers were empowered with great managing flexibility. There was a lack of cohesion and collectiveness in the Trusts and Boards. By the end of the 1990s, everything was achieved by negotiation. As one of the interviewees described:

*“All sides would meet separately beforehand. They would all march into the room, we would put out position and the unions would walk out. Everything got linked and traded against other items. Conflict was the main behaviour both at the table and away from the table. Managers were vilified both at*

*the table and away from the table. I was involved in the closure of a hospital and quite literally I couldn't go out in that town for the real fear of being attacked.” (Head of Staff Governance, NHS Scotland, 2010)*

Managers had dominated the negotiation process and adopted certain tactics to restrict union influence. For example, they refused to deal with ‘difficult’ trade union officials but dealt only with officials perceived to be compliant (Oxenbridge and Brown, 2002). Trade unions had very limited access to participate in the management decision-making process and can rarely challenge management prerogative. As some interviewees indicate below:

*“Prior to partnership there was not a lot of dialogue. Each side went through one speaker. Anyone who spoke and threatened to deviate from that line was taken out of the room and disciplined. Union representatives were craving more involvement and participation.” (A Unite FTO, 2010).*

*“The doors to Edinburgh and the minister were completely closed. The STUC had a once or twice yearly visit to the minister but there were no discussions.” (Chair of SWAG in NHS Scotland, 2010)*

*“We could not affect these policies so we attacked management.” (A Unison FTO, 2010)*

In the three particular health boards, management and union representatives in NHS GG&C described their traditional working relations as being extremely ‘conflictual’. In 1998, NHS GG&C took the first step to set up partnership arrangements with trade unions, establishing a Glasgow Partnership Forum which provided the original model for the partnership framework proposed in the NHS MEL 59 (1999). After the remit of partnership working was built, it was described by participants that “the culture has changed at GG&C from the time

we used to go into the partnership forum (A Unison FTO, 2010). However, interviewees mentioned that union management conflict was still remaining at a relatively high level. In the case of NHS Highland, union-management relations are described by managers and union representatives as ‘cooperative’. Management enjoyed the good relations with union representatives and involved union representatives in many managerial issues. However, it does not mean that the environment in NHS Highland is conflict-free. The cooperative relations were occasionally challenged by bouts of adversarialism, usually in connection with payment issues and employee grievance handling procedures. Nonetheless, such adversarial challenges did not damage the spirit of cooperative relationships between management and unions. When disputes arose, agreements would eventually be achieved with either party making concession to another. Sometimes it was the management, while in other times it was trade unions. In NHS Borders, the union management relations were described as ‘good’. However, different from its counterparts in NHS Highland, the good relations were based on the fact that management dominated the union-management relations and trade unions were bypassed by management when strategic issues were discussed.

#### **4.3.4 Trade Union Organisations and Strengths**

One stream of the partnership debate argues that strong, well-established trade union organisations with high union member density is a factor perceived to be a necessary condition for the development and successful operation of partnership (Oxenbridge and Brown, 2004; Kochan, 2000). It is noted that in all of the three health boards, their union member density is quite close, which is approximately

at 70%. However, the trade union organisations and their strength were different in the three health Boards under partnership agreements (table 4-5).

**Table 4-5. Trade Union Organisations in the Three Health Boards**

<b>NHS Highland</b>	<b>NHS GG&amp;C</b>	<b>NHS Borders</b>
Unison	Unison	Unison
The Royal College of Nursing (RCN)	The Royal College of Nursing (RCN)	The Royal College of Nursing (RCN)
The Royal College of Midwives (RCM)	The Royal College of Midwives (RCM)	The Royal College of Midwives (RCM)
British Medical Association (BMA)	British Medical Association (BMA)	Unite-Amicus
Unite-Amicus	Unite-Amicus	The Transport and General Workers Union (TGWU)
The Chartered Society of Physiotherapy (CSP)	GMB	The Chartered Society of Physiotherapy (CSP)
The Society of Radiographers (SoR)	The Chartered Society of Physiotherapy (CSP)	Unite-CPHVA
British Orthoptic Society (BOS)	The Society of Radiographers (SoR)	The Society of Chiropodists and Podiatrists (SoCP)
The Society of Chiropodists and Podiatrists (SoCP)	The Federation of Clinical Scientists (FCS)	British Dietetic Association (BDA)
	British Association of Occupational Therapists (BAOT)	British Association of Occupational Therapists (BAOT)
	British Orthoptic Society (BOS)	
	The Society of Chiropodists and Podiatrists (SoCP)	
	British Dietetic Association (BDA)	

In NHS GG&C, thirteen different trade union organisations are recognised and involved in the APF, representing staff like nurses, doctors, dentists, and ancillary workers from different sectors. The headquarters of STUC and many trade unions, such as Unison, are based in Glasgow, which may imply easier access to the central union power and greater union strength than other health boards. In the case of NHS Highland, nine different trade unions are recognised

and involved in the APF. Trade union organisations were stable in the board for a long period, and many union representatives enjoyed a long-term friendly relationship with the managers. In NHS Borders, there are ten different trade unions recognised and involved in the APF. However, only a few trade unions had official organisations and full-time officials since the origin of partnership agreements. Trade unions including TGWU, BDA, BAOT and SoCP joined the APF after 2006.

#### **4.4 Chapter Summary and Conclusions**

In summary, this chapter has described the general context of NHS Scotland in which social partnership was initiated and developed. It began by illustrating the political devolution and its impact on the divergence of health policy in Scotland compared to other nations. By bringing greater political autonomy across a range of competencies as well as providing new opportunities for nations to pursue different priorities, devolution has accelerated the extent of divergences in many aspects. Key dimensions have been found in terms of the political context; financial environment (BMA, 2007; 2010); policy context; and modernisation agenda.

It is in the context of political devolution, greater political autonomy and financial flexibility that a distinct approach to NHS modernisation in NHS Scotland was generated. Overall speaking, partnership working and staff involvement have become a central theme in Scottish Executive's health policy pronouncements. In contrast to the difficulties partnership may encounter in the private sector as a result of the lack of political support and weak union strength in some sectors, the combination of devolution and partnership has created a unique approach for partnership to emerge in the public sector, especially in the case in NHS Scotland (Bacon and Samuel, 2009). However, little is currently known about the operation and outcomes of this

partnership developments and conditions. It is possible that the degree of political autonomy, the changing environment of financial support and the extent of commitment from senior levels will ultimately constrain or nurture the development of social partnership in the devolved nations.

In addition to the external contexts, this thesis has also analysed the distinct internal contexts within the three health boards. It addresses the main purpose of the research design to compare the operation, evolution and outcomes of partnerships under the same legislative and political contexts, with variations between different boards expected to be linked to their specific internal contexts. The key features that distinguish the three health Boards include: the geographic and demographic context; organisation structure and size; history of industrial relations; and trade union organisations and their strength (see Table 4-6).

**Table 4-6. Operating Features Compared in the Three APFs**

<b>Internal Contexts</b>	<b>NHS Highland</b>	<b>NHS GG&amp;C</b>	<b>NHS Borders</b>
Geographic area	32,512 km <sup>2</sup>	1,190 km <sup>2</sup>	4,732 km <sup>2</sup>
Population Served	0.39 million	1.2 million	0.11 million
Number of Employees	11,000	44,000	1,000
Organisational Size	Medium	Largest	Smallest
History of Industrial Relations	Cooperative Union-Management Relations	Adversarial Union-Management Relations	Union Marginalised
Trade Union Strength	Medium	Strong	Weak

It concludes that the NHS GG&C has the most complicated organisation structure and the largest organisation size as it serves the largest population in the Glasgow area. The board has a tradition of union-management conflict. Trade unions organisations

were well embedded in the board and union power appeared to be the strongest among the three cases. NHS Highland was in the middle of the three boards in terms of the geography and demographic context and organisation structure and size. However, it is important to note that traditional industrial relations were described as ‘cooperative’ in the board. NHS Borders is the smallest board in the three cases. Albeit a good relationship between management and trade unions, it appears that union strength in NHS Borders is the weakest among the three boards. As a result, such variations across the three boards may lead to different modes of operation as suggested by many commentators (Kelly, 2004; Oxenbridge and Brown, 2002) which is the focus of Chapter 5.

## **Chapter 5. The Operation of Partnership**

### **5.1 Introduction**

Previous research has suggested that, in order to achieve a full understanding of partnership, it is essential to examine the operation of partnership in addition to the outcomes of partnership (Danford et al., 2005; Johnstone, 2009; Martinez-Lucio and Stuart, 2004; Oxenbridge and Brown, 2004). Thus, the second aim of this thesis is to describe the operation of partnership in NHS Scotland by examining four main dimensions, including the partnership structure, partnership agendas, participants' voice and behaviours.

This chapter begins by describing the partnership structures at the national, regional/board and local/CHP levels in NHS Scotland. This is followed by providing an insight into the composition of partnership forums at regional/board levels within the three health boards. It then goes on to explore the scope of the partnership agenda in each of these boards. Comments from different groups of participants in the partnership consultation meetings are examined. After that, it analyses the behaviours of different groups of participants in the forums by utilizing the analytic framework drawn from Bacon and Samuel (2009). The final section summarises the main findings in this chapter.

### **5.2 Partnership Structure**

It was suggested that for partnership to be effective, substantial partnership structures and process need to be established from the strategic to policy and workplace levels to ensure early-stage staff involvement in developing plans that have traditionally been the prerogative of managers (Kochan and Osterman, 1994; Kochan et al., 2008). Such structures are essential for involving partners in the formulation of overall strategic

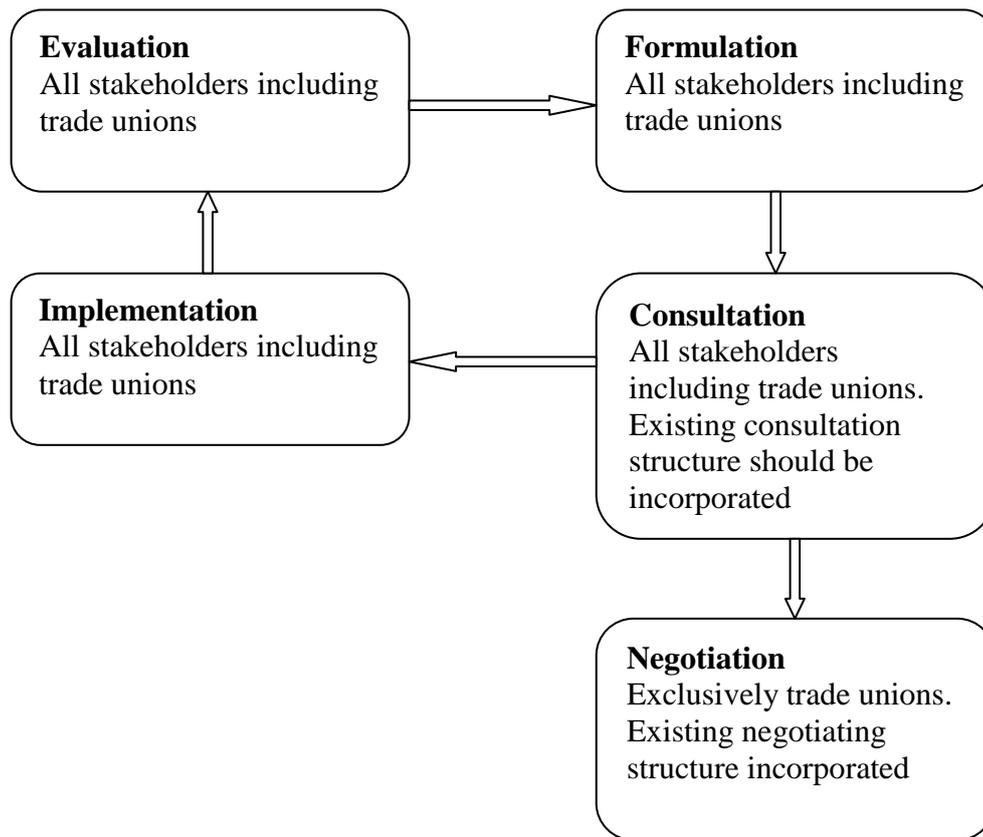
direction of the organisation, for developing in partnership the appropriate workforce policies, and for joint-problem solving. In this section, it will illustrate the partnership structures in NHS Scotland at three levels and then particularly examines in detail the partnership structures within the three health boards.

### **5.2.1 Partnership Structures in NHS Scotland**

The partnership structures in NHS Scotland are well-embedded at the national, regional/board and local/CHP levels. At the national level, the partnership structures have developed into three separate and appropriate forum each with smaller supporting Secretariats. At the regional/board level, Area Partnership Forums (APFs) and Staff Governance Committees (SGCs) are established in each NHS boards. While at the local/CHP level, Local Partnership Forums (LPFs) are responsible for ensuring the fair and consistent application of the Staff Governance Standard for staff working with the CHP.

#### **Partnership Structures at National level**

In 1999, the Scottish Executive set out a model of partnership arrangements which required the need for all stakeholders to be involved at the stage of formulating potential change or development before moving to the consultation stage (NHS MEL (1999) 59). All stakeholders, as appropriate, are also jointly responsible for supporting the effective implementation of change and are committed to review and audit the partnership approach in the spirit of continuous improvement and the seeking of clinical and organisational excellent. In addition, negotiation is perceived as part of the partnership arrangements which provides for all recognised trade unions to be exclusively involved in discussions including the terms and conditions for their members and requires agreement from both sides (Fig 5-1).



**Fig 5-1. Partnership Models in NHS Scotland (NHS MEL (1999) 59)**

Following the spirit of this national guidance, substantial partnership structures in NHS Scotland has been set up at three levels since 1998 (see Table 5-1). At the national level, the Scottish Partnership Forum (SPF) was set up in 1998 with the remit to champion partnership working across NHS Scotland. The SPF provided the main forum where all stakeholders, including the NHS Scotland employers, trade unions and professional organisations, could work together to influence national priorities and policies on health issues. In 2003, the Human Resources Forum (HRF) was set up. The remit of the HRF was to ensure that NHS Scotland operated as an exemplary employer and to ensure consistency of HR practice and procedures. In 2004, the National Workforce Committee (NWC) was launched by SEHD with the remit to provide focus and leadership on workforce planning and development for NHS Scotland.

From 1999 to 2005, there were over 30 sub-groups either directly or indirectly linked to the SPF, HRF and NWC. For instance, the NWC had split its work into nine work-streams, including labour market supply and demand; national workforce planning; commissioning plan for education; workforce redesign; careers, recruitment and retention; workforce performance and effectiveness; workforce observatory; occupational, professional and regulatory standards; and modernising medical careers. These groups were interacted with one another and were viewed as a significant duplication and overlap with the SPF and HRF. In 2005, the Scottish Executive published its report on a stocktaking of partnership working at the national level. The results indicated that the original partnership structures began to be bureaucratic, cumbersome, complex and time consuming, and there was a need to rebuild the partnership structures with a clear purpose to “improve health service and the wellbeing of the people of Scotland through engaging staff and their representatives at all levels in the early stage of the decision-making process in order to have improved and informed decision making, through achieving and maintaining a positive and stable employee relations culture and gaining commitment, ownership and consensus to decisions through joint problem solving” (Scottish Executive, 2005a: 10). It suggested that the partnership structures at the national level should have more capability and capacity to be both analytical and respond quickly and positively to a changing environment, but not to be complicated or bureaucratic. Subsequently, a reconstituted partnership structure was established in 2006. The SPF was restructured to be the single forum where SEHD, NHS employers, trade unions and professional organisations work together to improve health service for the people of Scotland. The scope of agenda in SPF was reshaped to focus on three main dimensions, including service change and modernisation; service delivery; and workforce. Furthermore, as

champions of partnership at national level, the SPF has responsibilities to facilitate the Employee Directors group through the provision of guidance, support and training and development; and support APFs through regular communication and by providing training and development events. The original role of HRF and NWC were replaced by the Scottish Workforce and Staff Governance Committee (SWAG) that is currently the single standing sub-committee of SPF. Functions of the SWAG are to support the development of the workforce strategy; to support the Director of Workforce in the development; and to support the implementation of employment policy and practice for NHS Scotland. The Scottish Terms and Conditions Committee (STAC) was constituted to be the forum to undertake negotiations at national level. Unlike the SPF and SWAG which are tripartite based on government, NHS employers and trade unions, the STAC is a bilateral organisation built with NHS employers and trade unions, which exists to collectively negotiate terms and conditions issues for NHS Scotland staff, other than those which pertain exclusively to recognised separate British collective bargaining arrangements. The STAC reports the minutes of its activities to the SPF. In addition, a Partnership Secretariat was put in place to take overview of the business of SPF, SWAG and STAC to ensure that the right business is transacted in the right place.

### **Partnership Structures at Regional/Board Level**

At the regional/board level, the HR Strategy “Towards a New Way of Working” issued in 1999 had called on all health boards to develop Local Partnership Agreements with staff and their representatives by October 1999. The document outlined some basic requirements for health boards to ensure that staff should be involved in the decision-making process; have access to information and board meetings; and have the opportunity to make their views known about organisational

changes which may affect them. In the meantime, the NHS MEL (1999)<sup>59</sup> has provided a template partnership agreement that was mandatory for all health boards to comply. The SPF developed guidance on Local Partnership Agreements to assist in directing the establishment of partnership structures at the regional/board level. While for the health boards, senior managers have also expressed great desire to establish partnership arrangement with trade unions, as partnership working was perceived to be a key element in the implementation of some key national policies, for example, the Agenda for Change.

Combining the national context and commitments from senior managers in the health boards, Area Partnership Forums (APFs) were then established across NHS boards. Complying with the national guidance, the remit of APFs in different Boards appeared to be quite similar, at least on paper. It was expected that the APF can play a key role to approve policy; to champion partnership working at regional/board level; to support workforce development; to support organisational change; and to provide advice to the NHS boards in relation to staff governance. The APF links with the SPF and provides reports on progress within its area on the issues listed above. The APF is managed on a shared Chair basis with each of the partners electing a designated Chair, chairing meetings on a rotational basis. It is important to note that the election of the staff-side Chair of the APF is a matter for the staff-side organisations only. The staff-side Chair, once nominated, serves as Employee Director on the NHS board. This appointment is for a period determined by the Chairman and is subject to approval by the Minister for Health and Social Care. In each NHS board, the Employee Director is also appointed to be a member of the board.

There is another committee for staff governance in NHS boards that needs to be mentioned here, although it is not named under a partnership facility. Complying with

the Staff Governance Standard 2007, a Staff Governance Committee (SGC) was established in each NHS board, with the remit to ensure that there are effective systems in place for the fair and effective management of all staff. The SGC is co-chaired by a senior manager and an Employee Director, with members consisting of management representatives and trade union representatives. The agenda mainly covers five work streams in accordance with the five principles<sup>3</sup> of staff management outlined in the Staff Governance Standard 2007. This situation suggests that there will inevitably be some overlaps between the APF and SGC.

### **Partnership structures at local/CHP level**

As discussed in section 4.4.2, the CHPs were established under the governance of health board in NHS Scotland in April 2005 to manage primary and community health services. It therefore required that partnership working should be propagated to the local/CHP level. A National guidance was set up in the Staff Governance Standard 2004. The document has explicitly indicated that partnership structures should be built in each CHP on the principle that staff and their representative organisations should be involved at an early stage in decisions affecting them. It was in this context that Local Partnership Forum (in some boards, it also named Staff Partnership Forum) was established with the aim to provide a mechanism for taking forward the requirements outlined in Staff Governance Standard and ensure the implementation of agreed strategy decisions as appropriate.

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<sup>3</sup> The Standard requires that all NHS Boards must demonstrate that staff are: well informed; appropriately trained; involved in decisions which affect them; treated fairly and consistently; and provided with an improved and safe working environment (Scottish Executive, 2007).

**Table 5-1. The current partnership structure in NHS Scotland**

<b>Main organisations</b>	<b>Role and responsibilities</b>	<b>Membership</b>
The Scottish Partnership Forum (SPF)	The SPF is the forum where provides Scottish Government, NHS Scotland employers and trade unions/professional organisations an opportunity to work together to improve health services for the people of Scotland.	The SPF comprises a maximum of 14 places to each of the constituent parties, with a minimum of seven places to be taken up. It normally meets four times a year.
The Scottish Workforce and Staff Governance Committee (SWAG)	The SWAG is the only standing sub-committee of the SPF. Its main function is to support the development of the workforce strategy and to support the Director for Workforce in the development and implementation of employment policy and practice for NHS Scotland.	The SWAG comprises a total of 38 participants taken from the three constituent parties. A maximum of 19 places go to the trade unions and professional organisations. It normally meets four times a year.
The Scottish Terms and Conditions Committee (STAC)	The STAC is a partnership organisation which exists to collectively negotiate terms and conditions issues for NHS Scotland staff other than those which pertain exclusively to recognised separate collective bargaining arrangements.	The STAC has a equal number of members from each of the constituent parties. Each party has 16 members. STAC will meet as and when required.
The Partnership Secretariat	The Partnership Secretariat manages and facilitates the business of the SPF, the SWAG and the STAC. It takes a high level strategic view of the overall agenda and ensures appropriate links are made and business effectively implemented.	It comprises eight Co-Chairs from the SPF, the SWAG and STAC and nine Joint Secretaries from these groups.
The Staff Governance Committee (SGC)	The SGC is a standing committee of each NHS Board which, together with the Clinical Governance Committee and Audit Committee, forms the full governance framework for NHS Boards. The role of this committee to support and maintain a culture within the health system where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the system and is built upon partnership and collaboration.	As a minimum, full membership of local SGC should include four non-executive directors of the NHS Board, of which one must be Employee Director; and two lay representatives, or more depending on the needs of the local area, from the trade unions and professional organisations, nominated by the APF.
Area Partnership Forum (APF)	The role of the APF is to provide a forum that allows the organisation to engage with the staff through their trade Unions and professional organisations on all operational and strategic matters that affect staff, in line with the requirement of the five Staff Governance Standards.	The APF consists of representatives of each of the trade unions and professional organisations as recognised by the NHS Staff Council, and all members of the Chief Executive Management Team.
Local Partnership Forum (LPF)	The CH(C)P Local Partnership Forum remit will be to ensure the fair and consistent application of the Staff Governance Standard for staff working with the CH(C)P.	The CH(C)P Local Partnership Forum will be jointly chaired by the CH(C)P Director and by an NHS Accredited Staff-side representative. Management representatives should be appointed by the CH(C)P Director and should be members of the Senior Management Team. Staff-side representatives must be accredited by an NHS Scotland recognised trade union/professional organisation that has members working within the CH(C)P.

Adapted from Scottish Executive (2005), "Partnership: Delivering the Future", Edinburgh.  
 Scottish Executive (2007), "Staff Governance Standard (3<sup>rd</sup> Edition)", Edinburgh.

### **5.2.2 Partnership Structures within the Three Health Boards**

The above section has introduced partnership structures at the national, regional/board and local/CHP levels in NHS Scotland. This section will examine the APFs in depth in the three NHS boards studied in this research. The findings presented below cover the frequency of partnership meeting and composition of APFs in each health board. The results suggest that, although APFs in the three boards were established in a same NHS Scotland context, the composition of the APFs and frequency of partnership meetings varied between the three boards.

#### **NHS Highland**

The frequency of well-attended partnership meetings is important because involvement in key decisions requires regular and well-attended partnership meetings. Infrequent and poorly attended meetings suggest that key decisions are made outside partnership meetings, implying a dysfunctional partnership agreement (Bacon and Samuel, 2012).

In the NHS Highland APF, 34 meetings were held in total from Feb 2005 to Sep 2009 (see Table 5-2). Prior to 2008, the APF held 5-6 meetings each year, but significant changes to the partnership structures occurred since 2008, with the APF and Pay Modernisation & Workforce Planning Board merging into one forum, named the Highland Partnership Forum<sup>4</sup> (HPF). Subsequently, the frequency of forum meetings increased to 10 times per year.

It is important to note that sub-groups continued to be a crucial method for developing policies in partnership, and ongoing partnership activities were operated outside the NHS Highland APF overall the time. For example, during the period 2005-

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<sup>4</sup> To avoid confusion of the appellation, the research will continue to use APF instead of HPF in the following chapters.

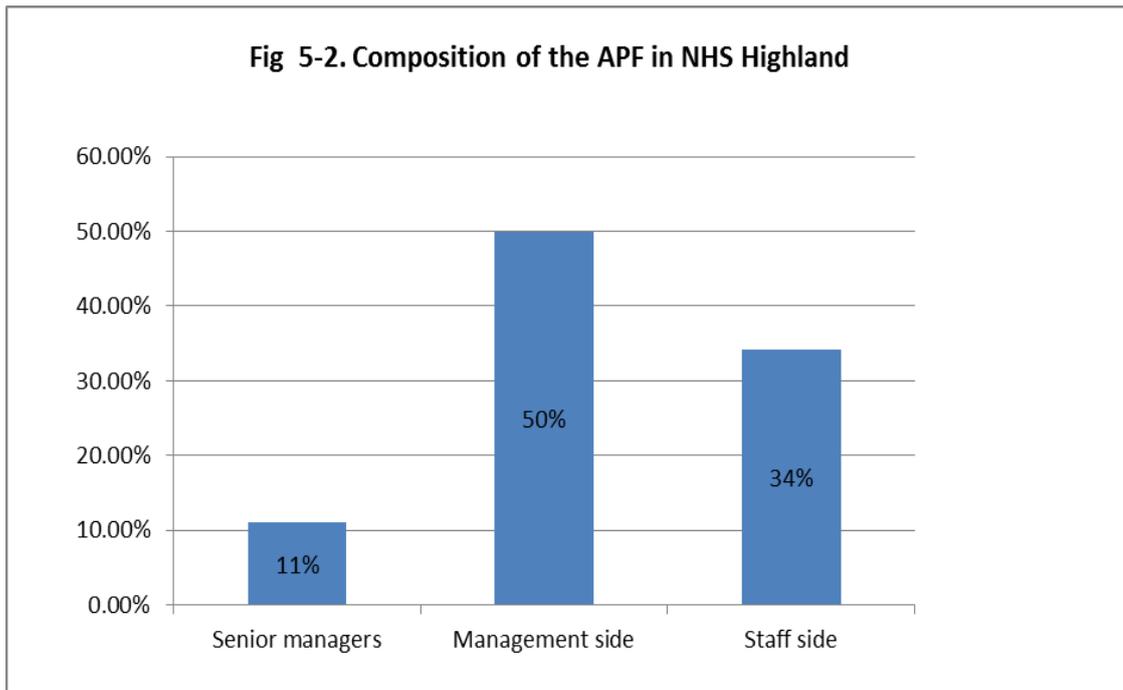
2007, the NHS Highland APF set up five sub-groups to develop work and report back on particular issues, including “HR Issues”, “Joint Future Partnership”, “Learning and Development”, “Health Working Lives” and “Workforce Planning”. After the APF was restructured in 2008, the numbers of sub-groups increased to nine, adding specific working groups on projects like “Dignity at Work”, “Organisation Change”, “Equality and Diversity” and “CHP Partnership Forum”.

**Table 5-2. Frequency of APF meetings in NHS Highland from Feb 2005 to Sep 2009**

	2005	2006	2007	2008	2009
Frequency of APF meetings	6	5	6	10	8

The forum is co-chaired by the Chief Executive and Employee Director on a rotation basis. During the period studied, 127 participants attended the Forum in total, including visits from the Chief Executive of NHS Scotland and the Chairman of the Board of NHS Highland. In total, the NHS Highland APF was attended by 64 management representatives, 34 trade union representatives from 9 different unions (see Table 4-5), 16 HR managers and 9 guests.

On average, there were 22 attendees in the APF in every meeting. As reflecting in the Fig 5-2 and Table 5-3, the management-side occupied half of the total seats (50%) in the Forum. It is noted that other management representatives (32%) has more seats than the HR managers (18%). The staff-side has more than one-thirds (34%) of total seats in the Forum. In addition, among the 9 different trade unions involved in the Forum, Unison, Royal College of Miwives (RCM), Royal College of Nursing (RCN) and British Orthoptic Society (BoS) have attended the forum more often than other unions.



**Table 5-3. Seats by groups in NHS Highland APF from Feb 2005 to Sep 2009**

<b>Groups</b>	<b>Per cent of seats</b>
Senior managers	11%
Management Representatives	32%
HR Managers	18%
Staff-side	34%

The proportion of senior managers in the forum was 11%. In addition, senior managers involved in the forum included the Chief Executive, HR Director, Finance Director and the Nursing Director, with the Chief Executive attending 23 meetings (67% of the total meetings), the HR Director attending 32 meetings (94% of the total meetings), the Finance Director attending 18 meetings (52% of the total meetings), and the Nursing Director attending 4 meetings (11% of the total meetings). The Employee Director has attended 32 meetings, accounting for 94% of the total meetings. Other senior managers from the board only attended in the forum once or twice during this period, and most of the time they were presenting to the forum with the purpose of giving a report rather than discussing some particular issues. For

example, the medical director attended the forum on 17<sup>th</sup> November 2006 and 19<sup>th</sup> January 2007 giving the forum a presentation related to the new clinical framework with the aim of seeking the forum’s cooperation in the development of knowledge, skills and behaviours of staff, but has not since attended the forum.

### **NHS GG&C**

The NHS GG&C APF met 50 times between December 2002 and November 2009. From 2003 to 2006, the forum held 5-6 meetings per year. It was restructured in 2006 and the frequency of meeting has increased to 9-10 times a year since 2007 (Table 5-4). The Forum is co-chaired by the Chief Executive and Employee Director on a rotation basis.

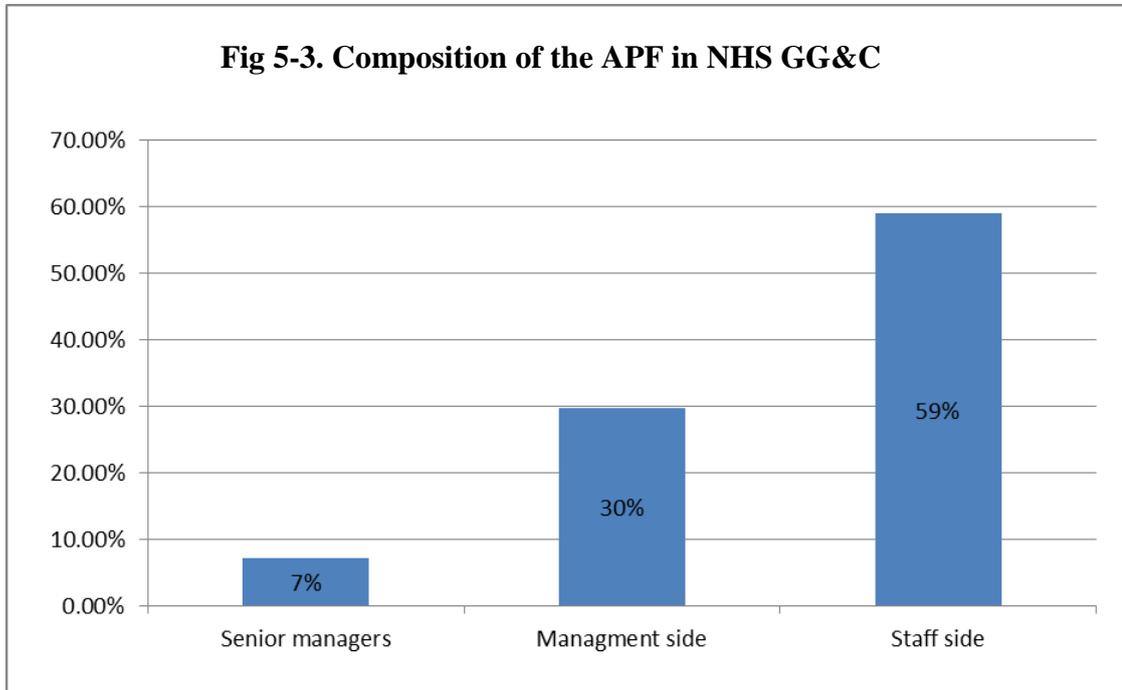
**Table 5-4. Frequency of APF meetings in NHS GG&C from Jan 2003 to Nov 2009**

	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
<b>Frequency of APF meetings</b>	6	5	5	6	10	9	9

During the period studied, 183 individuals attended the meetings, including the Chief Executive, Employee Director, 49 management representatives, 42 HR managers, 81 trade union representatives from 13 different unions (Table 4-5), 7 CHP/CHCP Directors, and 3 guests.

On average, there were 25 attendees in the meeting each time. As indicated in Fig 5-3 and Table 5-5, staff-side has occupied a large proportion of seats in the forum, accounting for nearly three-fifths (59%). Among the 13 different unions, representatives from Unison, RCN and Unite-Amicus attended the forum more often than other unions. Management-side has relatively less seats than the staff-side,

accounting for less than one-thirds (30%) of the total seats. It is also noted that, among the management-side, HR managers (20%) has occupied more seats than other management representatives (10%).



**Table 5-5. Seats by groups in NHS GG&C APF from Dec 2002 to Nov 2009**

<b>Groups</b>	<b>per cent of seats</b>
Senior managers	7%
Management Representatives	10%
HR Managers	20%
Staff-Side	59%

The proportion of seats by senior managers in the forum was 7%, lower than its counterparts in NHS Highland. In NHS GG&C, senior managers involved in the forum mainly including the Chief Executive, Finance Director and Nursing Director, with the Chief Executive attending 34 meetings (nearly 70% of total meetings), the Finance Director attending 10 meetings (nearly 18% of total meetings), and Nursing Director attending 6 meetings (nearly 11% of total meetings). The Employee Director has attended 50 meetings, accounting for nearly 94% of total meetings. Other senior

managers were invited to the Forum casually to discuss some particular issue, for instance, CHP Directors were invited to a special meeting held in 23<sup>rd</sup> Dec 2008 related to the recognised need for better strategic engagement between the CHPs and NHS GG&C as the employer.

### **NHS Borders**

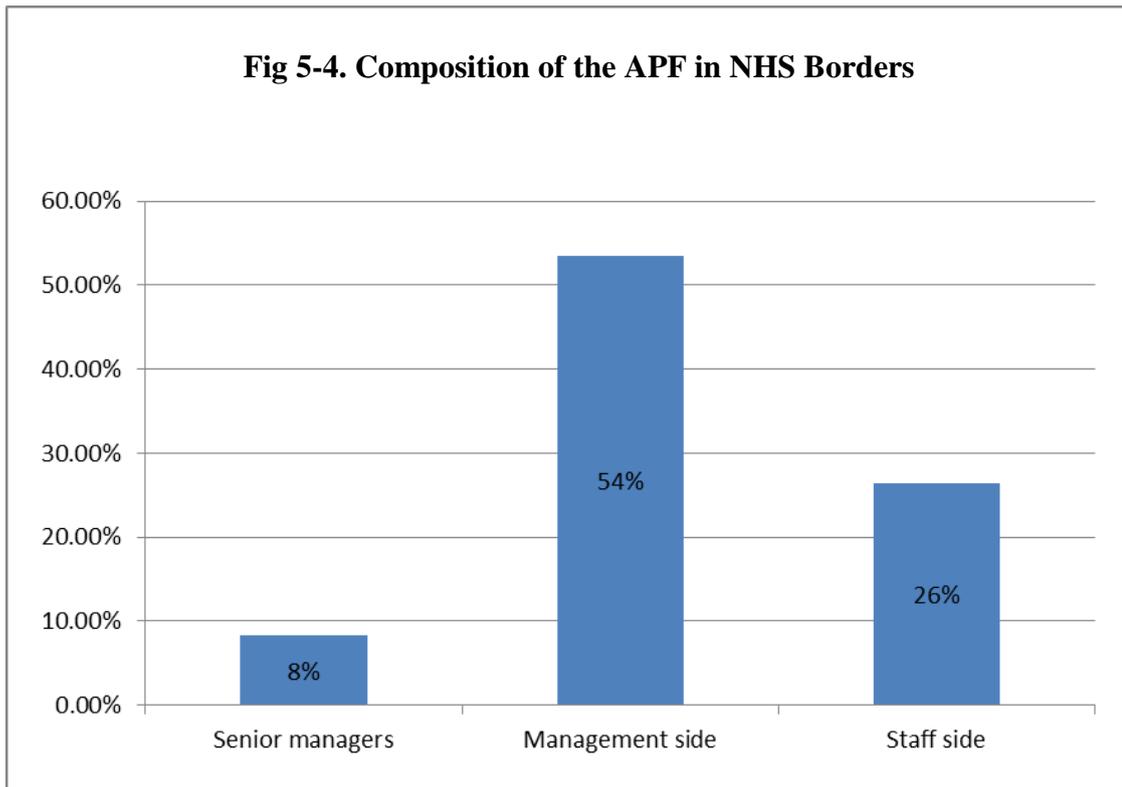
The NHS Borders APF has held 26 meetings in total between the period from January 2004 to August 2009, approximately 4 or 5 times a year. It is noted that the Forum met approximately 4 times a year from 2004 to 2007. After restructuring in 2007, the frequency of APF meetings has increased to 7 times since 2008 (see Table 5-6).

**Table 5-6. Frequency of APF meetings in NHS Borders from Jan 2004 to Aug 2009**

	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
<b>Frequency of APF meetings</b>	4	3	4	5	7	3

During the period recorded, 108 individuals attended the forum, including the Chairman of the Board, the Chief Executive, the Employee Director, 81 management representatives, 22 trade union representatives from 10 different trade unions (see Table 4-5) and 3 clinical professionals.

On average, there were 17 attendees involved in the Forum in each meeting. As Fig 5-4 and Table 5-7 indicate, seats by management-side accounted for more than half (54%) of total seats in the Forum. In addition, among the management-side, HR managers have accounted for less seats (16%) than other management representatives (38%). The staff-side has less than one-third (26%) of the overall seats in the Forum. Trade union representatives from RCN, RCM and Unison have attended the Forum more often than other unions.



**Table 5-7. Seats by groups in NHS Borders APF from Jan 2004 to Aug 2009**

<b>Groups</b>	<b>per cent of seats</b>
Senior managers	8%
Management Representatives	38%
HR Managers	16%
Staff-side	26%

The proportion of senior managers in the forum was 8%. Senior managers involved in the APF mainly included the Chairman of the Board, the Chief Executive and the Finance Director, with the Chairman attending 7 meetings of the forum (nearly 27% of total meetings), the Chief Executive attending 16 meetings (nearly 62% of total meetings) and the Finance Director attending 6 meetings (nearly 23% of total meetings). The Employee Director has attended 25 meetings, accounting for nearly 96% of total meetings. As same as NHS GG&C, the HR Director was not an executive member of the Board, while the Employee Director was. The HR Director has only

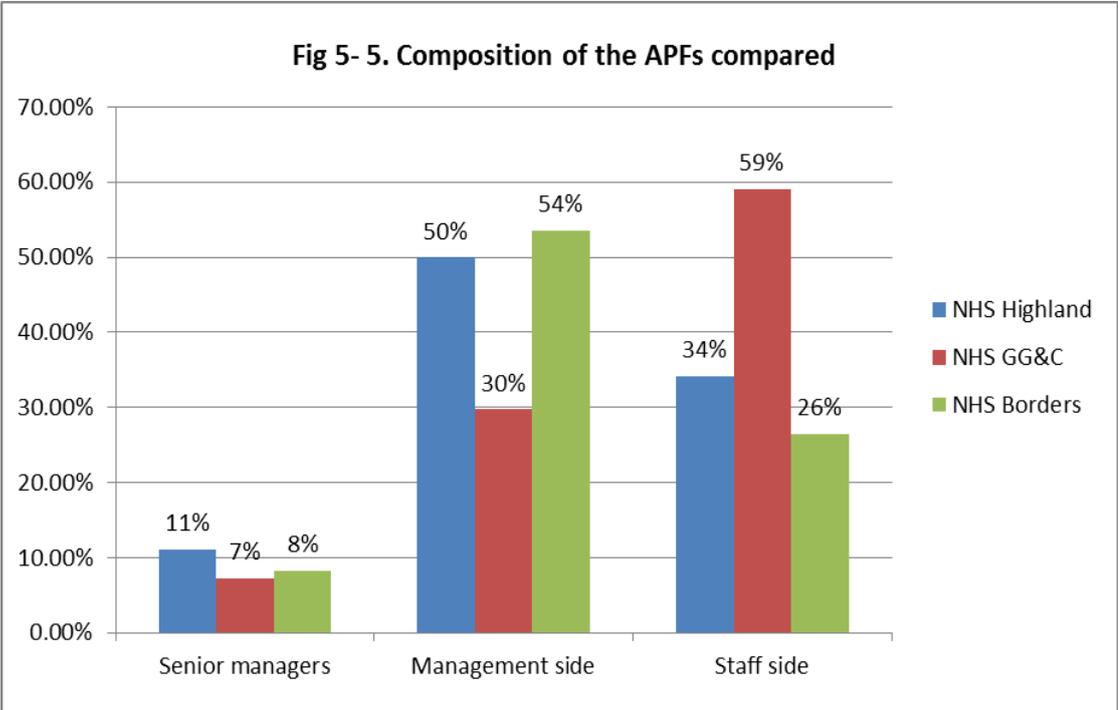
attended the APF 8 times, and other senior managers like the Nursing Director and Medical Director have attended the Forum infrequently.

### **5.2.3 Three Cases Compared**

By comparison, there are many similarities and differences in terms of partnership structures in the three APFs. The first similarity concerned the establishment of APFs. Following the instruction of SPF at the national level, APFs were established and well organized at all of the three boards using a same template. The second similarity was the commitment from senior managers. In all of the three boards observed, the chief executive or the chair of the board attended the APFs regularly, and co-chaired the forum with Employee Directors. However, other senior managers, for example the medical director and nursing director, joined the forum infrequently. Thirdly, all Employee Directors are member of the board. It therefore means a stable access to meet the senior managers and may also imply greater union influence on management decision-making. Fourthly, multi-unions were recognised in all of the three boards. However, the big unions, for example the Unison, RCN and Unite, have joined the forum more often than other unions.

In the meantime, there were several important differences as well. The most significant difference concerned the composition of the APFs. Above findings in section 5.2.2 reveal that composition of APFs varied between the three boards (see Fig 5-5). NHS Highland has a medium size of APF among the three health boards (average 22 attendees every meeting) with one-third (34%) of the total seats reserved for staff-side. Frequency of meetings was the highest among the three APFs. Senior managers frequently involved in the Forum, accounting for 11% of total seats. The Chief Executive was consistently involved in the Forum, attending 67% of total meetings. NHS GG&C has the largest size of APF (average 25 attendees every

meeting) with staff-side dominates nearly three-fifths (59%) of total seats in the Forum. Frequency of meetings was relatively high. It appeared that there was a lack of involvement from senior managers, only accounting for 7% of total seats. However, it is important to note that the Chief Executive was consistently involved in the Forum, attending for nearly 70% of total meetings. Comparing to the other two boards, NHS Borders has the smallest size of APF (average 17 attendees every meetings) with also a smallest proportion of staff-side in the Forum (accounting for 26% of total seats). In addition, frequency of meetings was the lowest between the three boards. Although senior managers have 8% of the seats, it appeared that the consistency of involvement from senior managers was an issue for the Forum. The Chief Executive has attended 62% of total meetings which was also the lowest between the three cases, and there were 8 times that the Chairman of the board joined the meeting instead of the Chief Executive.



Prior research has suggested that strong union presence, senior managers’ commitment and active involvement in regular and high frequency consultation

meetings were more likely to generate robust partnership outcomes, while limited union involvement in consultation meetings, absence of senior managers or management control over the consultative committee would lead to shallow partnership arrangements (Oxenbridge and Brown, 2004; Samuel, 2007). The data presented so far indicates that partnership arrangements in NHS Highland and NHS GG&C are likely to be more robust than NHS Borders. In addition, it seems like that the NHS GG&C APF is attached more attribute of labour-parity, which may imply greater union influence and larger possibility of achieving mutual gains (Kelly, 2004). The research will explore this further in the following sections.

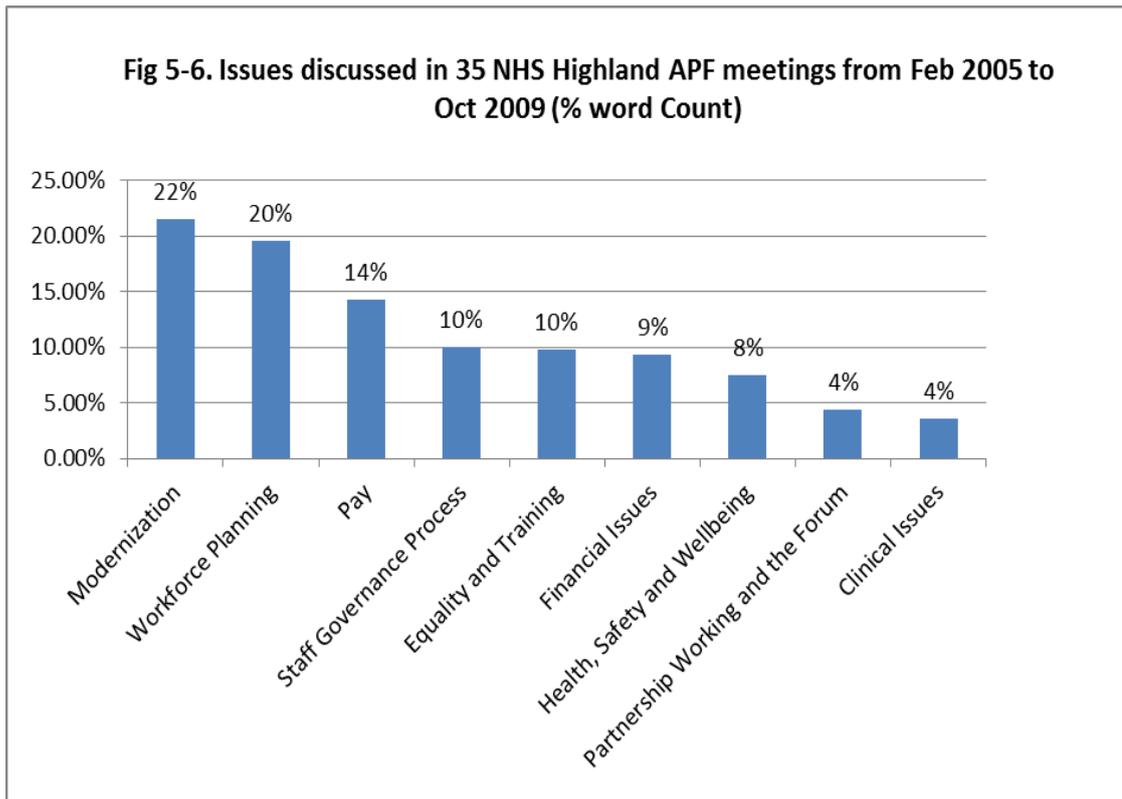
### **5.3 Partnership agenda**

Previous research has suggested that partnership agenda reflecting the mutual interests of both management and trade unions was an important element for enduring partnership arrangements (Haynes and Allen, 2001). Furthermore, a broader range of agenda items, combining with well-embedded structures at both operational and strategic levels is likely to produce more positive outcomes (O'Dowd and Roche, 2009). While the prior section has already examined partnership structures in the three health boards, this section will analyse partnership agendas.

#### **5.3.1 NHS Highland**

The partnership agendas in the APF of NHS Highland covered 180 different items over the period from February 2005 to October 2009 dealing with 9 broad issues (see Fig 5-6 and Table 5-8). Although some commentators have expressed concern that managers may constrain union involvement in strategic issues and narrow down the scope of partnership consultation to workplace issues only (Kelly, 1999; 2004; Terry, 2003), this is not the case in NHS Highland where partnership consultation has

involved trade unions in the strategic issues affecting the future of NHS Highland and the way to deliver health services. Data in Table 5-8 suggests that, the issues of Modernization (22%) and Workforce Planning and Development (20%) were the primary concerns in the Forum, accounting for more than two-fifths (41%) of total discussions, with each of these issues raised in almost every meeting.



The evidence echoes the view that partnership extends the range of issues in which unions are involved beyond those covered in traditional industrial relations, given the broad range of strategic issues discussed. In total, there were 72 items concerning Modernisation and Workforce Planning and Development, accounting for two-fifths (40%) of the total items discussed in the Forum (Table 5-9). In addition, the issue of Pay was raised in almost every meeting of the Forum, accounting for 14% of the total discussions. A large part of discussions in this area concerned the implementation of a national policy - Agenda for Change. Financial Issues, Equality and Training, Staff

Governance Process, Health, Safety and Wellbeing were regularly discussed in the forum, with each of these issues accounting for approximately 10% of the total discussions. However, Partnership and the Forum and Clinical Issues are less often discussed in the Forum, with each of these issues accounting for approximately 4% of the overall discussion.

**Table 5-8. Issues discussed in 35 NHS Highland APF meetings from Feb 2005 to Sep 2009**

	<b>Number of meetings issue raised (35 meetings in total)</b>	<b>Number of items discussed in the meetings (180 items in total)</b>	<b>Issue as a % of all discussion (word count)</b>
<b>Modernization</b>	34	40	22%
<b>Pay</b>	34	19	14%
<b>Partnership Working and the Forum</b>	20	19	4%
<b>Financial Issues</b>	26	12	9%
<b>Equality and Training</b>	28	12	10%
<b>Health, Safety and Wellbeing</b>	26	24	8%
<b>Staff Governance Process</b>	30	13	10%
<b>Workforce Planning and Development</b>	34	32	20%
<b>Clinical Issues</b>	15	9	4%

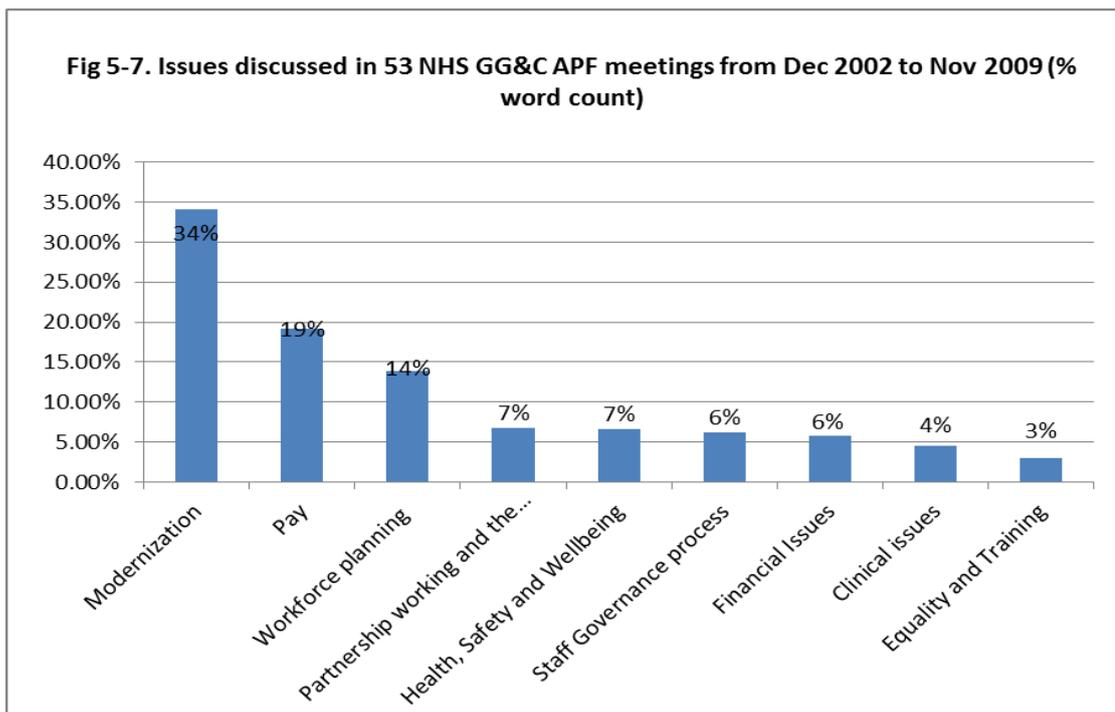
**Table 5-9. List of items discussed in 35 NHS Highland APF meetings from Feb 2005 to Sep 2009**

Category	Detail issues
<b>Modernization</b>	Argyll and Clyde consultation; Better Health, Better Care; Boost; Changing for the better; Communications strategy; Corporate Objectives; Counter fraud initiative; Delivering for health; Digital Dictation; Ehealth strategy; Feedback from NHS Board Strategy Day; HPF sub groups - Organisational change sub group; Implementation of community pharmacy contract; Internal communications; Kerr Report; Local delivery plan; Local development plan; Moving to the future; National review of CHPs; National Shared Services; NHS 60th Anniversary; NHS highland introduction; Performance - Policy harmonisation; PIN investigation timescales; Proposed filming with channel 5 programme; Public health change programme; Remote and rural work stream; Representative to spiritual care committee; Review of corporate services; Review of the AHP Service model; Revised policy for the management of policies, procedures, guidelines and protocols; Risk management policy; Service improvement programmes; Service redesign and transformation; Service transformation within NHS Highland; Efficient government; Single outcome agreements - workforce stream; Spiritual Care strategy; Study of CHPs; SWISS; Work for efficiency and effectiveness.
<b>Pay</b>	A4C - Assimilation, Arrears and Reviews; Car parking issues; Changes to pension Scheme; Chief Exe of NHS Scotland in the Forum; Childcare voucher provision for staff; Farepak - possible assistance; Fixed term contracts; Holidays; Lease Car policy; Long Service Awards; Pay and conditions of service for executive, senior manager and transitional grades; Benefits realisation plan; Valuing Service awards; Consultant Contract; Staff uniform allowance; Study leave policy; Subsistence rates; Visit by pay review board; Waiting Times Initiative Payments – Grievance.
<b>Equality and Training</b>	KSF gateway review policy; At-learning system; Dignity at work policy; Equality and diversity; Leadership and management development framework; Learning and Development Strategy; Lifelong learning partnership agreement and charter; Mandatory statistical information - Numbers of staff with PDP; Parental Leave and Carer Leave; KSF and PDP implementation; SAAT- Appropriately trained; SAAT- Treated fairly and consistently.
<b>Financial Issues</b>	Cash Releasing Savings; Efficiency savings; Endowment funds; Energy conversation; Financial planning; Financial savings plan; Financial report; Harmonisation of Catering price levels; Non-patient catering prices ; Property review; SG - development priorities for investment 2005-06; Work of the endowments committee.
<b>Partnership Working and the Forum</b>	APF sub groups - Joint future partnership forum; Board partnership forum; Communication and engagement plan; Facilities time; Feedback from NHS Highland partnership forum sub groups; HPF sub groups - CHP Raigmore partnership forum; HPF sub groups - CHP SSU partnership forum; Inquorate; Managers in Partnership; NHS highland partnership forum terms of reference - role, remit and membership; Partnership working at Raigmore hospital; Review of Board partnership forum and PM and Workforce planning board; Review of mediation services - feedback from SWAG on partnership involvement; SAAT- Involved in decision which affect them; APF development; partnership agreement; Partnership delivering the future; Partnership working; staff-side chair election.

<b>Workforce Planning and Development</b>	Adverse Weather conditions policy and procedure; APF/HPF sub groups - HR sub group; APF/HPF sub Groups - Workforce planning Group; Career framework; Development of workforce strategy; Employee assistance programme; Employee conduct; Healthcare support workers; Hospital at night steering group; Mandatory statistical information; National workforce framework; New Craigs Shift Pattern; Nurse bank monitoring report; Nursing and midwifery bank operational policy; Nursing and Midwifery workload planning project; Nursing in the community; European working times regulations action plan; Promoting attendance and managing absence; Safer pre and post-employment checks; Residential Accommodation; Review of charge nurses; Employee assistance programme resource utilisation; HEAT Target; Management of employee capability; Workforce report; Staff turnover; Volunteering policy; Workforce Establishment monitoring; Workforce headlines and workforce projections; Workforce monitoring and Vacancy management; Workforce planning - progress report; Workforce planning - workforce planning priorities.
<b>Clinical Issues</b>	Bed utilisation; Health improvement - pandemic flu report; Internet monitoring policy; National uniform policy; Office Accommodation; On call management arrangements; Patient focused booking; Scottish patient safety programme; Swine flu.
<b>Health, Safety and Wellbeing</b>	APF sub groups - SHAWHWL sub group; Cycle to work scheme; Fire alarm systems; Gender based violence employee policy; Health and Safety committee sub groups - Prevention of Violence and Aggression sub group; Health and Safety committee sub groups - Stress Management Steering group; Health Awards; Health conversations; Health improvement - Healthy working lives SHAW; HPF sub groups - Healthy working lives sub group; Moving and Handling policy; Biological and Chemical Hazards policy; Gloves selection; Incident Management; Policy on mobile phone use; Protecting against violence and aggression at work policy; Removal of fizzy drinks machines in healthcare establishments; Provided with an improved and safe working environment; Safer pre and post employment checks; Staff screening policy; Substance misuse policy; Tobacco policy; Working well challenge fund; Zero Tolerance policy to non hand hygiene compliance.
<b>Staff Governance Process</b>	SAAT; Annual review; Executive Report; Facilities Budget; Feedback from Board; Feedback from SG self assessment external validation; ICAS; Integrated Action Plan; Leaflet; Negotiating structure and procedures; Planning and prioritisation process; Staff governance standard; Staff survey.

### 5.3.2 NHS GG&C

The scope of the partnership agenda in the NHS GG&C APF covered 144 different items from Dec 2002 to Nov 2009 comprising 9 broad issues. As Fig 5-7 reveals, the APF in NHS GG&C has a stronger strategic focus than its counterparts in NHS Highland. Strategic issues concerning Modernisation and Workforce Planning and Development accounted for nearly one-half (48%) of the total discussions in the Forum. Furthermore, a broad range of issues were raised concerning these two strategic subjects. As Table 5-10 shows, 69 different items were raised under the category of Modernisation and Workforce Planning, accounting for nearly one-half (48%) of the total items discussed in the Forum. In detail, the issue of Modernisation was the primary concerns in the forum, accounting for 34% of the total discussions. Again, the data revealed Table 5-10 supports the point that a genuine partnership could extend the range of issues in which unions are involved and it is unlikely that partnership arrangements are used by managers to constrain union involvement in strategic issues in this case.



It is very important to note that the Forum has also given great attention to the issue of Pay which accounted for 19% of the total discussions and was raised almost every meetings. It is also noted that more than three-fifths (67%) of the total discussions in the forum were dealing with the top three issues concerning Modernisation, Pay and Workforce Planning. Discussions on all of the other 6 broad issues were relatively shallow, with the issue of Equality and Training the least often discussed issue in the Forum, accounting for only 3% of the overall discussions.

**Table 5-10. Issues discussed in 53 NHS GG&C APF meetings from Dec 2002 to Nov 2009**

	<b>Number of meetings issue raised (53 meetings in total)</b>	<b>Number of items discussed in the meetings (144 items in total)</b>	<b>Issue as a % of all discussion (word count)</b>
Modernization	44	43	34%
Pay	38	23	19%
Partnership Working and the Forum	25	15	7%
Financial Issues	19	5	6%
Equality and Training	19	6	3%
Health, Safety and Wellbeing	22	11	7%
Staff Governance Process	27	7	6%
Workforce Planning and Development	37	26	14%
Clinical Issues	15	8	4%

**Table 5-11. List of items discussed in 53 NHS GG&C APF meetings from Dec 2002 to Nov 2009**

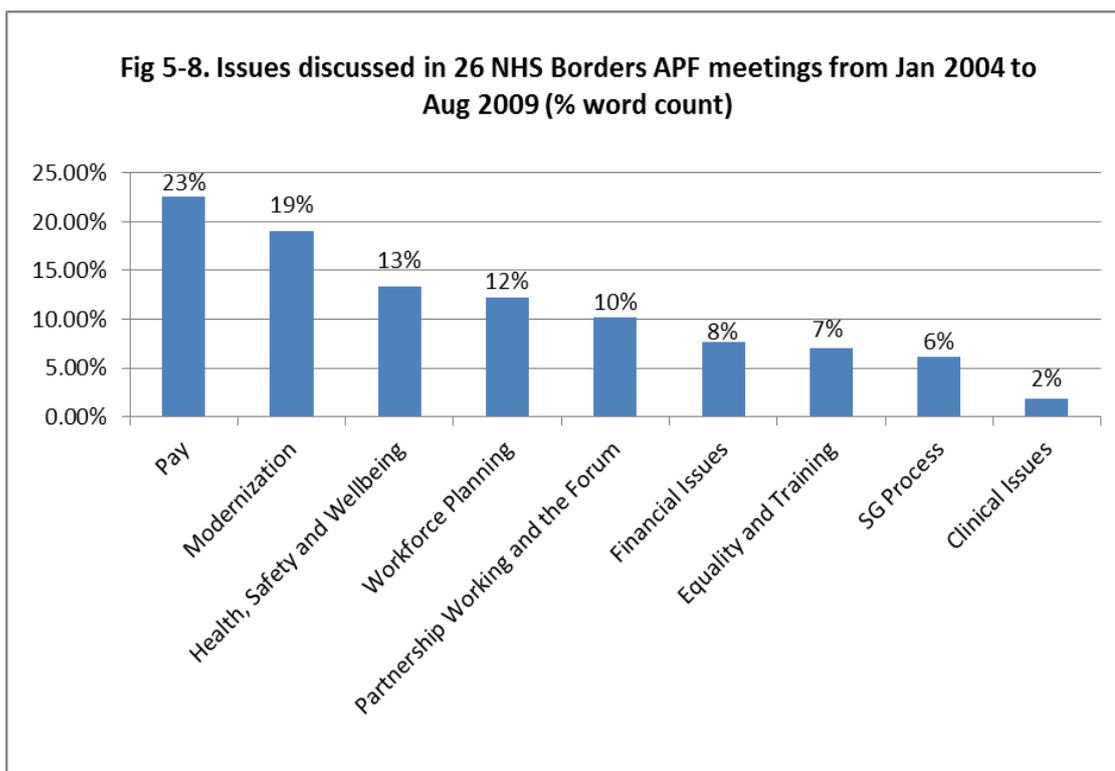
Category	Detail issues
<b>Modernization</b>	Acceleration of Acute Services plan; Accountability Review; Acute Service Review; Argyll and Clyde integration; Best Procurement Initiative; Better Health Better Care; Board Paper on Transport; CamGlen and Northern Corridor Transfer Implementation; Chief Executive report; CHP issues; Clinical Governance Strategy; Clinical Services Strategy review; Clyde - Independent Scrutiny; Continence Service; Corporate Objectives; Delivering for Health; Directions for Primary Care; Fraud Policy; GGNHSB Reorganisation; Glasgow Acute Services Strategy; Glasgow Clinical Strategy; Joint Working with Glasgow City Council; Kerr Report; Harmonised Policies and Procedures; Local Health Plan; Mapping Exercise; National Shared Support Services; New Glaswegians Project; New Sick Children's Hospital; New South Glasgow Hospitals; NHSGG City Council Pathfinder; Organisational Arrangements; Organisational Change Policy; Organisational Development; PIN Guidelines; Policy Development - Public Interest Disclosure Policy; Primary Care Framework; Recovery Plan; Rehabilitation Framework; Secretariat Report; Service Redesign; Single System Service; SWISS; Trust Action Plans.
<b>Pay</b>	A4C; Annual Leave and Sickness Absence; Argyll and Clyde Pay Date; Car parking; Childcare Tax Vouchers; Christmas and New Year Pays; Development of a strategic response to Poverty; Generic Job Description; Guidance on Starting Salaries; Low Pay Agreement and Pay Concordat; On Call Allowance Rates; On Call Payments During Sick Leave; Project Board establishment; Benefits Delivery Plan; Pensions Briefing Event; Pensions choice; Fixed Term Contracts; Public Holidays; Public Transport Assistance; Review of Mileage Payments; Senior Manager Pay; Staff Benefits; Unsocial Hours During Sick Leave.
<b>Equality and Training</b>	KSF; Commission for Racial Equality - workforce monitoring; Leadership Development; Parental Leave; Learning and Education; Sub-Group reports - Fair and Consistent Treatment.
<b>Financial Issues</b>	Clyde Recovery Plan; Catering Review; Financial Allocation; Financial plan; Financial Report.
<b>Partnership Working and the Forum</b>	APF development; Away Day; Communications; DTI Funding; NHS Conference; Partnership Arrangements and Agreement; Partnership conference; Partnership for care - Health White Paper; Partnership Working in NHSGG; Reduction in absenteeism; Joint Future; Partnership Conference; Staff-side Chair election; Staff-side Letter to Chief Exe and Response; Sub-Group reports.
<b>Workforce Planning and Development</b>	AHP Consultant Posts and Steering Group; Allied Health Professions Workload Measurement and Management; Clinical Supervision Model for Health Service Staff; Clinical Workforce Redesign Project; Disciplinary Policy and Procedure; Employers' Coalition; Grievance Policy and Procedure; HR Forum; HR plan; HR policy development programme; Managing Sickness Absence; Modernising Medical Careers; NHSGG Draft policies; Nursing Workforce Tool; Policy Development - Code of Conduct; Policy Development - Discipline and Grievance; Policy Development - Attendance Management; Regulation of health Care Support Workers; Senior Charge Nurse Review; Sub-Group reports - Workforce Planning Project Team; Support Workers Project; Workforce Challenges; Workforce planning and Development; Workforce Redesign Project; Work-life Balance.
<b>Clinical Issues</b>	Children's Services Seminar; Bed Modelling for ASR; Clyde Clinical Consultation; HAI Watt Group Report; Implementing the Recommendations of the organ donation taskforce; Laboratory medicine strategy review; Pandemic Flu; Patient Safety.
<b>Health, Safety and Wellbeing</b>	Health and Safety Forum; Challenge Fund; Decontamination; Health visitors; Miniature Glasgow and The health in Glasgow; Occupational Health; Our Staff Health; Health and Safety Policy Update; Smoking policy; Sub-Group reports - Occupational Health Sub-Group; Working Well Challenge Fund.
<b>Staff Governance Process</b>	Action plan; Annual Review; Consultation; Improvement Plan; SAAT; Staff Governance Standard; Staff Survey.

### **5.3.3 NHS Borders**

As Table 5-12 reveals, the range of the partnership agendas in the APF of NHS Borders covered 158 different items comprising the 9 main categories. Unlike its counterparts in NHS Highland and NHS GG&C, the issue of Pay was the most popular topic in the Forum, accounting for 23% of the total discussions. In addition, there is also a broad range of pay issues (22 items) discussed in the Forum (see Fig 5-8).

The APF of NHS Borders appeared to be less strategic focused than the APFs of NHS Highland and NHS GG&C, with strategic issues concerning Modernisation (19%) and Workforce Planning and Development (12%) accounting for 31% of the total discussions. Although 68 different items have been raised under these two categories, accounting for more than two-fifths (43%) of the total items raised in the Forum, most of the time, the discussions concerned managers seeking the Forum's endorsement for already-made policies or giving information on particular issues rather than putting forward a proposal at an early stage of development for discussion.

It is noted that Health, Safety and Wellbeing was frequently discussed in the Forum, accounting for 13% of the total discussions. It is also noted that the range of issues concerning Health, Safety and Wellbeing was relatively broader in the forum. Other issues like Partnership Working and the Forum (10%), Financial Issues (8%), Equality and Training (7%) and Staff Governance Process (6%) were regularly discussed in the Forum. Clinical Issues are less often discussed, accounting for only 2% of the overall discussions.



**Table 5-12. Issues discussed in 26 NHS Borders APF meetings from Jan 2004 to Aug 2009**

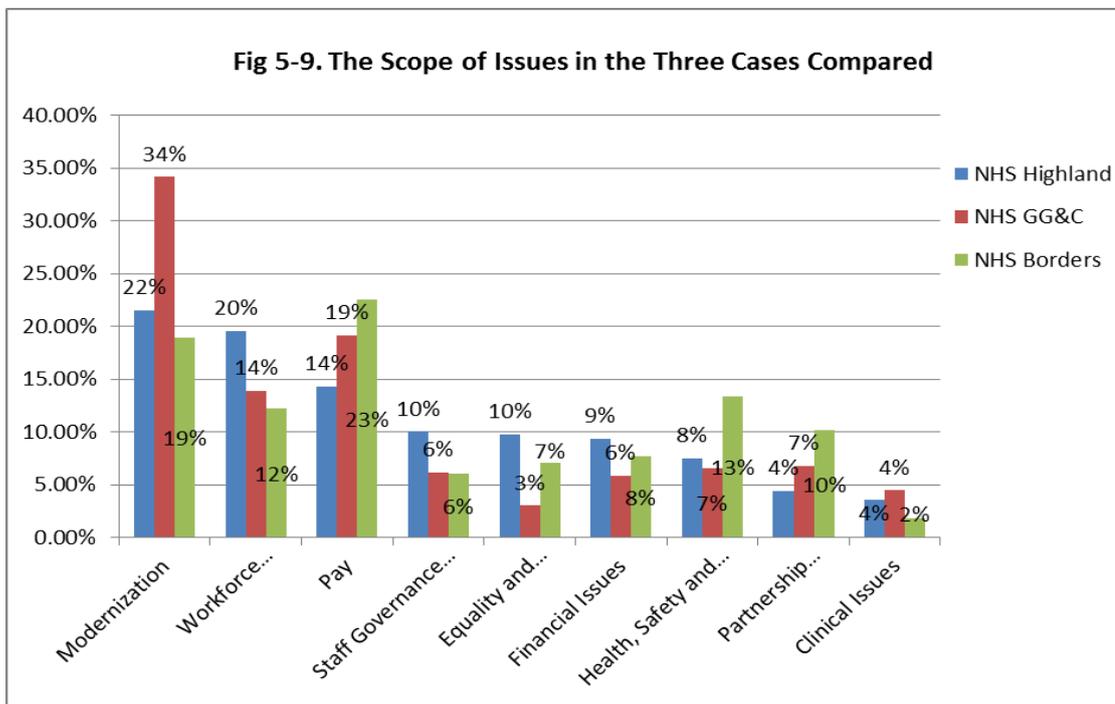
	<b>Number of meetings issue raised (26 meetings in total)</b>	<b>Number of items discussed in the meetings (158 items in total)</b>	<b>Issue as a % of all discussion (word count)</b>
Modernization	23	31	19%
Pay	20	22	23%
Partnership Working and the Forum	18	9	10%
Financial Issues	14	7	8%
Equality and Training	17	11	7%
Health, Safety and Wellbeing	23	23	13%
Staff Governance Process	12	5	6%
Workforce Planning and Development	22	37	12%
Clinical Issues	11	13	2%

**Table 5-13. List of items discussed in 26 NHS Borders APF meetings from Jan 2004 to Aug 2009**

Category	Detail issues
<b>Modernization</b>	Accountability Review; Board Performance report; Change Matrix;; CHI Numbers; CHP Issues; Community Planning; Corporate Objective; Data Protection Policy; E-health; Fast Tracking for Staff; Inpatient Redesign; Kerr Report; Key Performance Indicators; LEAN; Local Health and Delivery Plan; Managed Care Teams; National Fraud Initiative; National Shared Services; NHS Borders Board Leadership Development Plan; Organizational development; OHS - Strategy and Service action plan; Organisational Structure; PIN Guidelines; Policies ‘click button option’; Policy Development; Risk Management Policy; Staff Questionnaire – CHI Programme; Strategic Change - Discretionary Spend; Strategic Change - Your Health Our Future; Strategic Change Programme; Strategic Development Programme.
<b>Pay</b>	15-Year Awards; A4C; Terms and Conditions; Annual Leave Policy; Childcare Vouchers; Fixed Term Contract; Leased Car Policy; Long Service Awards; MSG; Mobile phones; On Call Arrangements; Pay Awards; Pay Benefits Delivery Plan; Pay Modernisation; Consultant Contracts; Public Holidays; Service Awards and Retirement Gifts; STAC; Staff Travel; Transitional Points ---Terms and Conditions; Unsocial Hours; Working Time Directive.
<b>Equality and Training</b>	Appraisal Policy; Dignity at Work; Equal Opportunities Group; Equality & Diversity - partnership role; Equality and Diversity Duty; KSF; OHS - Education Programme; OHS - First Aid Training; OHS - Moving and Handling Training; OHS – Risk Management for Managers Training; OHS – Training.
<b>Financial Issues</b>	Arbuthnott Formula; Big Lottery Fund – Investing in the Communities; Financial Report; Fund Raising; Icelandic Banks; NRAC; Operational Savings.
<b>Partnership Working and the Forum</b>	APF development; Attendance of Meetings; Election of Chair of BGH Local Partnership Forum; Fourth Partnership Forum for Support Services; Inquorate; Joint Executive; Joint Staff Forum; OHS - Joint working; Partnership Away Day; Partnership Working.
<b>Workforce Planning and Development</b>	Adverse Weather Policy; Conduct & Capability Policies; Control of Contractors Policy; Grievance Policy; HR Forum; HR Guidance; HR Policy Consultation Proposal; HR policy development and training; HR Structure; Induction Policy; Job Evaluation Policy; Local Workforce Plan; Managing Sickness Absence; Maternity Policy; NHS Borders Welcome Book; Nursing in the Community; Nursing Tools; OHS - An occupational self-assessment tool; OHS - Lone Working; OHS - OHS Stewards; OHS - Staff Counselling; OHS - Staff Governance; PDP; Pension Review; Volunteers for Job Matchers; Project Manager; Pre-employment Checks; Screening for HAI in HCW Policy; Staff Counselling Process; Taking HR Forward; Voicing Concerns Policy; Workforce development; Workforce Directorate; Workforce plan; Workforce Planning - Nursing and Midwifery; Workforce report; Working from Home.
<b>Clinical Issues</b>	BECC; Child Protection; Children’s Services Consultation; Hospital at Night; IT Situation; I.T. Security Policies for Approval; Needle stick Policy; Pandemic Flu; Patient Safety; Substance and Alcohol Misuse Policy; Staff Uniforms; USB Memory Sticks; Vulnerable Adult Protocol.
<b>Health, Safety and Wellbeing</b>	Cleanliness Champion & Hygiene Programme Report; Consultation on Draft NHS ill Health Retirement Provision; Control of Substances Hazardous to Health policy; Health & Wellbeing; Health Plan; OHS - Blood borne virus policy; OHS - Computer policy; OHS - Flu Vaccine; OHS - Gloves Use & Selection and Staff Immunisation Policy; OHS - Healthy Working Lives; OHS – HSE; OHS - Incident Reports; OHS - Legal Actions; OHS - Occupational Health and Safety Policy; OHS – Others; OHS - Review Working Group; OHS - Tobacco Review Group; OHS - Working Environment; Personal Safety Policy; Prevention and Management of Stress at Work; Tobacco Policy.
<b>Staff Governance Process</b>	Annual Review; Action plan; Consultation; Information system; Staff Survey.

### 5.3.4 Three Cases Compared

By comparison, there are many similarities and differences in terms of the scope of partnership agendas in the three APFs. The issues of Modernization, Workforce Planning and Development, and Pay were the primary concerns in all of these boards reflecting the impact of the general context that NHS Scotland went through a profound modernisation agenda. Furthermore, it also shows that trade unions were indeed involved in the management modernisation agenda through the APFs, albeit the extent to which trade unions influenced management decision-making still needs to be explored. However, there were also some variations between the three cases. For example, the NHS Highland APF has a broader partnership agenda that evenly covered both strategic and operational issues, while the NHS GG&C APF has shown a stronger focus on the strategic issues, but for NHS Borders, pay issues came to be the primary concerns for the APF.



In summary, the scope of APF meetings in the three health boards suggest that management and trade union representatives were indeed working together to develop

health policy and solve problems. The APF in NHS GG&C shows particular strong focus on strategic issues, which may imply greater union influence on management decision-making and more positive outcomes as some commentators suggested (Kelly, 2004; O'Dowd and Roche, 2009). The research will explore this issue further in following sections.

## **5.4 Participants' Voice in the APFs**

The above two sections have already examined partnership structures and agendas in the three health boards. A number of similarities and variations between the three APFs have been found. However, further analysis is still required in order to get a holistic picture of how partnership operates in the APFs.

In this section, participants' voice in the partnership consultation meetings will be calculated. It is expected that partnership arrangements should enhance employee voice by facilitating the wide involvement of a broad range of views (Bacon and Samuel, 2012). Furthermore, the distribution of voice between different parties in the partnership consultation meetings may imply some balance of power in partnership working which would eventually influence the flow of potential gains (Katz et al., 2008; Kelly, 2004).

### **5.4.1 NHS Highland**

As Fig 5-10 suggests, there is little evidence that managers dominated discussions in NHS Highland APF, as the staff-side (including Employee Director and trade union representatives) contributes 24% of the total discussions. Senior managers are highly involved in the forum, accounting for one-thirds (32%) of the total discussions. Management-side (including HR managers and other management representatives) contributes more than two-fifths (42%) of the discussions in the forum.

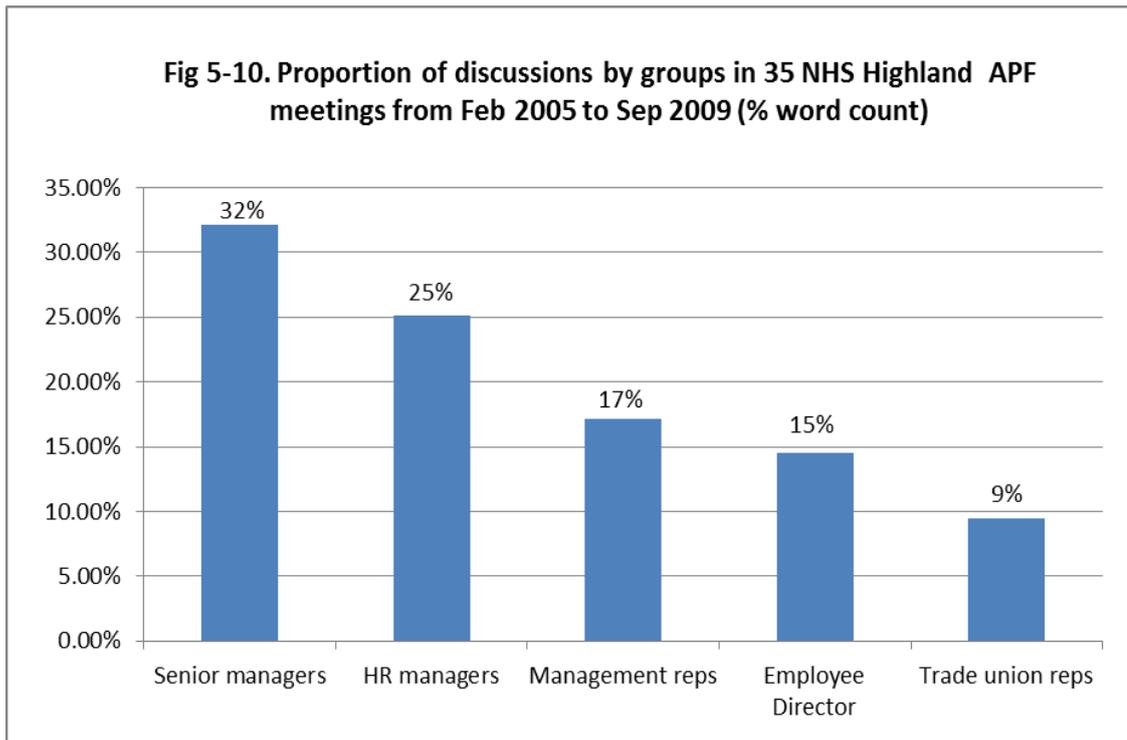
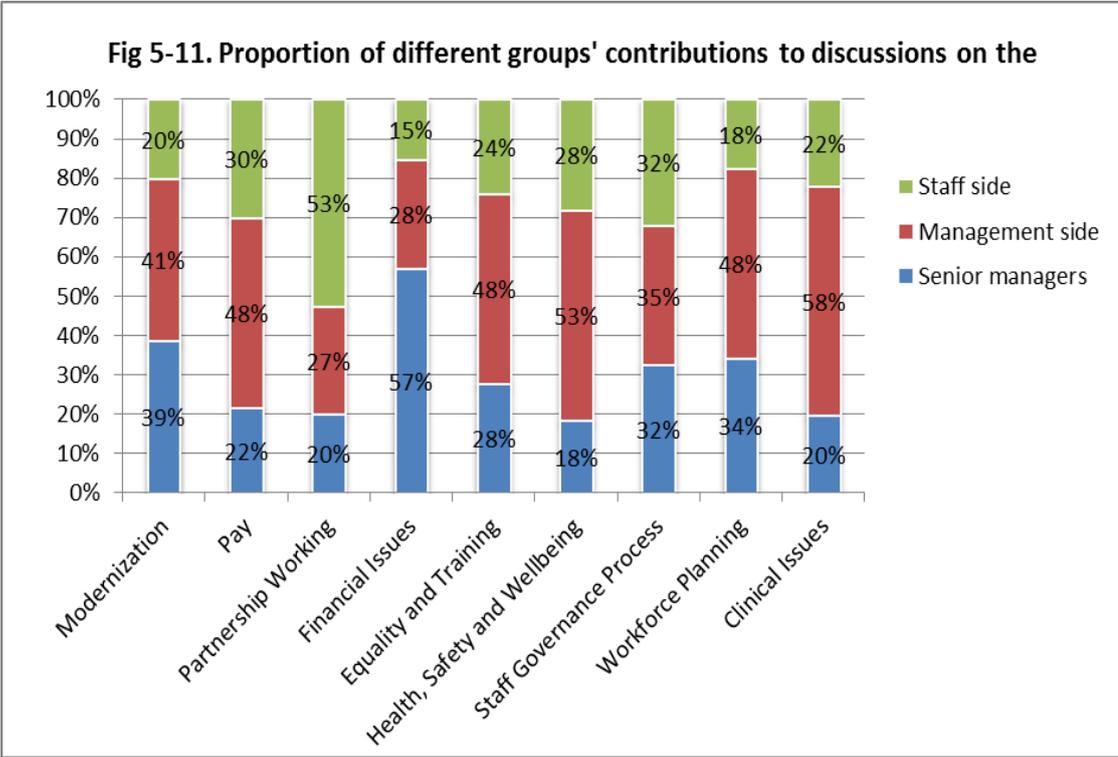


Fig 5-11 indicates the proportion of issues discussed by different groups. It is noted that senior managers appeared to lead the discussion of issues on Modernisation (39%) and Financial Issues (57%) as expected, but more surprisingly they also led the discussions on Workforce Planning and Development (34%) and Staff Governance Process (32%), reflecting strong senior manager's commitment to partnership working on a wide range of issues.

Management representatives are leading the discussions on several issues including Health, Safety and Wellbeing (35%) and Clinical Issues (41%), but contributing relatively low proportions on the issues of Staff governance process (7%) and Workforce Planning and Development (10%). The HR managers dominated discussions on the issues of Workforce Planning and Development (39%), Pay (35%) and Equality and Training (34%), and contributed to 25% of all the discussions (see Table 5-14). This is not surprising as these kinds of issues were all related to the domain of human resource management and implemented by relevant HR managers.

Staff-side has expressed strong voices on some issues, for example, contributing more than one-half (53%) of total discussions on the issue of Partnership Working and the Forum (see Fig 5-11). In addition, staff-side has also contributed moderate proportions on the issue of Pay (30%), Staff Governance Process (32%) and Health, Safety and Wellbeing (28%). However, it is important to note that the voice of trade union representatives is relatively weak in the Forum, accounting for only 9% of the total discussions. It was very significant to see that the staff-side was led by the Employee Director, who contributed 15% of total discussions in the Forum and three-fifths (62%) of staff-sides' overall voice. This shows strong leadership of Employee Director in the staff-side. The data also suggests that trade union representatives have devoted great concerns on the issues of Health, Safety and Wellbeing (17%) and Equality and Training (15%) than others, while the Employee Director appeared to be the main impetus to promote partnership working in the Forum, contributing 45% of the total discussions on this issue (see Table 5-14).



**Table 5-14. Issues discussed and contributions by different groups in 35 NHS Highland APF meetings from Feb 2005 to Sep 2009 (word count, row %)**

	% of issue commented on by senior managers	% of issue commented on by management reps	% of issue commented on by HR managers	% of issue commented on by Employee Director	% of issue commented on by trade union reps
Modernization	39%	20%	21%	11%	9%
Pay	22%	13%	35%	20%	10%
Partnership Working and the Forum	20%	15%	12%	45%	7%
Financial Issues	57%	22%	6%	7%	8%
Equality and Training	28%	14%	34%	10%	15%
Health, Safety and Wellbeing	18%	35%	18%	11%	17%
Staff Governance Process	32%	7%	29%	27%	5%
Workforce Planning and Development	34%	10%	39%	8%	9%
Clinical Issues	20%	40.60%	18%	16%	7%
In total	32%	17%	25%	15%	9%

#### **5.4.2 NHS GG&C**

As similar to findings from the NHS Highland APF, the data from NHS GG&C indicates that the APF was not dominated by management-side, with staff-side contributing nearly three in ten (30%) of the total discussions. As Fig 5-12 suggests, senior managers are positively involved in the Forum, accounting for one-third (33%) of the total discussion and management-side contributed another one-third (37%). However, it is very important to note that the distribution of voice inside the staff-side is very different between NHS Highland and NHS GG&C. The analysis shows that in NHS GG&C, the Employ Director has contributed the lowest proportion of comments in the APF meetings (only 4%) while other trade union representatives were more active than their counterparts in NHS Highland, accounting for 25% of the overall discussions (see Table 5-15).

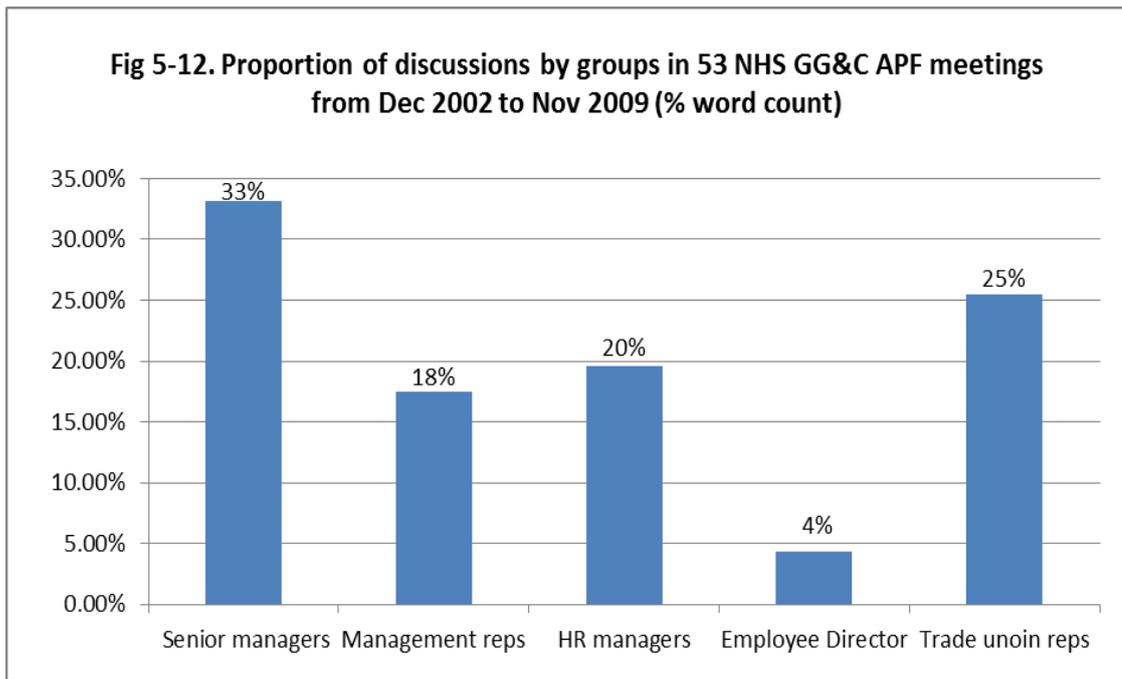
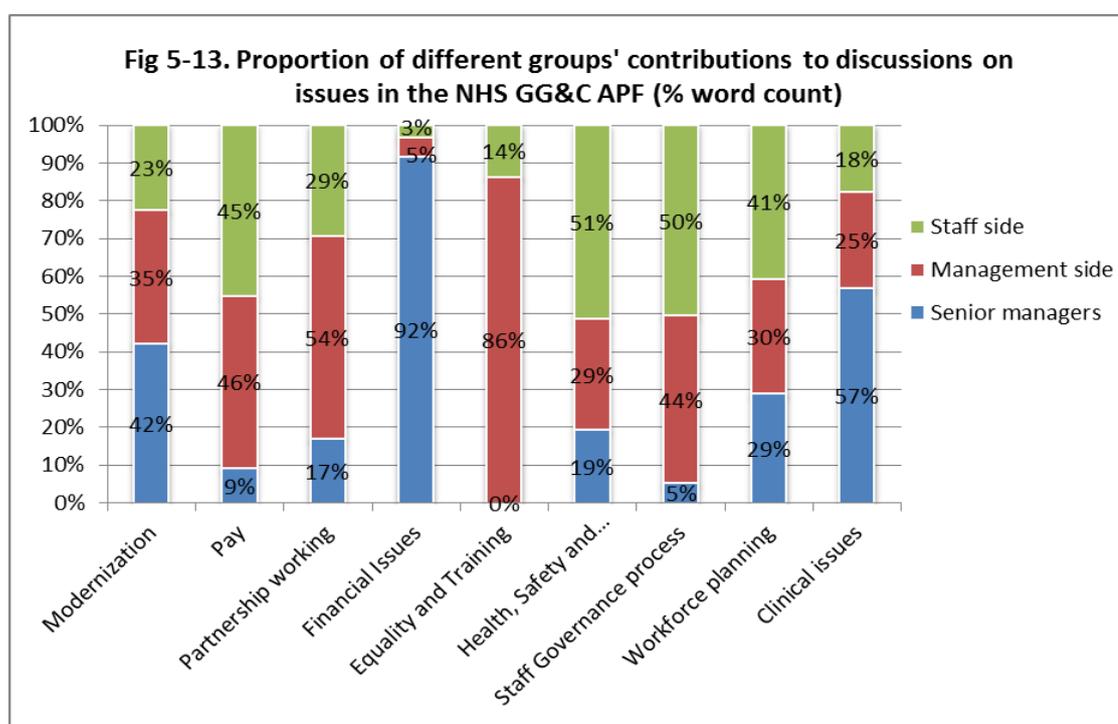


Fig 5-13 reveals the proportion of discussions on particular issues by different groups. It is noted that senior managers were predominately leading the discussion on issues of Modernisation (41%), Financial Issues (92%), Clinical Issues (57%) and Workforce Planning and Development (29%).

Among the issues which were dominated by management-side, there is a clearly boundary existing between HR managers and other management representatives. As Table 5-15 indicates, HR managers in NHS GG&C has primarily focused on the issues of Pay (34%), Staff Governance Process (44%), and Equality and Training (86%), while other management representatives concerned more on Modernisation (86%), while other management representatives concerned more on Modernisation (30%), Partnership Working and the Forum (39%) and Clinical Issues (25%).

It is significant to see from Fig 5-13 that staff-side were leading the discussion of several issues in the Forum, including Pay (45%), Health Safety and Wellbeing (51%), Staff Governance Process (50%) and Workforce Planning and Development (40%). In detail, as reflected in Table 5-15, trade union representatives have expressed a very strong voice on issues of Pay (42%), Health, Safety and Wellbeing (36%), Staff Governance Process (41%) and Workforce Planning and Development (38%), while

the primary concern of the Employee Director was the issue of Partnership Working and the Forum (14%) and Health, Safety and Wellbeing (15%).



**Table 5-15. Issues Discussed and the Contribution by Different Groups in 53 NHS GG&C APF meetings from Dec 2002 to Nov 2009 (word count, row %)**

	% of issue commented on by senior managers	% of issue commented on by management reps	% of issue commented on by HR managers	% of issue commented on by Employee Director	% of issue commented on by trade union reps
Modernization	42%	30%	5%	3%	20%
Pay	9%	12%	34%	3%	42%
Partnership working and the Forum	17%	39%	14%	14%	15%
Financial Issues	92%	1%	4%	1%	2%
Equality and Training	0%	0%	86%	5%	9%
Health, Safety and Wellbeing	19%	4%	26%	15%	36%
Staff Governance process	5%	0%	44%	10%	41%
Workforce Planning and Development	29%	4%	27%	2%	38%
Clinical issues	57%	25%	0%	3%	14%
In total	33%	18%	20%	4%	25%

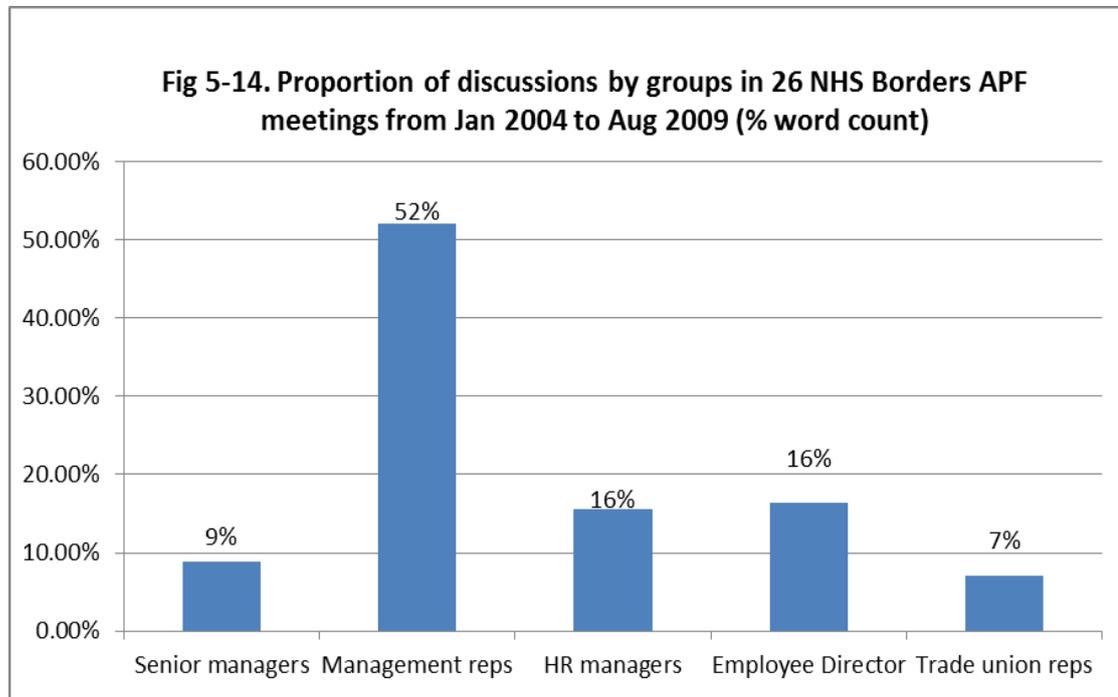
In addition, it is very interesting to see that more than one-half (54%) of the comments on the issue of Partnership Working and the Forum was contributed by management-side, while the Employee Director has only commented 14% on this issue. It reflects a distinct working style in the APF of NHS GG&C where management-side were actively seeking the cooperation of trade unions, unlike its counterparts in NHS Highland where the Employee Director (45%) was holding the main position to promote this issue. Furthermore, the role of Employee Director in NHS GG&C also seemed to be different with his counterparts in NHS Highland, only accounting for 4% of the total comments. The figure implies that the function and role of Employee Director in NHS GG&C may be distinct from the Employee Director in NHS Highland, given the general context that the overall number of unions and number of trade union representatives in NHS GG&C APF were larger than the those in NHS Highland, which may have resulted in dilution of the Employee Director's power.

#### **5.4.3 NHS Borders**

Among the three cases, the APF of NHS Borders probably represents the only case where the forum is predominately leading by management-side. As Fig 5-14 reveals, management-side has contributed over three-fifths (68%) of the total discussions in the Forum. In detail, HR managers contributed 16% of the discussions, while management representatives accounted for 52%.

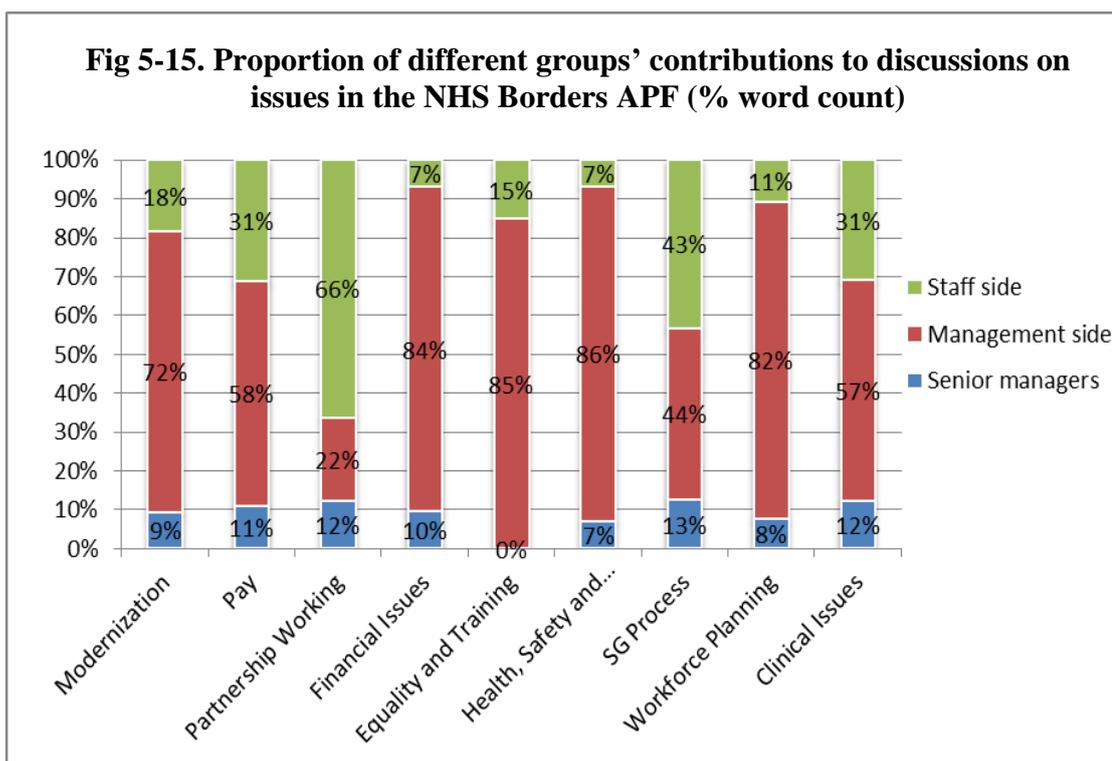
It is very important to note that, unlike its counterparts in NHS Highland and NHS GG&C, the involvement of senior managers in the APF of NHS Borders appeared to be shallow, accounting for only 9% of the total discussions. In the meantime, the proportion of discussions by staff-side was very close to the other two cases.

However, it is noted that trade union representatives contributed the lowest proportion of discussions in the Forum, which is 7%, while the Employee Director accounted for 16% of the overall discussions (Fig 5-14).



In terms of the discussions on specific issues, senior managers showed no particular preference. Management-side dominated the discussion of almost every single issue, except Partnership Working and the Forum. HR managers were co-leading the discussion of issues on Pay (23%), Equality and Training (30%) and Workforce Planning and Development (34%).

As Fig 5-15 indicates, the primary concerns of staff-side were issues of Pay (31%), Partnership Working and the Forum (66%), Staff Governance Process (44%) and Clinical Issues (31%). It was noted that, as same as his counterpart in NHS Highland, the Employee Director in NHS Borders took the main position to promote the issue of Partnership Working and the Forum, accounting for 65% of the total discussions on this issue. The Employee Director was also leading on the discussion of Staff Governance Process (35%).



**Table 5-16. Issues Discussed and the Contribution by Different Groups in 26 NHS Border APF meetings from Jan 2004 to Aug 2009 (word count, row %)**

	% of issue commented on by senior managers (row %)	% of issue commented on by management reps (row %)	% of issue commented on by HR managers (row %)	% of issue commented on by Employee Director (row %)	% of issue commented on by trade union reps (row %)
Modernization	9%	66%	6%	13%	6%
Pay	11%	35%	23%	15%	17%
Partnership Working and the Forum	12%	12%	9%	65%	2%
Financial Issues	10%	84%	0%	4%	3%
Equality and Training	0%	55%	30%	4%	11%
Health, Safety and Wellbeing	7%	84%	2%	5%	2%
Staff Governance Process	13%	21%	23%	35%	9%
Workforce Planning and Development	8%	47%	34%	10%	0%
Clinical Issues	12%	57%	0%	23%	8%
In Total	9%	52%	16%	16%	7%

#### **5.4.4 Three Cases Compared**

This section provides a more explicit understanding of the extent to which different groups contributed to the partnership agenda. First of all, it is necessary to point out a similarity between all of these cases. It was found that discussions of some issues were dominating or lead by certain groups that reflects the expert power of such groups. For example, in both NHS Highland and NHS GG&C, senior managers were leading the discussions of strategic issues like Modernization and Financial issues. Issues of Pay, Equality and Training, Staff Governance Process and Workforce Planning and Development were generally led by HR managers. However, NHS Borders has represented a distinctive case, as the senior managers and trade union representatives in the forum were generally inactive, but management representatives were dominating the discussions of almost every topics except the issue of Partnership Working and the Forum.

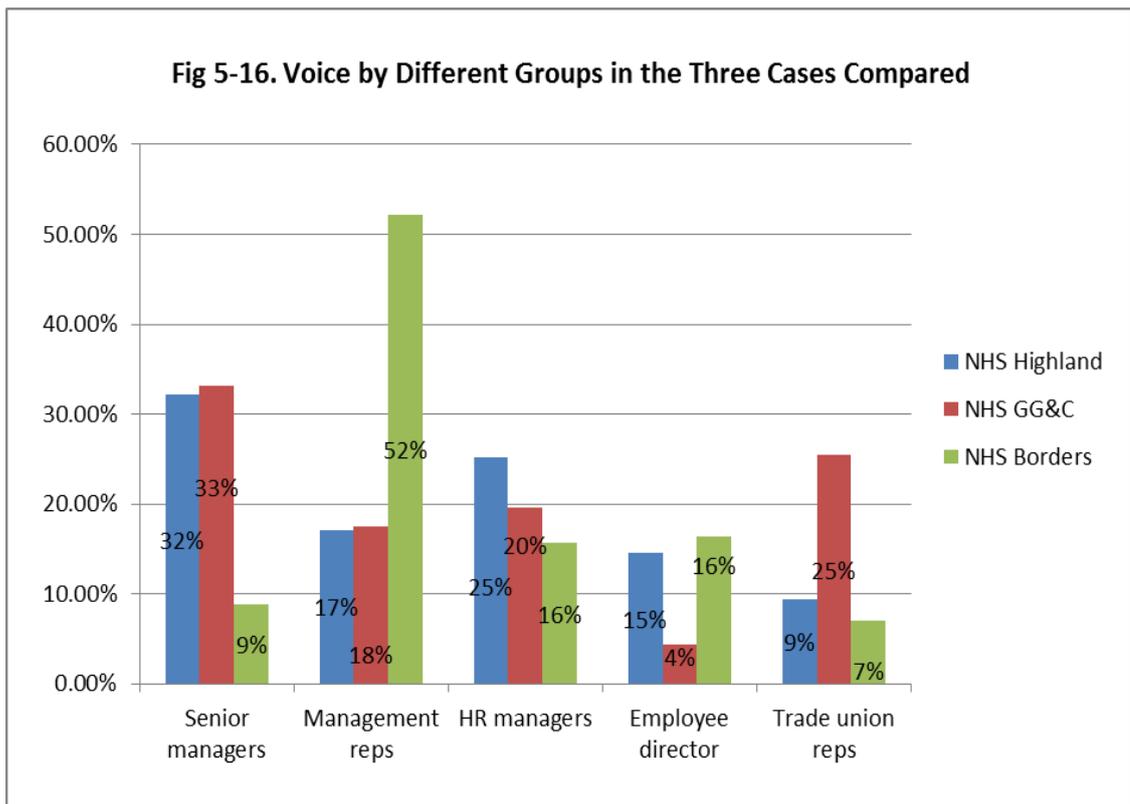
Fig 5-16 compares the voice by different participants in the three APFs. In light of the composition of the three APFs which was discussed in previous section 5.2.2, the data indicates three different styles of leadership in the APFs.

In NHS Highland, voice was evenly distributed between the senior managers, management-side and staff-side. Senior managers were actively involved in the APF and led discussions on many issues. While in the meantime, staff-side has also expressed a strong voice in the Forum and the Employee Director shows strong leadership within the staff-side.

In NHS GG&C, senior managers were actively involved in the Forum as well. Comparing to NHS Highland APF, it is more appropriate to describe the NHS GG&C APF as co-governance by both unions and managers, given the fact that trade union representatives occupied nearly three-fifths of the seats and expressed stronger voice

in the Forum. In addition, there is a significant distinction between the two APFs, as the role of Employee Director in NHS GG&C appeared to be more powerless than his counter in NHS Highland.

In stark contrast to NHS Highland and NHS GG&C, management-side evidently dominated the NHS Borders APF given the large proportion of seats occupied by managers and voice they expressed. It is also significant to see that the NHS Borders APF was in lack of senior managers' buy-in. It is noted that in both NHS Highland and NHS Borders, the Employee Directors contributed a similar proportion of discussions in their Forums and both of them had taken the position to lead on the discussion of Partnership Working and Development.



## 5.5 Partnership Behaviours in the APFs

At the heart of partnership is the idea that unions and managers actively work together to identify optimal solutions to problems. Advocates have suggested that interactions

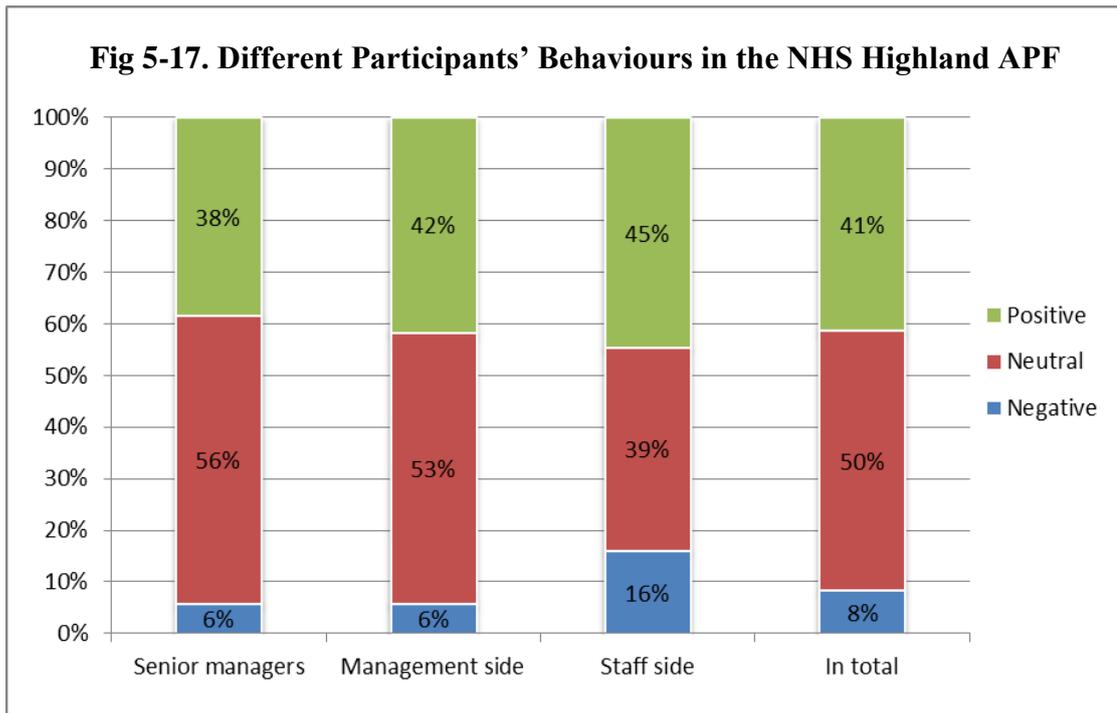
need to be positive from all participants and are necessary to develop a cooperative partnership climate. They furtherly indicated that cooperative behaviours like sharing information, plans and problems to a greater degree, or resolving problems in a more open and honest manner are likely to associate with more robust partnership relationship and generating more positive outcomes for both management and trade unions (Kochan and Osterman, 1994; Oxenbridge and Brown, 2002). However, many critics of greater cooperation have expressed concerns that partnership might be used by management as a strategy to co-opt trade union and isolate unions from their members (Kelly, 1998; Taylor and Ramsay, 1998). So far, no systematic research has examined the balance between cooperative or conflictual behaviours in partnership arrangements, or considered the implication of these behaviours for the operation and the outcomes of partnership. To explore these issues, this section examines partnership behaviours by utilizing the “Behaviour Coding Framework” drawn from Bacon and Samuel (2009; 2012).

### **5.5.1 Participants’ Overall Behaviour**

Firstly, this section will analyse different participants’ overall behaviours in the three APFs.

#### **NHS Highland**

Relevant data suggests that the NHS Highland APF was very cooperative, with over 90% of the participants’ behaviours involved exchanging information (50%) and cooperative behaviours (41%), the remaining 8% involved challenging other parities (see Fig 5-17).

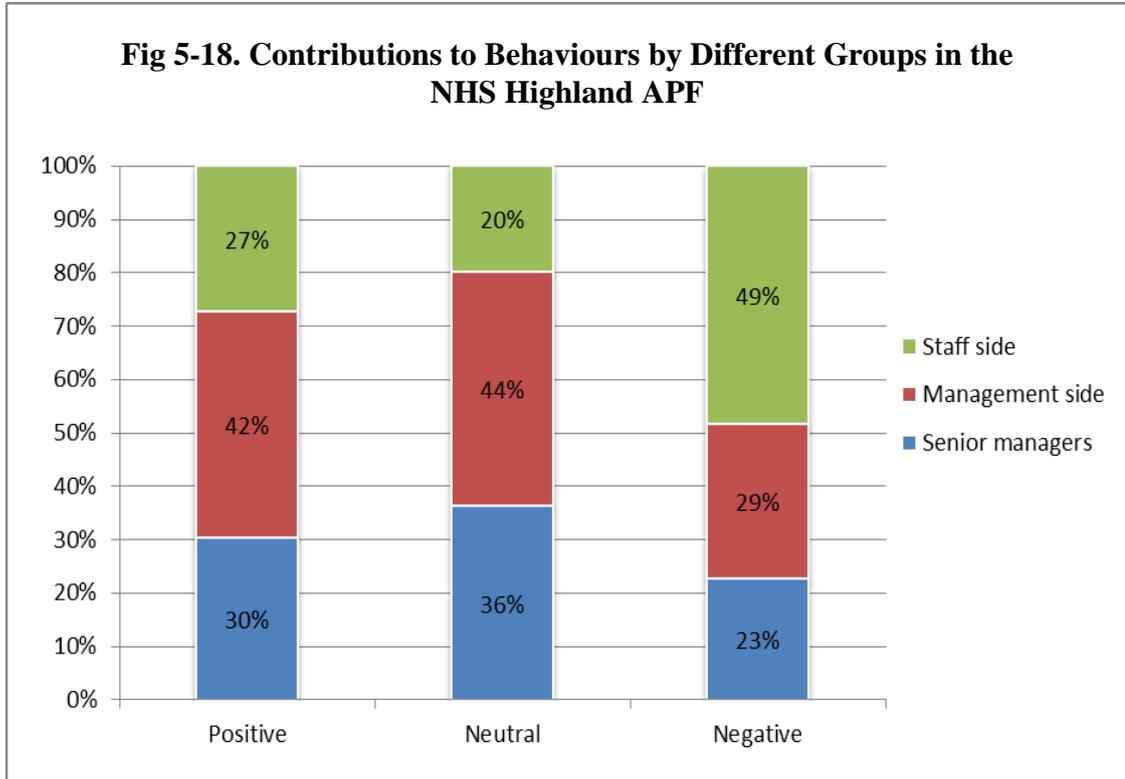


The behaviour patterns of senior managers, HR managers and management representatives are very similar to each other, with most of their behaviours involving exchanging information and being positive (see Table 5-17). However, it appears that staff-side has more challenge behaviours than other groups, with 16% of their behaviours involving an expression of apprehension and criticising. Specifically, trade union representatives are the most aggressive party in the Forum, with 25% of their behaviours were attacking and criticising management. It is very interesting to note that the Employee Director's behaviour pattern is quite different from both trade union representatives and management representatives, with 11% of his behaviour were negative, lower than the trade union representatives (25%), but higher than management (5%). It implies that the characteristic of the role of Employee Director has been shifted from the pure union side to a more complicated position between unions and management, and their behaviour changed accordingly.

**Table 5-17. Proportion of Behaviours by Different Groups in the NHS Highland APF Meetings from Feb 2005 to Sep 2009 (row %)**

	Positive	Neutral	Negative
Senior managers	38%	56%	6%
Management reps	45%	50%	5%
HR managers	40%	54%	6%
Employee Director	45%	45%	11%
Trade union reps	45%	31%	25%
The Forum in total	41%	50%	8%

Data in the Fig 5-18 indicates the contributions to different sets of behaviours by groups in the Forum. It is noted that staff-side contributed nearly one-half (49%) of the total negative behaviours in the Forum, while management-side was the most cooperative party in the Forum, accounting for two-fifths (42%) of the total positive behaviours.



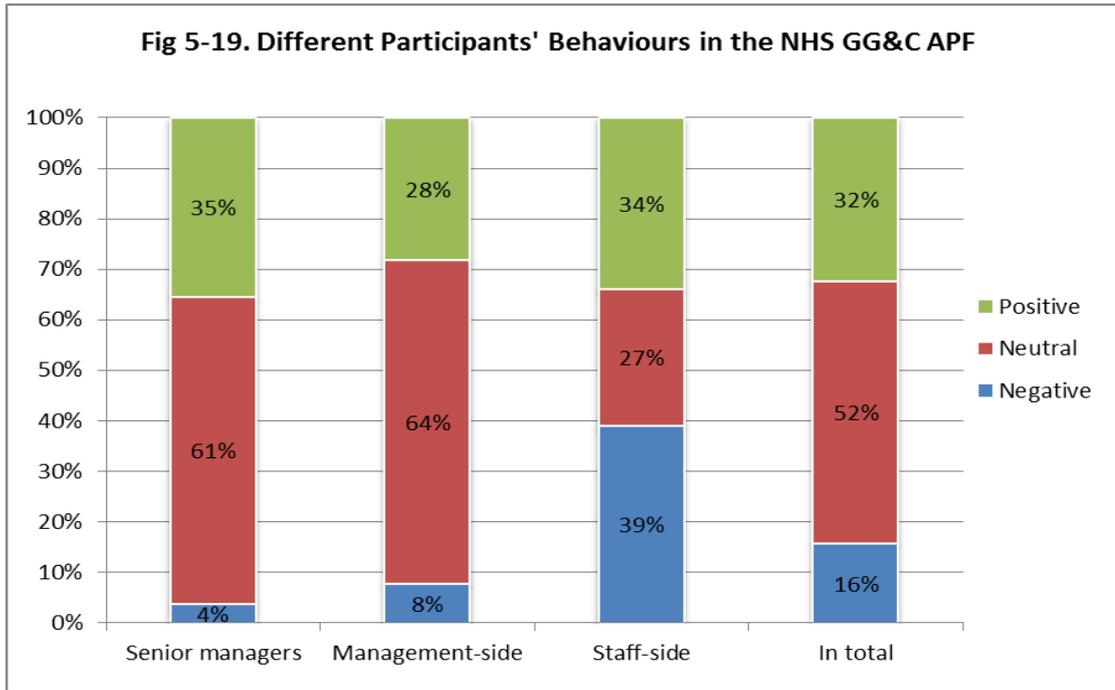
**Table 5-18. Proportion of Behaviours Contributed by Different Groups in the NHS Highland APF meetings (column %, word count)**

	<b>Positive</b>	<b>Neutral</b>	<b>Negative</b>
Senior managers	30%	36%	23%
Management reps	18%	17%	11%
HR managers	24%	27%	18%
Employee Director	17%	14%	20%
Trade union reps	10%	6%	28%

### **NHS GG&C**

Comparing to its counterpart in NHS Highland, the NHS GG&C APF appeared to be more aggressive. Although four-fifths of all the participants' behaviours in the forum involved positive (32%) or neutral (52%), the remaining 16% of the total behaviours involved challenging and attacking other parties (Fig 5-19).

There is little evidence showing that trade unions were incorporated by the management-side. In contrast, trade union representatives behaved very critically and aggressive in the forum, with two-fifths (39%) of staff-side's behaviours are negative. A large proportion of management-side's behaviours are sharing information with other parties. While the senior managers were the most cooperative group in the Forum, with only 4% of their behaviours were negative.



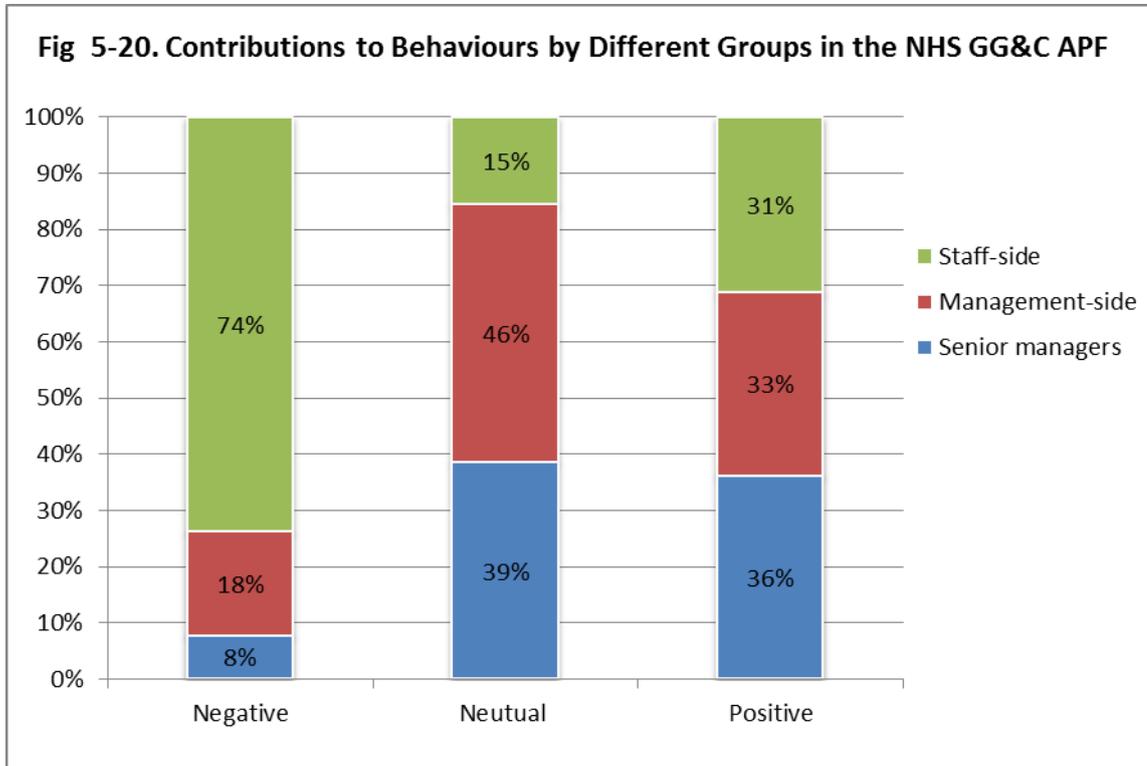
As same as its counterpart in NHS Highland, the Employee Director in NHS GG&C behaved more cooperatively than other trade union representatives, but more aggressively than the management-side (Table 5-19). Again, the behaviour pattern of HR managers, Management representatives and senior managers were very similar and over nine-tenths of their behaviour involved neutral and positive comments.

**Table 5-19. Proportion of Behaviours by Different Groups in the NHS GG&C APF meetings from December 2002 – November 2009 (row %)**

	<b>Positive</b>	<b>Neutral</b>	<b>Negative</b>
Senior managers	35%	61%	4%
Management reps	28%	66%	6%
HR managers	28%	62%	10%
Employee Director	30%	49%	21%
Trade union reps	35%	24%	42%
The Forum in total	32%	52%	16%

Fig 5-20 indicates staff-side was the most aggressive group in the Forum, contributing 74% to the total negative behaviours. In detail, most of the negative behaviours were come from trade union representatives, but not the Employee

Director. Management representatives and HR managers exchanged a lot of information in the Forum and contributed a very low percentage to the overall negative behaviours.



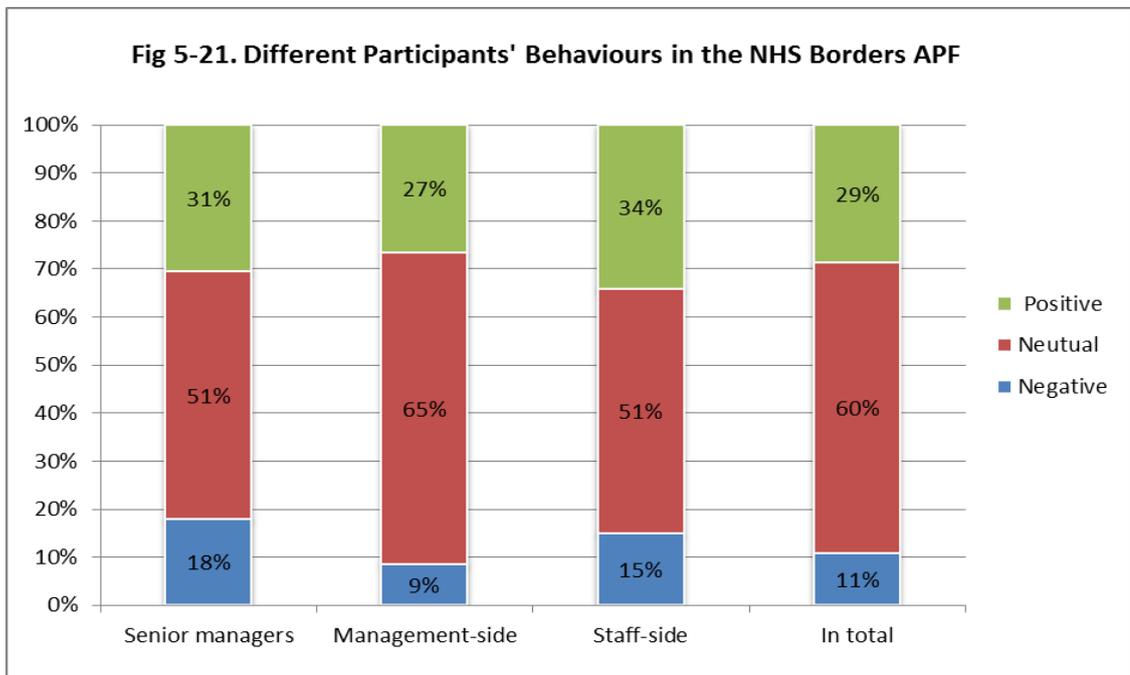
**Table 5-20. Proportion of Behaviours Contributed by Different Groups in the NHS GG&C APF meetings (column %, word count)**

	Positive	Neutral	Negative
Senior managers	36%	39%	8%
Management reps	15%	22%	6%
HR managers	17%	24%	12%
Employee Director	4%	4%	6%
Trade union reps	27%	11%	68%

### NHS Borders

Generally, the forum was cooperative, with nearly nine-tenths of the participants' behaviour involving exchanging information (60%) and being positive (29%), the remaining 11% involved challenging other parties (Fig 5-21). The data suggests that

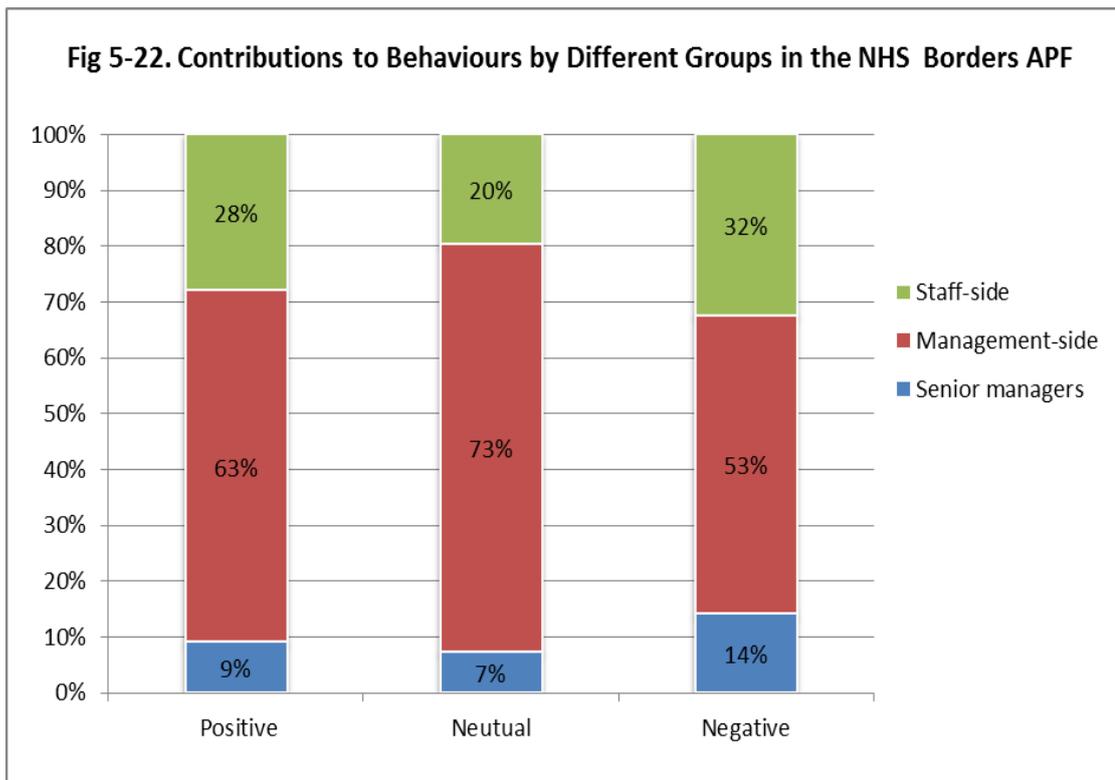
senior managers in NHS Borders were relatively more aggressive than their counterparts in NHS Highland and NHS GG&C, with nearly one-fifth (18%) of their behaviours was negative. The behaviour pattern of management representatives and the HR managers was very similar, with a large proportion of their behaviours in the Forum was exchanging information. Again, as similar to his counterparts in NHS Highland and NHS GG&C, the Employee Director in NHS Borders behaved more cooperatively than trade union representatives, while at the same time more aggressive than the management-side.



**Table 5-21. Proportion of Behaviours by Different Groups in the NHS Borders APF meetings from Jan 2004 to Aug 2009 (row %)**

	<b>Positive</b>	<b>Neutral</b>	<b>Negative</b>
Senior managers	31%	51%	18%
Management reps	27%	65%	8%
HR managers	25%	65%	10%
Employee Director	33%	54%	13%
Trade union reps	36%	44%	20%
The Forum in total	29%	60%	11%

Fig 5-22 indicates that management-side has contributed more than half of every different kind of behaviours, suggesting management-side was dominating most of the activities in the Forum. In light with the findings in previous sections that management-side has more seats and a larger proportion of voice expressed in the Forum, it evidently indicates that the NHS Borders APF was a management dominated Forum.

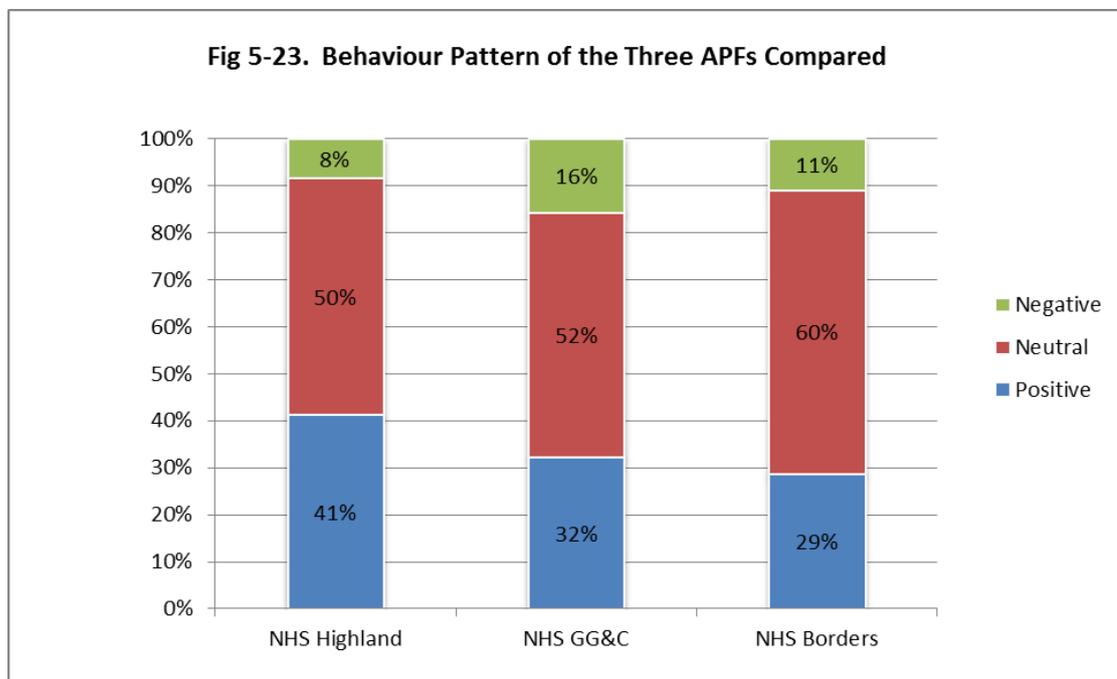


**Table 5-22. Proportion of Behaviours Contributed by Different Groups in the NHS Borders APF Meetings (column %, word count)**

	<b>Positive</b>	<b>Neutral</b>	<b>Negative</b>
Senior managers	9%	7%	14%
Management reps	49%	56%	39%
HR managers	14%	17%	14%
Employee Director	20%	15%	20%
Trade union reps	8%	5%	12%

### Three Cases Compared

In summary, the behaviour patterns in the three APFs are different. Partnership in NHS Highland represents a cooperative management-union relationship, with cooperative behaviours accounting for 41% of the total behaviours. The APF in NHS GG&C appears to be the most aggressive forum, with challenging and conflicting behaviours accounting for 16% of the total behaviours. In NHS Borders, an important function of the forum is to share information, with three-fifths of the total behaviours seeking and offering information (see Fig 5-23).



In both NHS Highland and NHS GG&C, the behaviour patterns of senior managers, management representatives and HR managers were quite similar, with most of their behaviours are cooperative. While in NHS Borders, senior managers behaved more aggressively than other managers. In all of the three Forums, trade union representatives behaved more aggressive than the managers. Compared to their counterparts, staff-side in NHS GG&C behaved extremely aggressively, contributing to 74% of the total negative behaviours.

There is a common feature in all of the three APFs that the behaviour patterns of Employee Directors are different from both the managers and trade union representatives, they are less aggressive than trade union representatives and more aggressive than management representatives. This reflects the complexity of the role of Employee Director as the lead negotiator of trade unions and a non-executive member in the Board. The behaviour pattern also suggests that Employee Directors are not co-opted by managers, as some researchers concerned.

### **5.5.2 Bargaining Behaviours on issues**

The previous section has already analysed participants' overall behaviours in the three APFs. The findings indicate that NHS Highland APF was the most cooperative Forum, while in contrast NHS GG&C APF was the most aggressive Forum, and the main activity in NHS Borders APF was sharing information. In this section, the research will go on to examine participants' bargaining behaviours on different set of issues.

#### **NHS Highland**

Fig 5-24 shows that no single issue appears especially controversial in the Forum. The issues of Health, safety and wellbeing (13%) and Pay (10%) were relatively more controversial than others, and it is important to note that these issues were also the top three issues with which staff-side concerned.

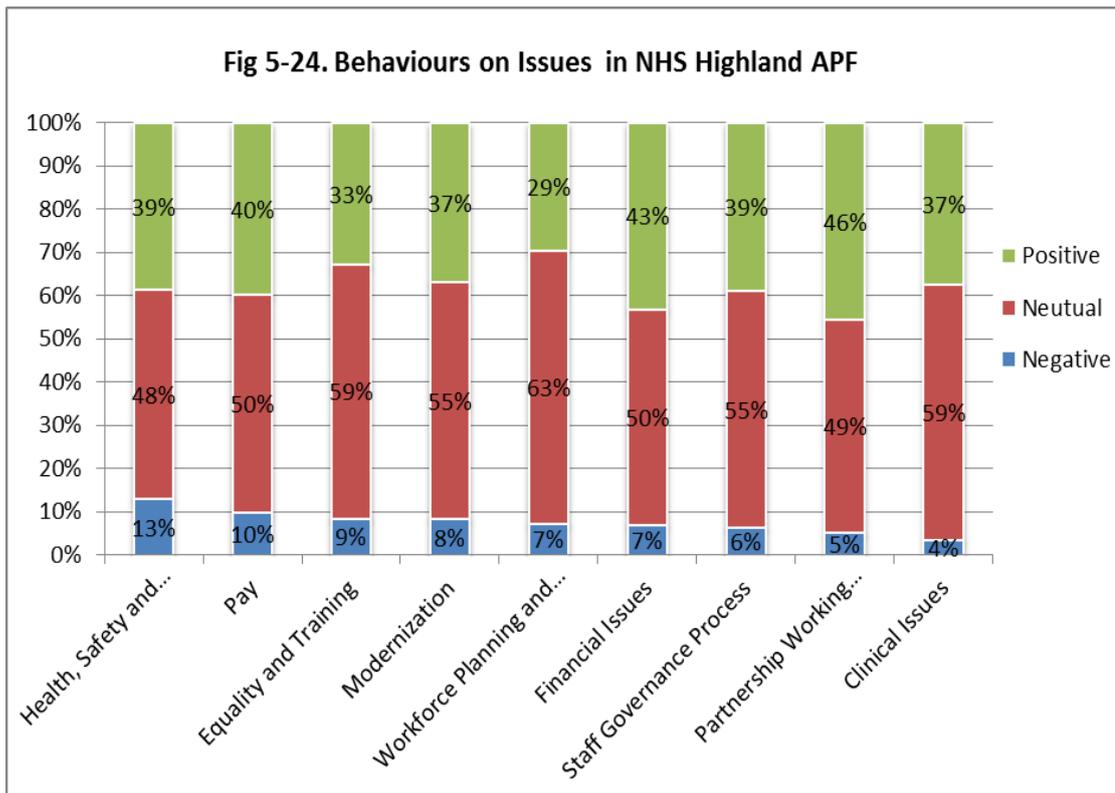
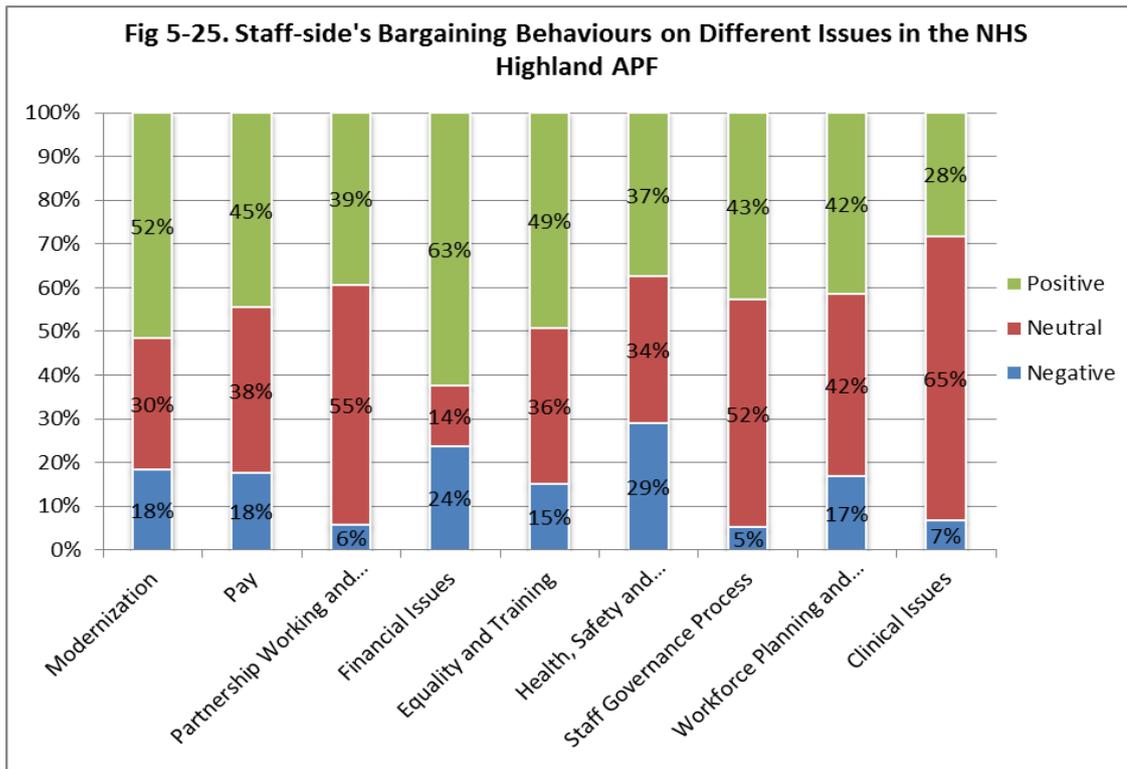


Fig 5-25 reveals staff-side's bargaining behaviours on different issues in NHS Highland. Staff-side's behaviour on Financial Issues and Health, Safety and Wellbeing were more conflictual than others. Behaviour patterns on the issues of Modernisation, Pay, Equality and Training and Workforce Planning and Development were very similar, with approximately one-fifth of overall behaviours was negative. Behaviours on the issues of Partnership Working and the Forum, Staff Governance Process and Clinical Issues were very cooperative, with less than one-tenth of the total behaviours were negative.



## NHS GG&C

Fig 5-26 shows that the issues of Pay (15%), Health, Safety and Wellbeing (15%), and Equality and Training (14%) were the most three controversial issues. In general, trade unions in GG&C behaved aggressively on most of the issues except the Financial Issues, Partnership Working and the Forum and Staff Governance Process. It is noted that Financial Issues has only accounted for 6% of total discussions in the Forum, and most of the time, it was management-side giving reports to the Forum. Staff-side was extremely aggressive on the issue of Pay, Equality and Training and Health Safety and Wellbeing, with nearly half of the total behaviours on these issues were negative.

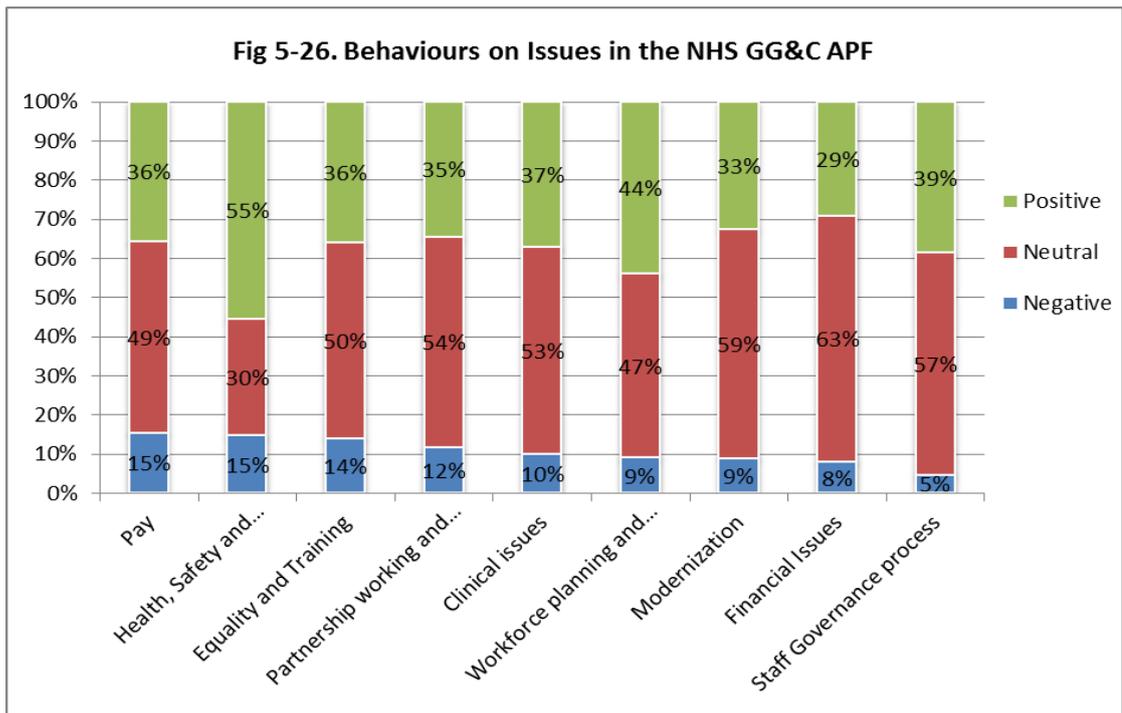
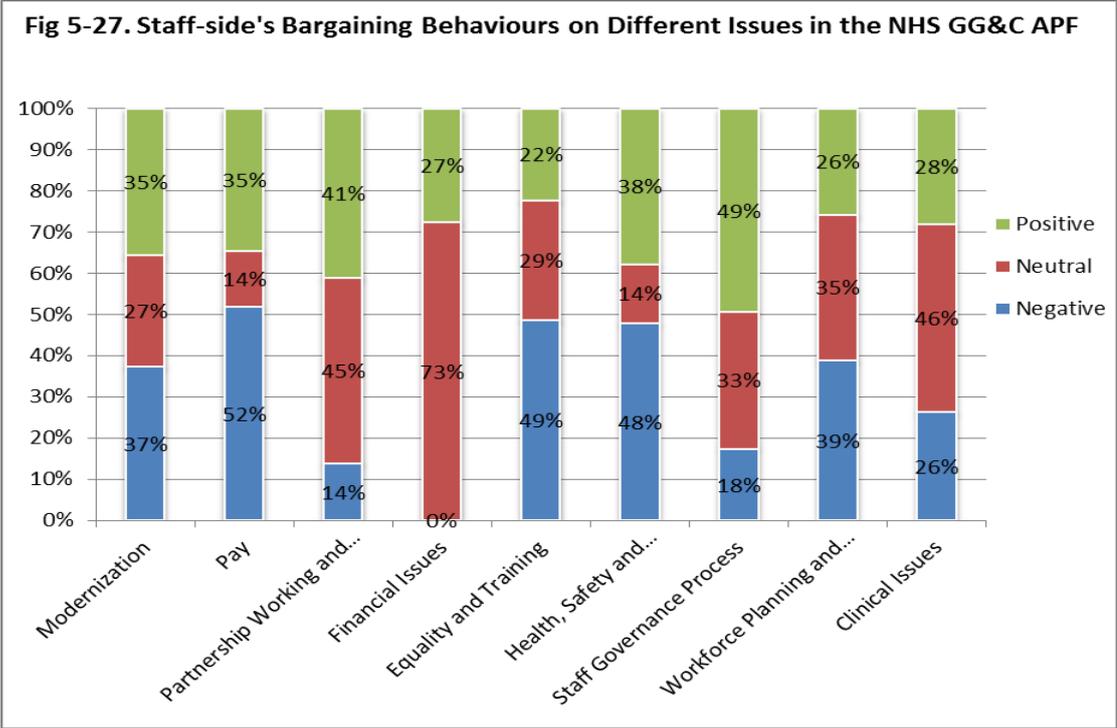


Fig 5-27 reveals staff-side's bargaining behaviours on different issues in NHS GG&C. Staff-side's behaviour on Pay, Equality and Training and Health, Safety and Wellbeing were more conflictual than others. Behaviour patterns on the issues of Modernisation and Workforce Planning and Development were very similar, with nearly two-fifths of overall behaviours was negative. Behaviours on the issues of Partnership Working and the Forum and Staff Governance Process and Clinical Issues were relatively cooperative.



**NHS Borders**

The Fig 5-28 indicates that no single issue appears to be particularly conflictual. The issues of Pay, Partnership Working and the Forum and Equality and Training were relatively more controversial than others.

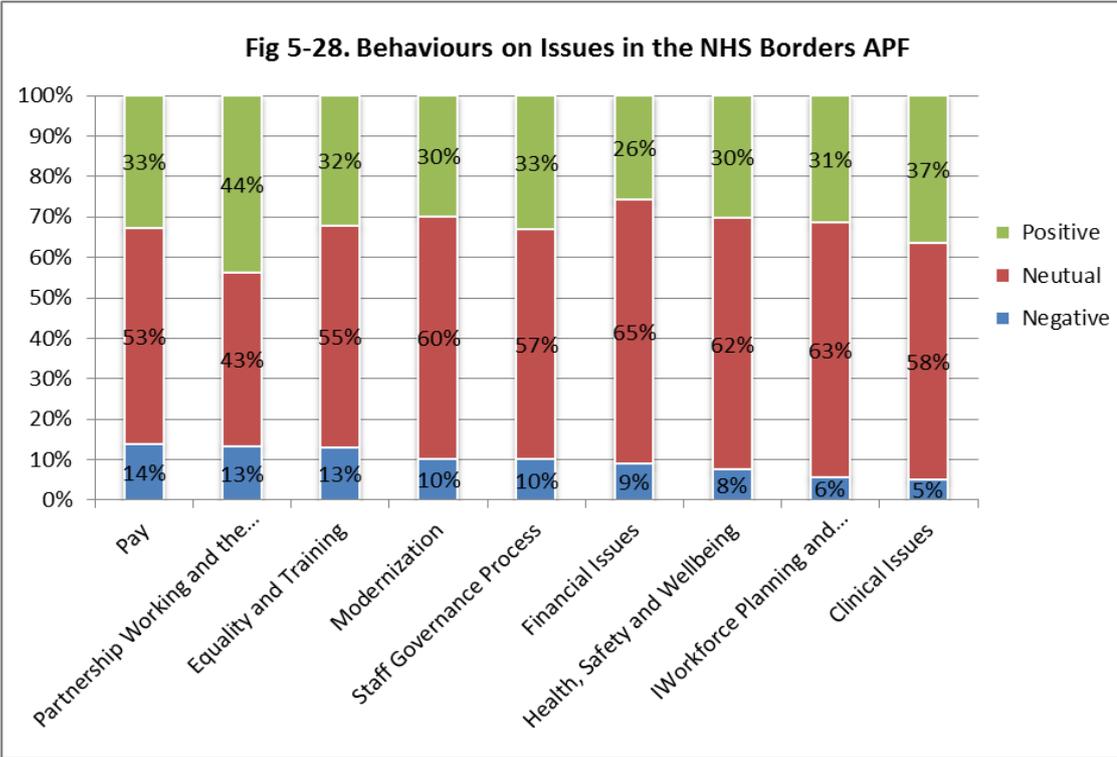
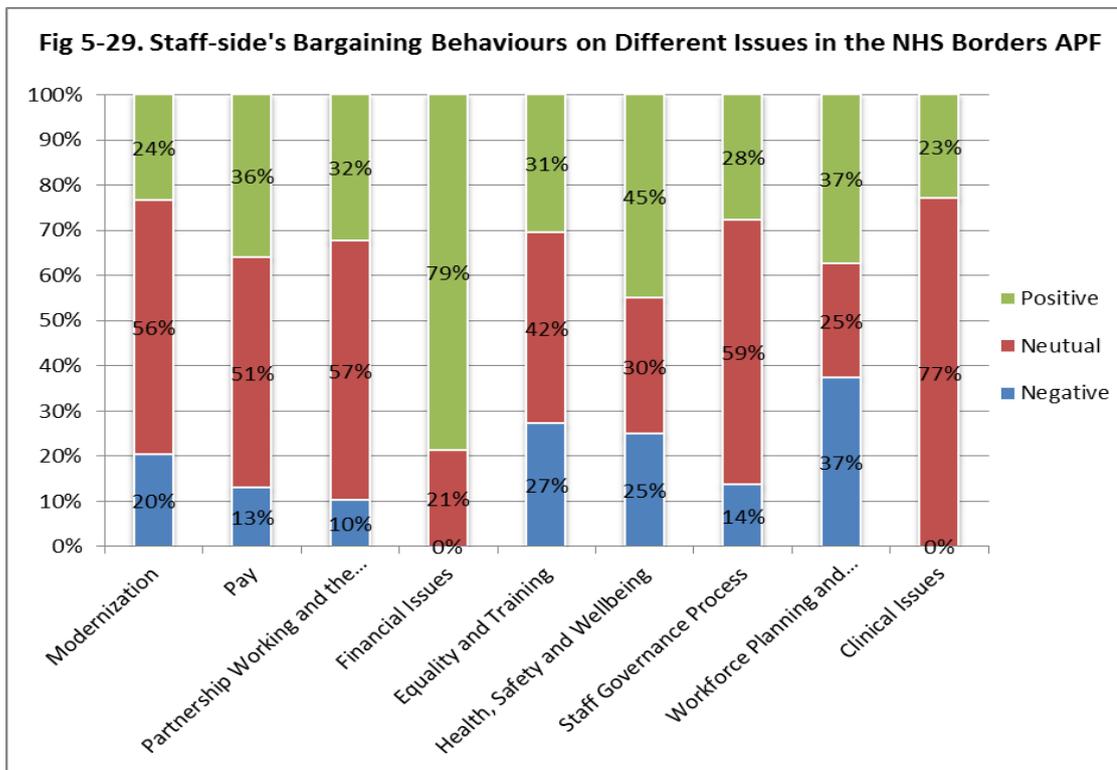


Fig 5-29 reveals that staff-side was significantly cooperative on the Financial Issues and Clinical Issues, with no negative behaviours observed. However, there is a need to point out that Clinical Issues are rarely discussed in the Forum (see Fig 5-6). As for Financial Issues, most of the time it was managers providing financial updates to the Forum, no substantial discussions actually occurred on this issue in the APF. Staff-side showed primarily concerns on the issues of Workforce Planning and Development, Equality and Training, Health, Safety and Wellbeing and Modernisations, with negative behaviours on these issues were above 20%. In contrast to other two Boards, it is interesting to see that staff-side behaviours on the issue of Pay were not as aggressive as its counterparts. This is mainly because some critical conflictual issues regarding pay were not discussed in the Forum, for example, car parking charges.



### **Three Cases Compared**

In summary, this section has analysed the behaviour patterns of the APFs and participants' behaviour on issues, particularly staff-side's behaviours. The results show that the behaviour patterns of the three cases were notably different with each other, as summarized in previous section 5.5.1. It also suggests that there were a number of similarities and variations with participants' behaviours on specific issues. For example, in all of the three cases, some issues like Pay, Equality and Training and Health, Safety and Wellbeing are essentially more conflictual than other issues, as one party's gain potentially means loss for other parties. However, differences were existed with respect to participants' behaviours on particular issues. For example, in NHS GG&C, staff-side challenged managers on almost every set of issues. In contrast, staff-side appeared to be very cooperative with managers in NHS Highland APF.

The findings here are highly related to a central debate within Human Resource Management and Industrial Relations that what kind of bargaining tactics should trade unions and managers adopt in order to deliver benefits for both sides. Some commentators have suggested that cooperative behaviours between managers and trade unions can introduce higher performance working practices to the mutual benefits of shareholders and employees (Kochan and Osterman, 1994). However, critics have also pointed out that competitive markets provide a pretext for managers to exploit union cooperation and restructure working practices at the expense of employee's terms and conditions (Kelly, 1998; Taylor and Ramsay, 1998). As argued by Bacon and Blyton (2007) that, unions had to adopt conflict strategies in bargaining to achieve mutual gains.

It therefore generates an important question that how would the different behaviour patterns associate to the outcomes, or does conflict or cooperative behaviours bring

any robust benefits for trade unions? The research will address this question in following chapters.

## 5.6 Chapter Summary and Conclusions

Overall, this chapter has reported three different operating modes of partnership in the APFs (see Table 5-23).

**Table 5-23. Operating Features Compared in the Three APFs**

<b>Operating Features</b>	<b>NHS Highland</b>	<b>NHS GG&amp;C</b>	<b>NHS Borders</b>
Composition of the APF	Relatively Evenly Distributed	Trade Union Representatives in the Majority	Management-side in the Majority
APF Size	22 attendees	25 attendees	17 attendees
Participation of Senior Managers	Consistent	Consistent	Inconsistent
Scope of Partnership Agenda	Wide	Medium	Limited
Focus on Strategic Issues	Strong	Strongest	Medium
Voice in the APFs	Evenly Distributed	Evenly Distributed	Management-side Dominated
Behaviour Patterns	Cooperative and Positive	Challenging and Criticising	Information Exchange
The Role of Employee Director	Strong Voice	Weak Voice	Strong Voice

NHS Highland APF represents a mode of partnership with trade unions actively involved in the Forum and cooperating with managers. Important features are found in the aspects of structure, agenda, voice and behaviour. Seats in the Forum are evenly distributed between staff-side and management-side, reflecting the balance of power between unions and managers. Senior managers are consistently involved in the Forum, contributing one-thirds (32%) of the total discussions and leading the discussions on the strategic issues like Modernisation and Financial Issues. Trade unions are highly involved in the discussion of many issues. In general, participants'

behaviour in the forum are very cooperative, with more than nine-tenths of the total behaviours are cooperation and exchanging information.

NHS GG&C APF represents a mode of partnership where management and trade unions co-governance the forum and unions were able to challenge management all over the time. Three-fifths (59%) of the total seats in the Forum are occupied by trade unions, reflecting the attribute of labour-parity. Further evidence shows that trade unions are leading the discussion of many issues in the forum, for instance, the issues of Pay, Health, Safety and Wellbeing, Equality and Training and Workforce Planning and Development. In addition, trade unions behaved extremely aggressive in the forum, accounting for more than three-fifths (74%) of the total negative behaviours. As similar to NHS Highland, senior managers in NHS GG&C are consistently involved in the forum, accounting for one-thirds (33%) of the total discussions and dominate the discussions on strategic issues like Modernisation and Financial issues.

NHS Borders APF represents a mode of partnership where managers are dominating the Forum, albeit staff-side has 26% of total seats and contributed 23% of overall discussions in the Forum. There is no consistency of senior managers to join the forum, the Chief Executive and Chairman of the Board took part in the Forum by turns. The overall behaviours in the Forum are very cooperative, but mainly because the controversial issues that affect staff are rarely discussed in the Forum.

## **Chapter 6. The Evolution of Partnership**

### **6.1 Introduction**

It is recognised that partnership arrangements evolve over time to adapt to the changing organisational environment (Bacon and Samuel, 2009; Kochan et al., 2008). In the context of profound organisational restructuring and the launching of modernisation agendas in NHS Scotland, partnership arrangements at the regional/board level will inevitably be changing accordingly. Therefore, the third aim of this thesis is to explore how partnership arrangements have evolved over time in the three health boards.

This chapter begins by exploring the changes in partnership structures in the three health boards. It then goes to analyse the changes in the scope of partnership agendas in each of these boards. This is followed by examining the changes in participants' voice in the three APFs. After that, it analyses the changes in the behaviour patterns of the three APFs and changes in different participants' behaviours. The final section summarises the main findings in this chapter.

### **6.2 Changes in Partnership Structure**

Partnership structures in NHS Scotland have undergone significant changes over the past decade (Scottish Executive, 2004). At the national level, for example, a new partnership agreement was signed in 2006 that led to the reconstitution of the SPF and the establishment of new organisations like SWAG (Scottish Executive, 2006). In the meantime, there was also a requirement for NHS boards to propagate partnership arrangements to the newly established CHPs. It was in this context that all of the three case organisations have experienced significant structural changes during the research period.

### 6.2.1 NHS Highland

Discussions on partnership structure changes prevailed to be a continuing item in the NHS Highland APF, not only driven by the national context, but also stimulated by members of the Forum who shared a common view that the Forum needed to change in order to adapt to the changing environment.

From Feb 2005 to Oct 2009, two significant changes had occurred to the NHS Highland APF. The first restructuring occurred in March 2006 when the APF signed off a new revised Partnership Agreement that aimed to make a progress on embedding formal partnership structures to the local/CHP level. It is noted that before the revised Partnership Agreement signed off, there was a lack of partnership working at the local/CHP level within the CHPs in NHS Highland. As the Employee Director stated:

*“..., business units such as CHPs and SSU had, in general, only been able to have short discussions on staff.” (Employee Director, NHS Highland)*

Complying with the updated Staff Governance Standard published in 2004<sup>5</sup> which requires establishing support structures within CHPs and SSU for the APF, NHS Highland board has started an early consultation within the APF since March 2005. Attitudes on establishing new partnership organizations at the local/regional level were polarised between the staff and some CHP managers. On the one hand, the staff preferred to choose a model of establishing a formal forum at the local/CHP level, for example, a Local Partnership Forum for each business unit. On the other hand, some general managers of CHPs and Special Support Unit (SSU) were concerned about setting up additional forums. Managers argued that not all CHPs or SSU have

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<sup>5</sup> The second edition of Staff Governance Standard for NHS Scotland Employees was published in August 2004 which required that each CHP must have a Staff Partnership Forum in accordance with local structures.

substantial items on staff governance on their agendas and as such there is no need to have a formal forum in their CHPs.

In order to make progress on this issue, the HR Director and Employee Director proposed to hold a special meeting for relevant CHP managers and staff representatives to discuss possible solutions. Many senior managers have expressed their positive opinions on setting up partnership infrastructure and arrangements within the CHPs and SSU, with the spirit that substructures would best allow resolution of local issues within CHPs and SSU. For example, as the HR Director stated:

*“... the principle of partnership working would be key in helping to set the context of ‘Delivering for Health’ the Kerr Report that had been published earlier that year, especially in operational areas of the organisation, ..., there was a need to reinforce the idea that partnership working was crucial to Benefits Realisation, Staff Governance etc.” (HR Director, NHS Highland)*

On 23 January 2006, a special meeting was held with the main goal to imbed Staff Governance in the SSU and CHP areas, which eventually led to the formation of a substructure of the APF at the local/CHP level. There were 46 attendees in the meeting including representatives from the SEHD Partnership Support Unit, the non-executive members of the NHS Highland board who were also Chairs of CHPs, members of the Staff Governance Committee, general and assistant managers of CHPs, the board Director of Nursing and representatives from the APF. It is noted that, among the six business units in NHS Highland<sup>6</sup>, the original partnership infrastructure

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<sup>6</sup>The six business units in NHS Highland include four CHPs (North Highland CHP, Mid Highland CHP, South East Highland CHP and Argyll & Bute CHP), New Craigs Psychiatric Hospital and Special Support Unit (SSU).

and working arrangements were quite different. This special meeting has resulted in great progress in embedding partnership substructures within some business units, including the New Craigs Psychiatric Hospital, the Argyll and Bute CHP, the South East Highland CHP and the North Highland CHP. There has already been Local Partnership Forums in the New Craigs Psychiatric Hospital and Argyll and Bute CHP before the workshop, and general managers from these two units assured that the partnership arrangements would continue to work. Significant progress was achieved in the South East Highland CHP and North Highland CHP after the special meeting, as general managers from these CHPs promised to establish a Local Partnership Forum in their CHPs and request appointed local representatives to sit on the Forums. The new Forums would meet bi-monthly and would be populated by managers and staff representatives from the areas concerned.

However, managers from the SSU and Mid Highland CHP still rejected to build a new partnership forum in their units. They expressed that there was no appetite for another forum to be established. Furthermore, they suggested that an integrated approach would be a more appropriate way forward given the Staff Governance formed a standard item on all area agendas.

The second profound change of the NHS Highland APF occurred in 2008 when the Employee Director found that the Forum was losing interest in middle level managers and many managers chose not to attend the APF. The problem was then raised by the employee director in May 2007, which eventually led to the restructuring of the APF in 2008. It is noted that, full consultation including the Chief Executive, HR Director, Employee Director, as well as management and union representatives had been taken place before the restructuring. The Forum has held several meetings to discuss why the APF was losing interest in managers.

On the matter of attendance, concerns were expressed by the staff and the management team. Some key issues were relating to strategic matter consideration, the frequency of meetings and shared agendas. Representatives stated that there was a lack of consideration of more strategic issues in the forum and managers felt that there was no need to join the forum. Generally, the APF could be seen as a body that rubber-stamped matters rather than a decision-making body that may affect attendance accordingly. Furthermore, managers expressed the view that there was duplication of agenda items through the APF, Pay Modernisation and Workforce Planning Board (PM&WPB) and Staff Governance Committee agendas on workforce planning. They were confused as to the role of the APF and its authority to make decisions, and to managers they sometimes found it difficult to see this having an effect at the operational level. In addition, sheer number of meetings was also an issue that may affect the attendance level, as the slow responding speed cannot be adapted to the fast changing organizational environment. Therefore, as proposed by the Employee Director, there was a need to reconsider the role, remit, responsibility and membership of the forum. This point was positively echoed by the HR Director and Chief Executive. As the Chief Executive stated:

*“... management would require to consider this point further with a view to there being established a small, consistent group...” (Chief Executive, NHS Highland)*

In November 2007, after assessing the functionality of both the APF and the PM&WPB, the NHS Highland board approved the proposal to merge the APF and PM&WPB into one forum called the Highland Partnership Forum. The new Forum would meet on 10 times per year, with the agenda linked to issues under consideration by the NHS Highland board which also met on the basis of alternate

strategy/performance meetings. With regard to membership, both the staff and the management team are obliged to encourage an appropriate membership that are able to fully contribute to any discussion as well as being empowered to make any decisions where required. Subsequently, the APF approved the changes to the terms of reference related to the role, remit and membership of the Forum in April 2008.

Based on the discussion above, it is therefore useful to divide the history of the NHS Highland APF into two main periods: Feb 2005-Nov 2007 and Jan 2008-Oct 2009 which was before and after the restructuring of the Forum.

Fig 6-1 shows the composition of the Forum in those two periods. It is noted that proportion of management-side attendees in the APF had decreased from 51% to 49% after the Forum was restructured. In the meantime, the proportion of senior managers had also declined from 12% to 11%. In contrast, more trade union representatives attended the APF meetings after Jan 2008, given that proportion of staff attendees had increased from 32% to 37%.

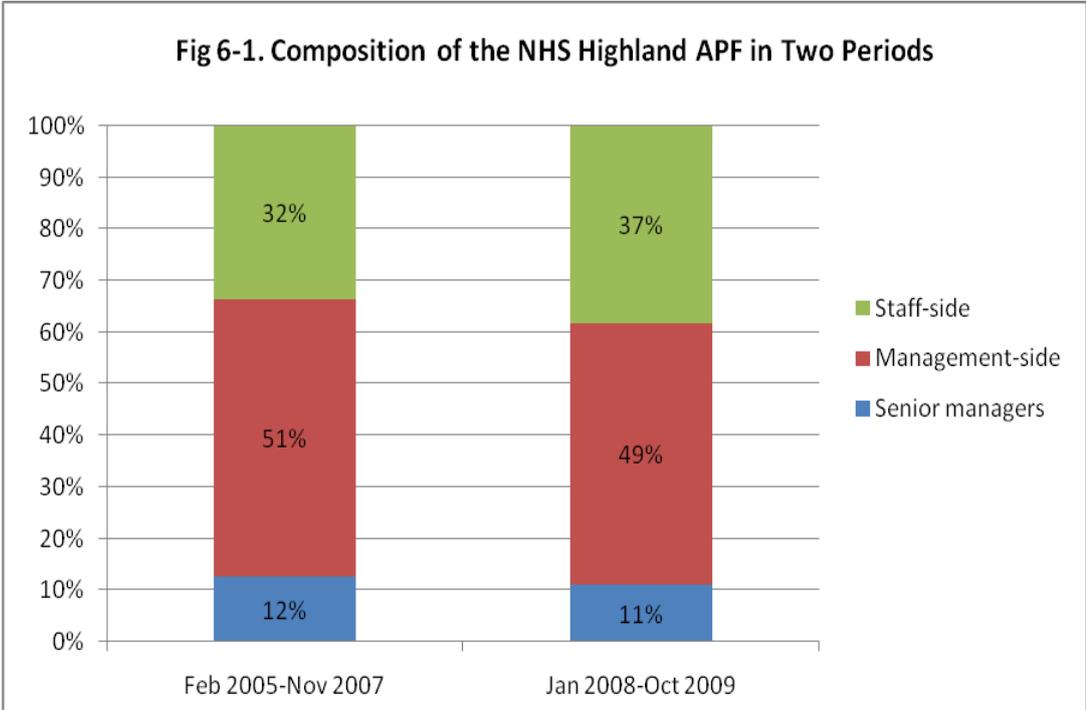


Table 6-1 indicates details about the changes in the composition of the APF each year. The proportion of senior managers increased from 11% to 15% but sharply declined to 9% in 2009. It is also very important to note that even though the number of senior managers in the Forum had decreased, involvement of some key participants in the Forum had increased. For example, from Feb 2005 to Dec 2007, the Chief Executive attended 10 meetings out of a total of 17. While from Jan 2008 to Sep 2009, 17 meetings were held in total, and the Chief Executive attended 13 meetings.

It is noted that proportion of management-side attendees in the Forum had started to decline since 2005, and then remained stable after 2008. Particularly, the proportion of management representatives declined from 37% in 2006 to 27% in 2007, supporting the reality that the APF was losing middle managers' interest before restructuring in 2008. However, the proportion of HR managers remained very stable in the Forum from 2006 to 2009, reflecting a consistent interest of HR managers involving in the APF. The proportion of staff representatives has significantly increased after the restructuring and remained stable since then, suggesting a broader involvement of trade union representatives in the APF.

**Table 6-1. Proportion of attendees by Groups in NHS Highland APF from Feb 2005 to Oct 2009**

<b>Groups</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Senior managers	11%	11%	15%	12%	9%
Management Reps	34%	37%	27%	33%	31%
HR managers	23%	15%	18%	17%	17%
Staff Reps	29%	32%	37%	37%	36%
Average attendees per meeting	22	26	20	21	22

In brief, the data analysis above indicates that the membership of the NHS Highland Forum tends to remain stable, involving more trade union representatives and it is

forming a style of a smaller number of regular attendees after restructuring in 2008, as the Chief Executive suggested.

### **6.2.2 NHS GG&C**

From 2003 to 2009, the organisation structure of NHS GG&C had undergone significant changes according to the national guidance. It was well recognised by the members that there was a need for the partnership structure to be changed in order to adapt to the changing organisational structure.

Discussions on the issue of restructuring APF in NHS GG&C have started since 2003. Key aspects included the involvement of APF in strategic matters, the membership of APF and agendas in the Forum. For example, an away day was held on 9th April 2003. The aim of the event was to bring the APF to a “level playing field”, with the object of engaging with the NHS GG&C board in a more effective way. It was suggested that partnership engagement should occur at strategic level in important issues, for instance, the Greater Glasgow response to the national policy consultations and the Acute Service Review. As the Employee Director stated:

*“... this has been a positive start to building partnership within the new structures, ... the APF had tended to be rather process oriented in the past, but it now require to be much more focussed on the key strategic issues including, for example, national and local health policies, corporate delivery, human resource policy development and associated matters.”*

*(Employee Director, NHS GG&C)*

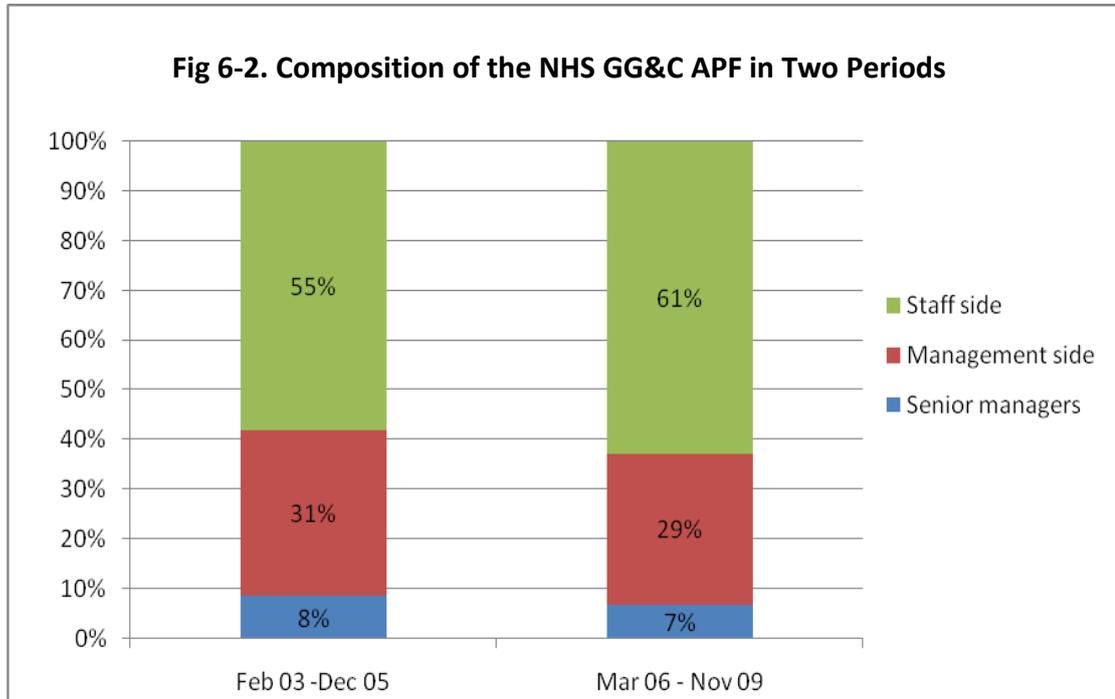
In terms of the membership, it was recognised that several members had not attended the meetings for some time and there was also a need to refresh the membership of the APF, as there had been changes since the Forum’s inception. On the meeting held on 5th Feb 2004, the staff representatives proposed that the constitution of the APF

should be amended to show that staff partner membership of the Forum would include two representatives from each Local Partnership Forum, one representative from each trade union/professional organisation, and specially, two representatives from Unison. The response from management-side was positive in principle.

On 23<sup>rd</sup> January 2006, a special APF meeting was arranged in NHS GG&C APF with the aim to jointly develop a structure to enable partnership work to be taken forward in the reformed NHS GG&C, recognising the impact of the dissolution and integration of NHS Argyll and Clyde. It was agreed in the special meeting that the remit of the new Forum in the future would focus on involvement with the development of the board's strategy and associated delivery plans as well as overseeing the development and implementation of system-wide human resources policies and matters. In terms of membership and agenda, it was agreed that the new APF would meet on 4 occasions per year to discuss strategic matters, 5-6 times per year on HR development and other operational issues; the restructured Forum would be supported by a formal secretariat of two senior managers and two senior trades union representatives; and the APF would host an annual partnership conference. All these proposals were finally stated in the new Partnership Agreement that was subsequently signed off by the Chief Executive and Employee Director in March 2006. It is noted that there was no evidence suggesting that development of partnership in NHS GG&C had been confronting resistance from middle/front-line managers, as both of the management team and trade unions shared the view that "this has been a positive start to rebuilding partnership within the new structures".

Broadly speaking, the history of NHS GG&C APF can be divided into two main periods: Feb 2003-Dec 2005, the period before the Forum was restructured and Mar 2006 - Nov 2009, the period after the restructuring of the Forum.

Data in Fig 6-2 indicates the composition of the APF in NHS GG&C before and after the restructuring. It can be noted that the proportion of staff representatives in the APF had significantly increased after restructuring, accounting for 61% of the overall attendees.



It is important to note that the seats by senior managers in the Forum decreased from 9% in 2003 to 5% in 2007 (see Table 6-2). The consistency of senior managers' involvement in the Forum appeared to be an issue after it was restructured. For example, 17 meetings were held between the period of Dec 2002 to Dec 2005 before the restructuring of the Forum, and the Chief Executive has attended every meeting. However, after the Forum was restructured, from Mar 2006 to Nov 2009, the Chief Executive has only attended 16 meetings out of a total of 33 meetings. This is mainly because meetings in the Forum were divided between those that dealt with strategic issues and those that dealt with workforce and general employment issues after restructuring, and the Chief Executive and other senior managers missed most of the latter ones. In the meantime, unlike its counterparts in NHS Highland where the

format of meetings of APF was evolving towards a small group style with consistently involvement by regular members, the APF in NHS GG&C has enlarged the scale of the Forum as more participants became involved in the Forum. As indicated in Table 6-2, the average number of attendees in the Forum had significantly increased from 19 in 2005 to 30 in 2006, and remained at the higher level in the subsequent years.

Staff-side was the biggest party in the Forum, predominating most of the seats in the forum all over the time. From 2003 to 2005, the proportion of staff-side attendees in the APF had increased from 51% to 61%, and remained stable in the following years. The increase of staff-side partners in the Forum in the early years was mainly because Unison and BMA were invited to be members in the Forum in 2003/4.

In contrast, the proportion of management-side attendees in the Forum had reduced from 35% in 2003 to 24% in 2005. After a slight rebound, it remained relatively stable in the subsequent years. On the management-side, it is also noted that HR managers had more seats than other management representatives, reflecting the tendency of the Forum to resolve workforce and HR-related issues.

**Table 6-2. Proportion of Attendees by Groups in the NHS GG&C APF  
from Feb 2003 to Nov 2009**

<b>Groups</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Senior managers	9%	7%	8%	8%	5%	6%	9%
Management reps	7%	11%	7%	12%	10%	12%	7%
HR managers	28%	22%	17%	17%	19%	19%	21%
Staff reps	51%	54%	61%	60%	63%	60%	60%
Average attendees per meeting	21	24	19	30	27	29	27

### 6.2.3 NHS Borders

In NHS Borders, the staff representatives were generally very active in promoting partnership working within the organisation, especially the Employee Director. Yet it seemed that the management-side has no enthusiasm in building the partnership relationship with trade unions. For example, on 6<sup>th</sup> Jan 2004, an extraordinary meeting was held in the Forum with the aim to discuss the future of partnership working. However, responses from the management-side were very passive and managers showed no interest in building long-term partnership relationships with trade unions. Subsequently, the Forum held another meeting which involved the four general managers of Clinical Boards<sup>7</sup> in the discussion. The main theme of the meeting was to consult the Clinical Boards about how they would take forward partnership working within their organisations. Again, the Forum only received comments from one Clinical Board, and replies from the other three Clinical Boards were that they were confused about the consultation and did not understand what was expected from them. Again, in the meeting held in March 2004, the Employee Director put forward a new proposal referring to the new role, function and membership of the APF. However, no agreement was achieved. Managers felt that the APF was not well organised and had no effect on the daily operations, and therefore, there was no need to join the APF. As one of the management representatives stated that:

*“... partnership working is not only a management issue, it is a holistic issue. We have not succeeded in getting it out to the organisation.” (HR manager, NHS Borders)*

The development of partnership was therefore stuck at this stage, and no progress had been made until the end of 2006 when the Chief Executive felt that “the APF

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<sup>7</sup> There are four Clinical Boards in NHS Borders covering Acute, Primary and Community Services, Mental Health Services, and Learning Disability Services.

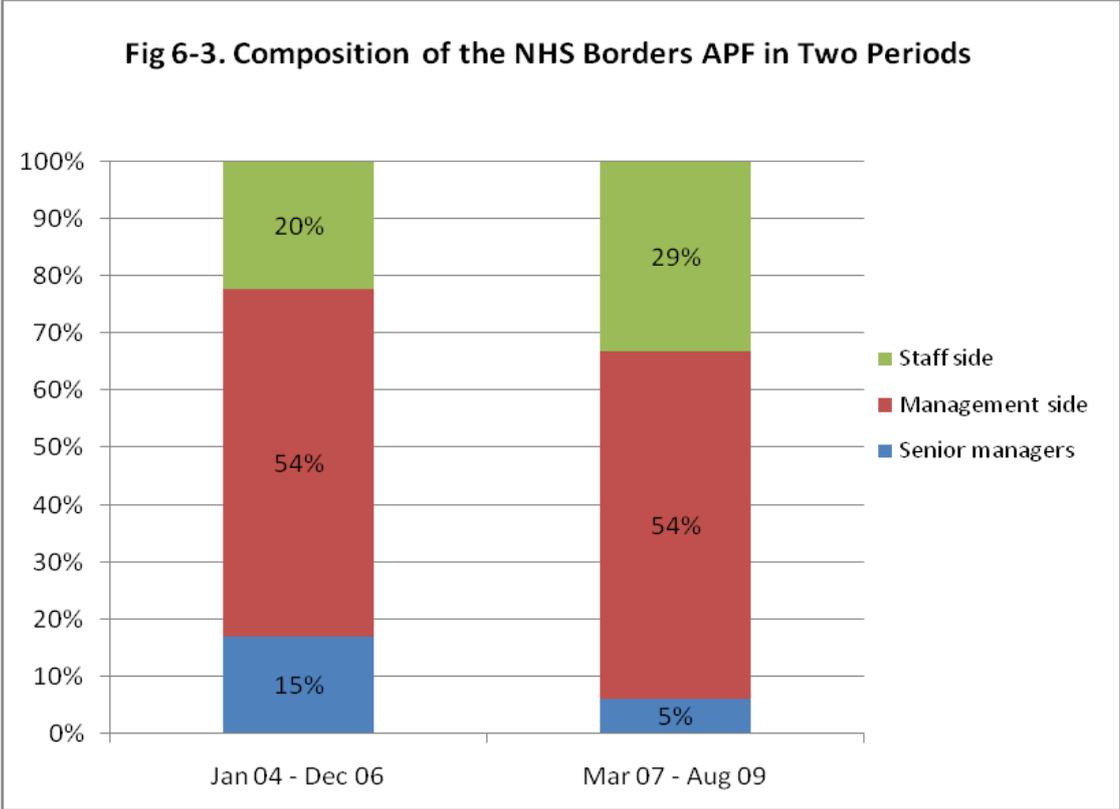
requires to be active". On 1<sup>st</sup> Dec 2006, the Chief Executive of NHS Borders called for a special discussion regarding the development of the APF. This meeting finally led to a consensus on a new Partnership Agreement and Terms of Reference. With support from the Chief Executive, the Forum then imitated the partnership model of NHS Arran & Ayrshire, abandoning the original plan proposed by the Employee Director. The new Agreement clearly defined the role and functions of Staff Governance Committee, HR Forum and APF. The role of Staff Governance Committee is to ensure that the Staff Governance Standards are adhered too. The HR Forum would be an ad-hoc and a negotiating committee. As for APF, it is to monitor the Staff Governance Committee and it is the place where business is done and where HR policies are approved. In terms of membership, it was expected that there would be an equal representation from the management and staff sides within the APF group.

It therefore suggests that the history of NHS Borders APF can be divided into two main periods: from Jan 2004 to Dec 2006 before the Forum is restructured; and from Mar 2007 to Aug 2009 after restructuring of the Forum.

It was noted that significant changes has occurred to the Forum after restructuring. As Fig 6-3 indicates, the proportion of staff-side attendees increased from 20% to 29% after restructuring, suggesting that more trade union representatives were involved in the APF. In detail, the proportion of staff-side attendees in the Forum had increased since 2005, and went up more rapidly since 2007. In 2008, one-third of the participants (34%) in the Forum were trade union representatives (see Table 6-3).

The proportion of management-side attendees in the APF remained stable before and after restructuring. Although the proportion of representatives from the management-side in the APF had slightly declined after the restructuring, they accounted for more than half of the overall attendees in the Forum over the time.

However, it is observed that that the APF was losing senior managers' interest after the restructuring, as the proportion of senior managers dramatically declined from 15% to 5%. Basically, the proportion of senior managers in the Forum had significantly declined since 2006, and remained at a very low level after the Forum was restructured (see Table 6-3). From Jan 2004 to Dec 2006, the Forum was co-chaired by the Employee Director and the Chairman of the Board. There were 11 meetings in total and the Chairman attended 7 of them. After the Forum was restructured in 2007, the Forum was then co-chaired by the Employee Director and the Chief Executive. There were 15 meetings by Aug 2009, and the Chief Executive attended 8 of them.



**Table 6-3. Proportion of Attendees by Groups in the NHS Borders APF  
from Jan 2004 to Aug 2009**

<b>Groups</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Senior managers	19%	6%	18%	3%	5%	8%
Management Representatives	34%	45%	37%	40%	35%	39%
HR managers	17%	21%	12%	19%	15%	15%
Staff-side	19%	18%	22%	25%	34%	26%
Average attendees per meeting	12	11	13	18	21	24

It is also noted that size of the Forum had significantly expanded since restructuring, almost doubling from an average of 13 participants in 2006 to an average of 24 participants in 2009, suggesting that although the objective of reaching an equal representation of the management and staff sides within the APF group has yet to be realised, the Forum was evidently evolving towards a better structured forum where broader participants were involved.

#### **6.2.4 Three Cases Compared**

In summary, the above analysis indicates that in the context of national guidance and local needs, all of the three NHS boards have undergone structural changes. There are many similarities and differences regarding the restructuring process. The first similarity concerns the external context that impacts on the APF restructuring. It is noted that all the three boards have received national instructions with regard to APF restructuring. This provides a similar external context for all the three boards in facilitating APF restructuring. The second similarity was the proportion of staff representatives has increased in all the three APFs since restructuring, reflecting the APFs were evolving towards involving a broader participation.

However, there were several important differences between the three health boards. Although the evolution trajectory of partnership forums of the three boards was quite

similar, the above analysis also suggests that different parties' attitudes in each APF towards restructuring were different. In NHS Highland, the development of partnership arrangements continued to be a prevailing issue in the Forum. There was a shared commitment from both senior managers and trade union representatives to further develop partnership relationships. Although the Forum has confronted resistance from a few middle-level managers when new partnership structures were established in the new CHPs, managers and trade union representatives have worked together to address the issue successfully. Within NHS GG&C senior managers were also committed to the partnership working with trade unions. There were no obstructions to the development of APF due to strong union power in NHS GG&C, indicating the importance of trade union power in facilitating partnership development. In contrast, the development of partnership has confronted with strong resistance from many middle-level managers in NHS Borders. The issue was eventually intervened by the Chief Executive. Secondly, although full consultations have been conducted in all the three health boards with trade union representatives involved in a very early stage, discussions in NHS Highland and NHS GG&C have a clear understanding of the problems and expectations from structural change. In addition, it is noted that in the two APFs, the Chief Executives attended the discussion from the beginning, whereas within the NHS Borders, the Chief Executive attended the discussion only at a later stage and the main motive for managers to facilitate structural change was to respond to the national instruction.

### **6.3 Changes in Partnership Agendas**

Some previous empirical studies on NHS England have indicated that the partnership agendas in local joint consultation committees were largely shaped by the concerns of HR departments and that national policy priorities have limited the discretion of local

committees and placed constraints on trade union involvement in the workplace (Bach, 2004; Tailby et al., 2004). In the period of conducting this research, a series of policies embraced in the modernisation agenda were launched in NHS Scotland, for example, the Agenda for Change. The implementation of these policies required cooperation from trade unions through partnership working which implies that it may provide great opportunities for trade unions to exert more influence on traditional management domain or it may place constraint union involvement in the workplace issues as some commentators argued. To address this question, this section will therefore examine the changes that had occurred to the scope of partnership agendas that trade unions have engaged in the three health boards.

### **6.3.1 NHS Highland**

As indicated in Section 6.2.1, a central aim of partnership restructuring in NHS Highland APF was to engage trade union partners in more strategic issues in an early stage. The data in Fig 6-4 suggests that the NHS Highland APF has succeeded in achieving this objective. Based on a five-year record, the percentage of strategic issues concerning Modernisation and Workforce Planning and Development in the agendas was doubled. For instance, discussions on the issue of modernisation had increased from 16% in 2005 to 31% in 2009 (see Table 6-4). It is noted that the issue of modernisation remained as a high profile in the APF of NHS Highland through the five years, accounting for 22% of the total discussions. However, it is also noted that the percentage declined to 12% in 2007, but sharply increased after the restructuring in 2008. Discussions on the issue of workforce planning and development had doubled from 11% in 2005 to 22% in 2007, and the percentage remained very stable in the following years. It reflects the success of the strategy to restructure the Forum in 2008, as the aim of the restructuring was to merge the APF and Pay Modernisation and

Workforce Planning Board into one forum so that more focus would be placed on strategic issues.

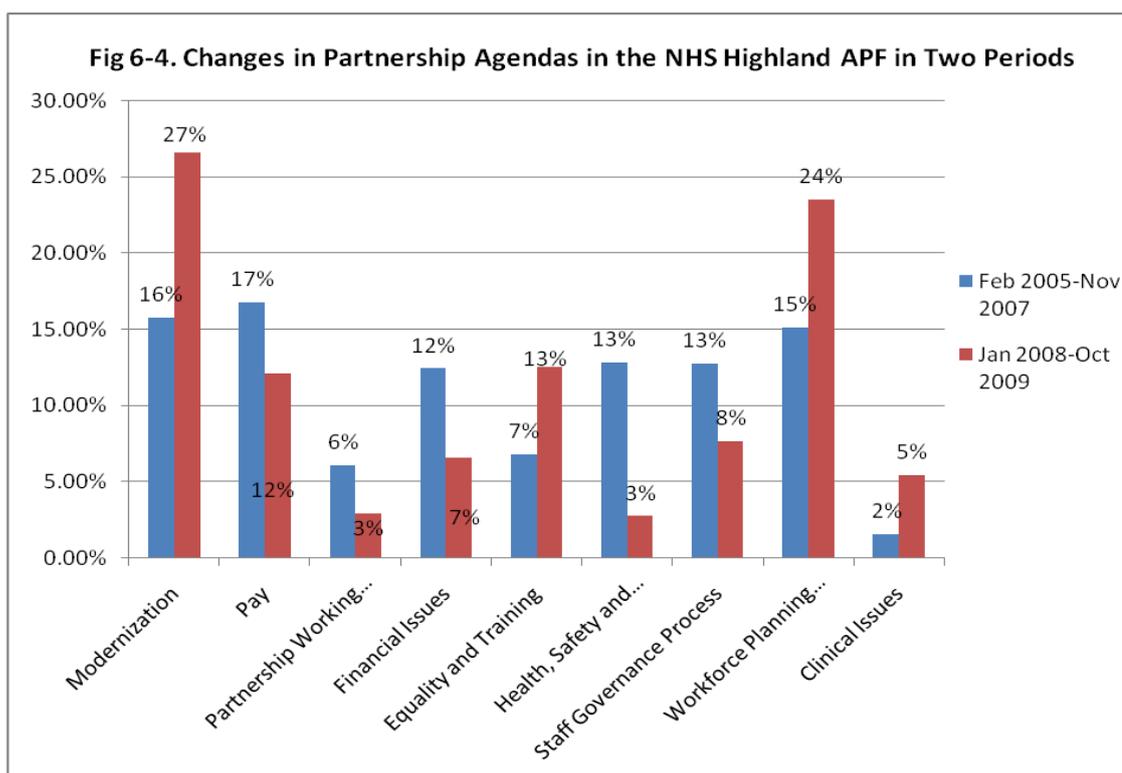
In addition, the frequency of discussions on the issue of Equality and Training had also doubled from 7% in 2005 to 18% in 2009. However, it is important to note that the significant changes only occurred in 2009. While in most of the other years, the percentages of discussions on this issue were relatively low.

There was a significant increase in the frequency of discussions on clinical issues which increased ten-fold from 1% in 2005 to 7% in 2009. It is also important to note that there is an increasing trend on the discussion of this issue.

The data also reveals a clear declining trend on the discussion of some other issues. For example, the forum halved its attention on the issues related to Pay and Staff Governance Process. In detail, discussions on the issue of pay decreased from 22% in 2005 to 10% in 2009, and discussions on issues related to the staff governance process decreased from 12% in 2005 to 6% in 2009.

In addition, discussions on financial Issues and partnership working and the Forum had significantly declined. The percentage of partnership forum meetings dealing with financial Issues acutely decreased from 17% in 2005 to 2% in 2009. The Director of Finance in NHS Highland only attended the forum twice in 2009, comparing to 5 times in 2008. Discussions on the issue of partnership working and the Forum declined from 10% in 2005 to 1% in 2009.

The annual percentage of discussions on the issue of health, safety and well-being has followed an irregular pattern. Discussions on this issue significantly increased from 4% in 2005 to 19% in 2006 and remained at 15% in 2007, however, the figure declined to 5% in 2009.



**Table 6-4. Percentage of Discussions by Issues in the NHS Highland APF from Feb 2005 to Oct 2009 (words count, column %)**

	Issue as a % of all discussions in 2005	Issue as a % of all discussions in 2006	Issue as a % of all discussions in 2007	Issue as a % of all discussions in 2008	Issue as a % of all discussions in 2009
Modernisation	16%	20%	12%	23%	31%
Pay	22%	11%	17%	14%	10%
Partnership Working and the Forum	10%	5%	3%	4%	1%
Financial Issues	17%	13%	7%	11%	2%
Equality and Training	7%	1%	12%	8%	18%
Health, Safety and Well-being	4%	19%	15%	1%	5%
Staff Governance Process	12%	17%	9%	9%	6%
Workforce Planning and Development	11%	13%	22%	26%	20%
Clinical Issues	1%	1%	3%	4%	7%

### **6.3.2 NHS GG&C**

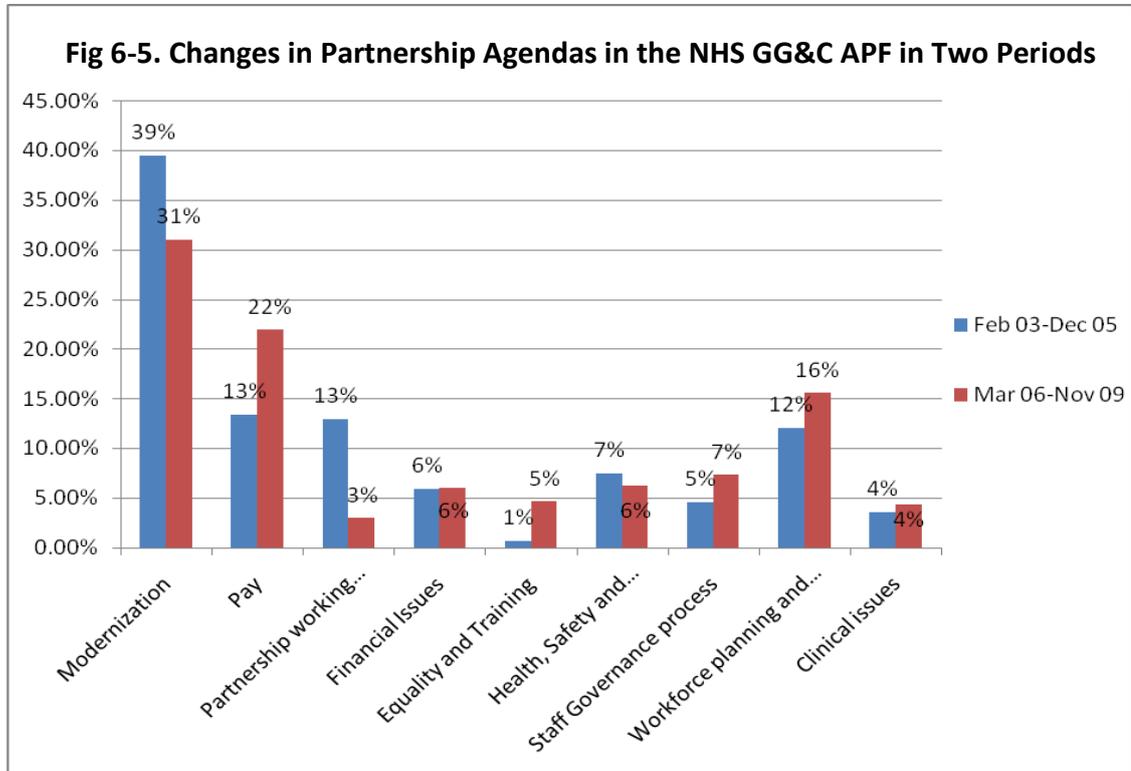
As the data in Fig 6-5 reveals, the NHS GG&C APF has a strong focus on the issues of Modernization, Pay, Workforce Planning and Development before and after restructuring. These three broad issues were regularly discussed in the Forum throughout the period which account for nearly four-fifths (78%) of the total number of discussions in 2009. In detail, Modernisation was the most prevalent topic in the Forum. It is noted that more than two-fifths of discussions in the Forum were about Modernisation from 2004 to 2006. In addition, the Forum doubled its discussion on the issues of Pay and Workforce Planning from 2003 to 2009 (see Table 6-5). Discussions on Pay increased from 14% in 2003 to 24% in 2009 and discussions on Workforce Planning increased from 16% in 2003 to 30% in 2009. However, it is important to note that there were nearly no discussions on the issue of Workforce Planning and Development in 2005 and 2006.

There is an obvious declining trend on the discussions of Partnership Working and the Forum. As the data in Table 6-5 indicates, the issue of Partnership Working and the Forum, which was the second most popular topic during that year from 2003 to 2005, accounts for 17% of the total number of discussions in 2005. However, 2006 saw the turning point after the restructuring and discussions on this issue faded out in the later years, with the percentage finally declined to 2% in 2009.

The Financial Issues and Staff Governance Process were regularly raised in the Forum. However, these issues were not included in the main agenda of the Forum. The Forum has an increasing trend on the discussion of Equality and Training, although the percentage still remained relatively low.

Some issues were discussed more often in particular years, for example, the issue of Health, Safety and Well-being was raised more frequently in 2003 (16%) and 2008

(14%). However, the percentage of discussions on this issue remained relatively low in other years. The clinical Issues are one of the least frequently discussed issues in the Forum which were basically not discussed in the APF in 2004 and 2007.



**Table 6-5. Percentage of Discussions by Issues in the NHS GG&C APF from Dec 2002 to Nov 2009 (words count, column %)**

	<b>Issue as a % of all discussions in Dec 2002</b>	<b>Issue as a % of all discussions in 2003</b>	<b>Issue as a % of all discussions in 2004</b>	<b>Issue as a % of all discussions in 2005</b>	<b>Issue as a % of all discussions in 2006</b>	<b>Issue as a % of all discussions in 2007</b>	<b>Issue as a % of all discussions in 2008</b>	<b>Issue as a % of all discussions in 2009</b>
Modernisation	28%	27%	43%	49%	48%	25%	31%	24%
Pay	44%	14%	15%	11%	17%	31%	14%	24%
Partnership Working and the Forum	5%	11%	11%	17%	5%	2%	3%	2%
Financial Issues	0	8%	2%	7%	13%	9%	0%	3%
Equality and Training	0	1%	1%	0	3%	6%	6%	3%
Health, Safety and Well- being	0	16%	1%	5%	2%	4%	14%	4%
Staff Governance Process	0	3%	9%	1%	6%	10%	7%	6%
Workforce Planning and Development	0	16%	17%	3%	2%	12%	16%	30%
Clinical Issues	23%	4%	0	7%	4%	0	9%	5%

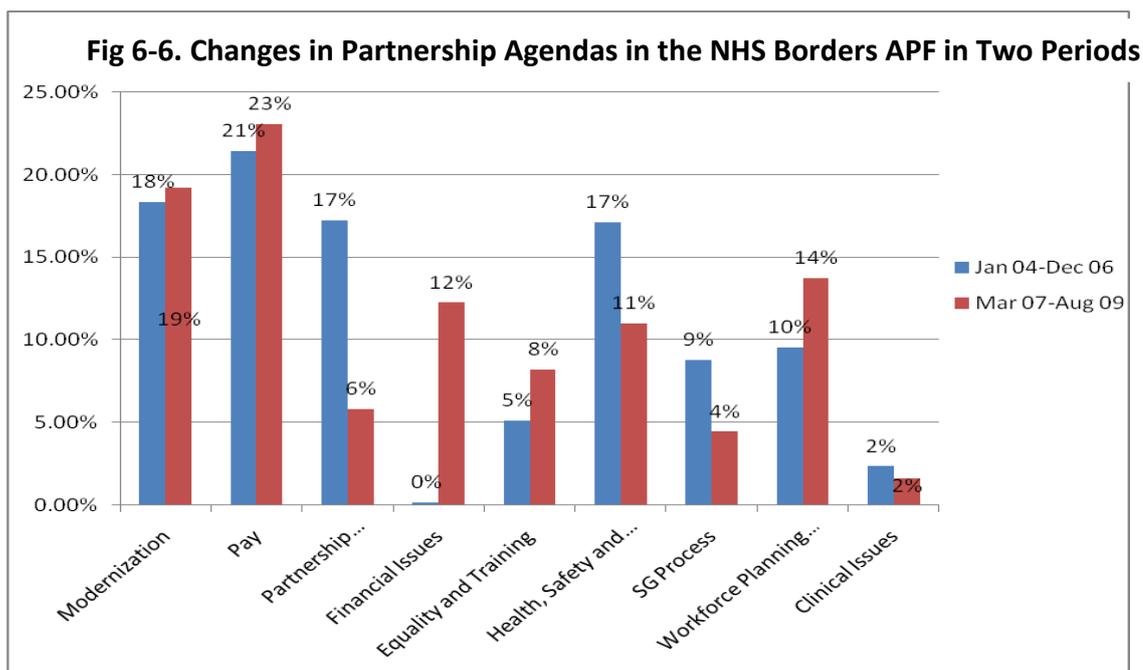
### 6.3.3 NHS Borders

Data in Fig 6-6 compares the changes to partnership agendas in NHS Borders APF before and after restructuring. It is noted that there was no significant changes in strategic issues concerning Modernisation and Workforce Planning, which were regularly discussed in the Forum and the figures remained stable. The data suggests that the issue of Modernisation was particularly stressed in 2005, accounting for 47% of the overall discussions in that year (see Table 6-6). However, the figure declined in the following year, only accounting for 7% in 2006. In other years, it remained a high profile issue in the Forum. Discussions on the issue of Workforce Planning and Development significantly increased from 4% in 2004 to 15% in 2005, and remained a regular issue in the Forum.

The issues of Pay and Health, Safety and Wellbeing comprised a main agenda in the Forum. Discussions on Pay remained stable throughout the years except for the year of 2005 when the percentage sharply declined to 6%. Discussions on Health, Safety and Well-being declined from 19% in 2004 to 6% in 2007. However, it returned to the average level in 2008 and 2009 (see Table 6-6).

It is important to note that the Financial Issues were not on the partnership agenda before 2007. However, they had been given more attention by the Forum since 2007. Discussions doubled from 8% in 2007 to 20% in 2009.

Similar to NHS Highland and NHS GG&C, a decreasing trend on the discussion of Partnership Working and the Forum in NHS Borders was observed, which declined from 223% in 2004 to 2% in 2009. The issue of Staff Governance Process was particularly discussed in 2005, 2006 and 2009 but not much discussion in the Forum was observed in other years. Clinical issues were least discussed in the Forum, with no significant changes observed throughout the years.



**Table 6-6. Percentage of Discussions by Issues in the NHS Borders APF from Jan 2004 to Aug 2009 (words count, column %)**

	Issue as a % of all discussions in 2004	Issue as a % of all discussions in 2005	Issue as a % of all discussions in 2006	Issue as a % of all discussions in 2007	Issue as a % of all discussions in 2008	Issue as a % of all discussions in 2009
Modernisation	19%	47%	7%	27%	15%	20%
Pay	22%	6%	26%	22%	26%	16%
Partnership Working and the Forum	23%	0%	18%	13%	3%	2%
Financial Issues	0%	0%	0%	8%	13%	20%
Equality and Training	4%	4%	7%	10%	8%	6%
Health, Safety and Well-being	19%	17%	15%	6%	14%	13%
Staff Governance Process	6%	11%	11%	2%	4%	11%
Workforce Planning and Development	4%	15%	13%	12%	15%	13%
Clinical Issues	4%	1%	1%	1%	2%	0%

### 6.3.4 Three Cases Compared

By comparison, the restructuring has different effects on each health board. In NHS Highland, a central aim of the restructuring of partnership arrangements was to make

the Forum more strategically focused. It is noted that strategic issues like Modernisation and Workforce Planning have been given more attention in the NHS Highland APF, reflecting the success of restructuring.

In NHS GG&C, one aim of restructuring was to re-define the meetings and subject the APF to discuss different kinds of issues, for example, distributing one meeting focus on strategic issues with the other meetings focusing on operational issues. The results suggest that the restructuring was also successful, and there was a slight increase in the discussion of operational issues.

In NHS Borders the restructuring was predominately driven by management needs to respond to national instruction. The APF has no clear expectations from the restructuring. As a result, there were no significant changes to partnership agendas after it. Perhaps one point worth mentioning here is that the scope of partnership agendas in NHS Borders has been broadened, as financial issues were put on the partnership agendas after restructuring, reflecting the influence of a tightening financial environment on the operation of partnership.

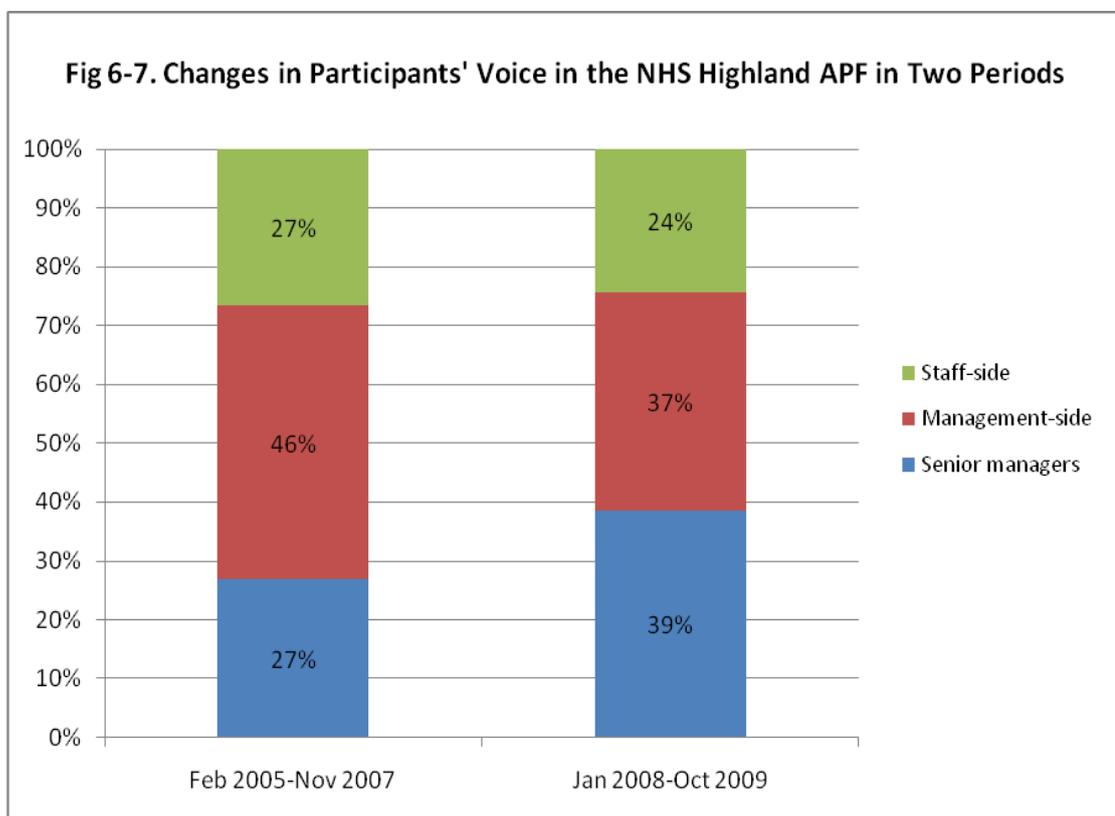
There is no evidence to suggest that the partnership agendas in the APFs were largely shaped by the concerns of HR departments, as other commentators indicated (Bach, 2004). The HR managers had formed a key group and regularly attended the three forums, but they could not shape the partnership agendas or dominate the discussions. However, it echoes with the point that national policy priorities have limited the discretion of local committees (Bach, 2004; Tailby et al., 2004), as many policies included in the modernisation agendas were fixed terms, for example, the Partnership Information Network (PIN) policies. There is no scope for the APFs to influence the policies, but only the manner and style of implementation was open to discussion.

## 6.4 Changes in Participants' Voice

The above two sections have analysed the structure and agenda changes in each APF. Data analysis in section 6.2 has indicated that the proportion of trade union representatives has increased after restructuring in each APF, suggesting a broader involvement of trade unions, and also implying greater voice of trade unions in the Forums. This section will therefore examine changes to different participants' voice in the three APFs.

### 6.4.1 NHS Highland

Fig 6-7 shows the changes in voice for different groups of participants in the NHS Highland APF before and after restructuring. It should be noted that voice by senior managers in the APF significantly increased after restructuring, while voice by the management-side declined, and the proportion of voice by staff representatives remained stable.



In detail, the proportion of voice by senior managers increased from 2005 to 2008, doubling up from 22% in 2006 to 45% in 2008 (see Table 6-7). At the same time the proportion of management-side voice decreased from 52% in 2006 to 32% in 2008. Between the years 2008 and 2009 it is observed that the proportion of voice by senior managers was decreasing, and at the same time management-side voice was increasing. It is also noted that among the management-side, HR managers have a stronger voice than other management representatives in each year.

Although the number of trade union representatives in the APF increased after restructuring, the proportion of voice by the staff representatives in the Forum appears to be stable, hovering at around 25%. It is noted that the Employee Director contributes more voice than other trade union representatives in the Forum.

**Table 6-7. Proportion of Discussions by Groups in the NHS Highland APF from Feb 2005 to Oct 2009 (words count, column %)**

	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Senior Managers	28%	22%	30%	45%	30%
Management Reps	20%	20%	18%	14%	15%
HR Managers	29%	32%	21%	19%	29%
Employee Director	13%	16%	18%	17%	16%
Trade Union Reps	11%	10%	13%	7%	10%

#### **6.4.2 NHS GG&C**

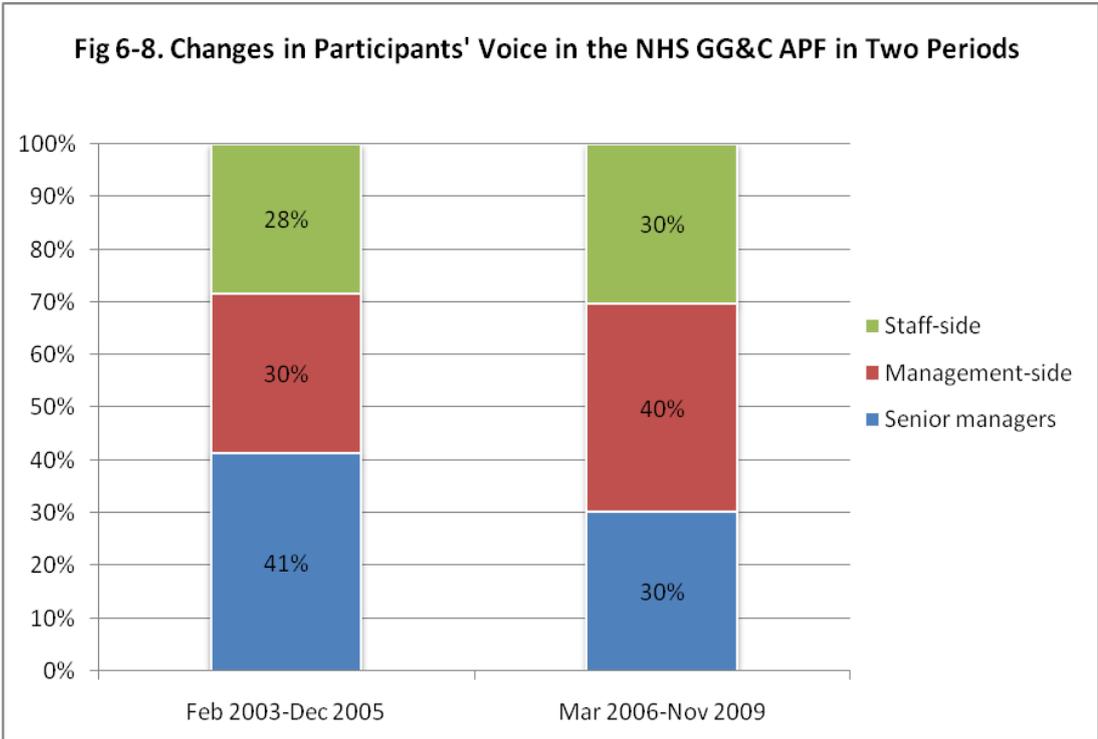
The evolving trajectories with respect to the proportion of voice by actors in NHS GG&C are quite different to its counterpart in NHS Highland. As Fig 6-8 indicates, the proportion of voice by senior managers declined after restructuring. In contrast, voice by management-side increased and voice by staff-side remained stable.

Between the years 2003 and 2006 senior managers had a very strong voice, accounting for almost half of the total discussions in the Forum. However, the

proportion of voice by senior managers acutely declined from 48% in 2006 to 21% in 2007, and had remained stable at a lower level since then (see Table 6-8).

Management-side contributed nearly half of the total discussions in 2003 and 2004, although the proportion declined acutely to 21% in 2005, and voice by senior managers increased in that year. However, the proportion of voice by management-side had increased year by year since the restructuring, and reached 45% in 2009. On average, HR managers had a stronger voice than other management representatives.

Voice by staff-side had increased sharply since 2003 which increased three-fold from 13% in 2003 to 42% in 2008, and remained at 31% in 2009. It is also noted that among the staff-side, most of the contributions were made by trade union representatives. Employee directors' voice in the Forum was relatively weak (see Table 6-8).

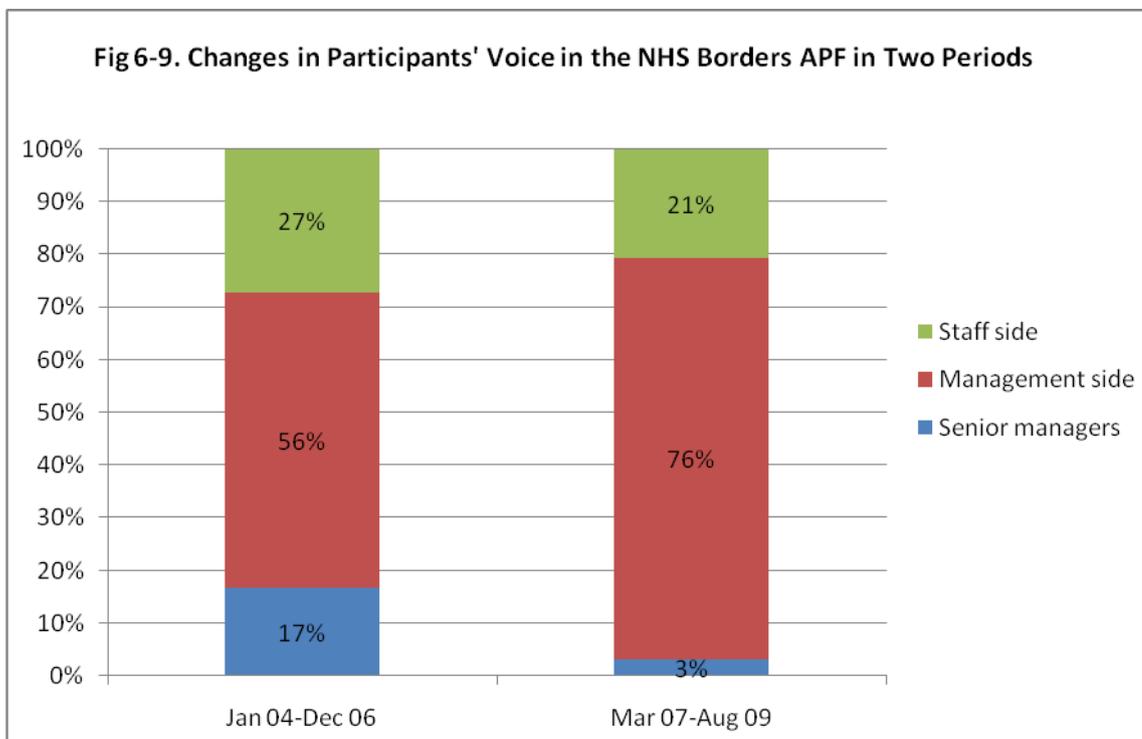


**Table 6-8. Proportion of Discussions by Groups in the NHS GG&C APF from Feb 2003 to Nov 2009 (words count, column %)**

Participants	2003	2004	2005	2006	2007	2008	2009
Senior managers	41%	28%	49%	48%	21%	24%	24%
Management reps	26%	45%	11%	10%	20%	12%	24%
HR managers	19%	5%	11%	18%	30%	22%	21%
Employee Director	7%	0%	11%	6%	11%	1%	4%
Trade union reps	7%	23%	18%	17%	27%	41%	26%

### 6.4.3 NHS Borders

Distribution of voice in the NHS Borders APF was quite different from its counterparts in NHS Highland and NHS GG&C, as management-side dominated discussions in the Forum all of the time. As data in Fig 6-9 indicates, the proportion of voice by both senior managers and staff declined after restructuring, while the proportion of voice by management representatives significantly increased from 56% to 76%, suggesting stronger management control of the APF after restructuring.



It is noted that the proportion of voice by senior managers increased in 2006, reaching 23%. However, this had sharply declined since the Forum was restructured, accounting for only 4% in the second period (see Table 6-9). The NHS Borders APF is predominately a management-led forum, but with senior managers playing a less central role in the discussions. The proportion of voice by management-side reached 73% in 2005, which generally contributed more than half of the total discussions in all of the remaining years. It is also important to note that HR managers' voice was not as strong as its counterparts in NHS Highland and NHS GG&C.

Voice by staff-side declined from 27% to 21% since restructuring. It is also notable that the proportion of voice by trade union representatives was particularly low in 2005 and 2008, and it remained stable in the other years. The Employee Director expressed a stronger voice in the forum than other union representatives.

**Table 6-9. Proportion of Discussions by Groups in the NHS Borders APF from Jan 2004 to Aug 2009 (words count, column %)**

<b>Participants</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Senior managers	156%	3%	23%	0%	4%	5%
Management reps	40%	73%	41%	54%	58%	57%
HR managers	16%	7%	6%	27%	18%	10%
Employee Director	20%	13%	22%	10%	17%	14%
Trade union reps	8%	3%	8%	9%	2%	13%

#### **6.4.4 Three Cases Compared**

In summary, the distribution of voice by different participants in all three of the APFs changed after restructuring. In NHS Highland the proportion of voice by staff-side remained stable in the Forum. However, it is important to note that voice by senior managers had significantly increased from 27% to 39%. This was in line with the fact that discussions on strategic issues also increased after restructuring. At the same time,

the frequency of attendance at the Forum by some key senior managers had also increased, reflecting a stronger commitment from senior managers and suggesting that a stable elite group now exists in the APF.

In NHS GG&C voice by staff-side had slightly increased since restructuring. Voice by senior managers had declined, but still remained at a relatively high level, while voice by management representatives had increased. This was in accordance with the purpose of restructuring to separate strategic issues and operational issues from the overall partnership agenda.

In contrast, it is highly significant to see that both staff-side and senior manager's voice in the Forum had decreased in the NHS Borders APF. Although more trade union representatives were involved in the Forum after restructuring, their voice had actually decreased. As for senior managers, their voice declined from 17% to 3%. This therefore suggests that the APF was further controlled by management-side in NHS Borders after restructuring.

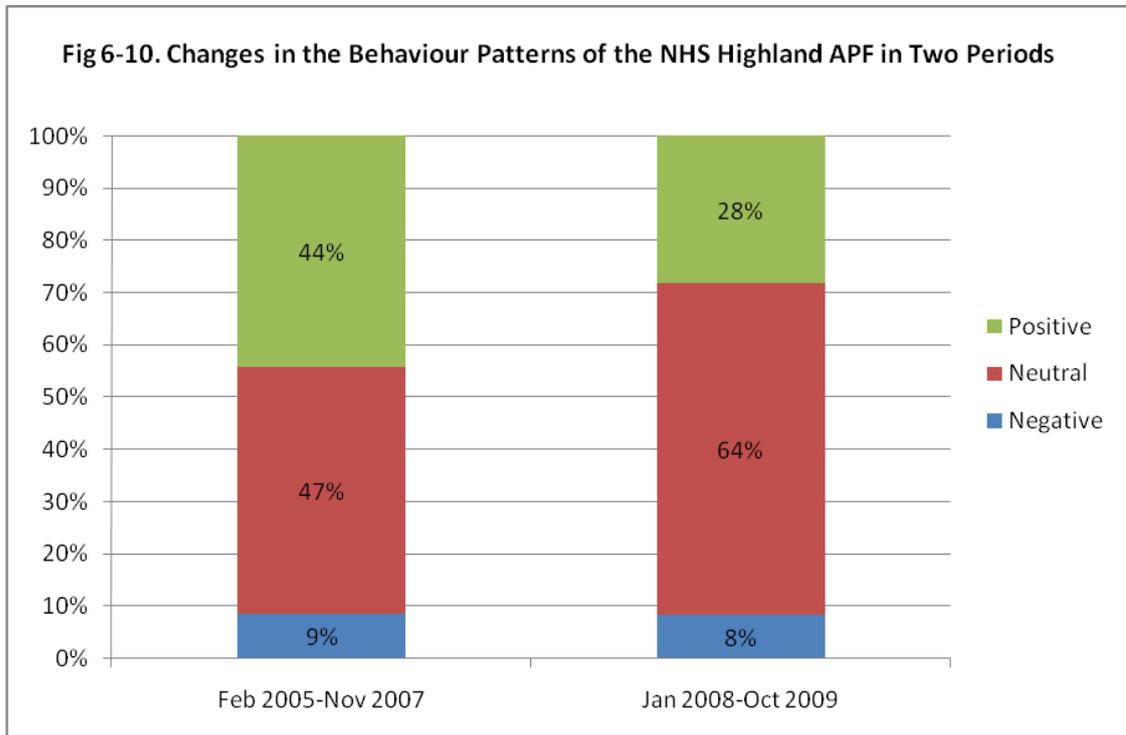
## **6.5 Changes in Behaviour Patterns of the APFs**

The previous two sections suggest that the scope of partnership agendas and voice by different participants had changed after restructuring in each APF. This section will analyse the changes in behaviour patterns of the three APFs. Advocates of partnership expect that union-management relations may change from the tradition of adversarial relations to a new cooperative relationship by encouraging partnership arrangements (Ackers and Payne, 1998; Kochan and Osterman, 1994).

### **6.5.1 NHS Highland**

As the data in Fig 6-10 suggests, the behaviour pattern moved from problem solving to information exchange after restructuring, as the proportion of positive behaviours

declined while the proportion of information exchange increased. It is also noted that the proportion of negative behaviours remained stable at a very low level.



The fluctuation of the wave indicates that positive behaviours were predominant in the Forum from the start of February 2005, but this has significantly shifted to information exchange since 2006 (see Table 6-10). After restructuring, the proportion of positive behaviours declined from 44% to 28%, while during the same period information exchanges increased from 47% to 64%. In general, the Forum provides a platform for senior managers, middle/front-line managers and trade union representatives to share information and cooperate with each other.

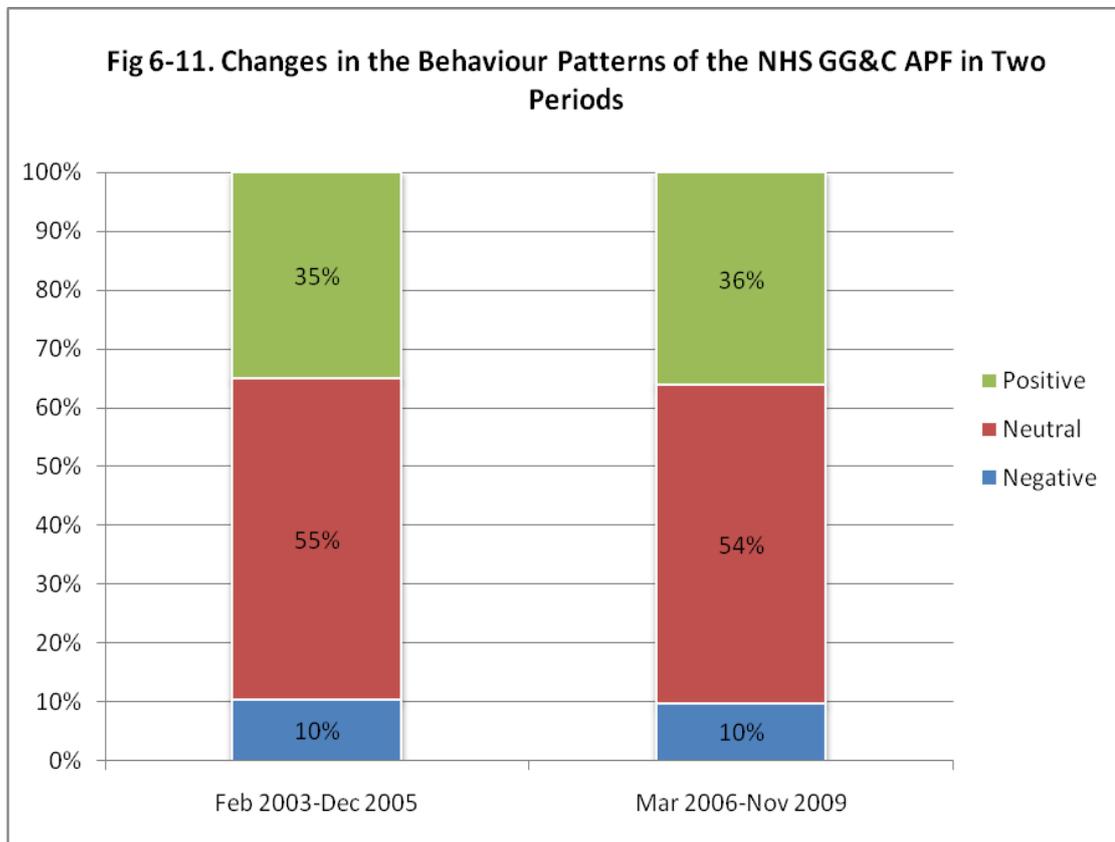
Although negative behaviours slightly increased between 2005 and 2007, they then declined after restructuring and remained stable. It is also important to note that some issues were internally more contentious than others, as challenging behaviours acutely increased when such issues were raised. For example, on 12<sup>th</sup> December 2008, when the issues of nurse bank policy and car parking policy were raised, negative behaviours doubled to 18%.

**Table 6-10. Proportion of Behaviours in the NHS Highland APF from Feb 2005 to Oct 2009 (column %, word count)**

	2005	2006	2007	2008	2009
Negative	6%	8%	11%	8%	8%
Neutral	37%	50%	54%	64%	63%
Positive	57%	41%	35%	28%	29%

### 6.5.2 NHS GG&C

In general, no significant changes had occurred in participants' behaviour patterns after restructuring in NHS GG&C APF, as reflected in Fig 6-11.



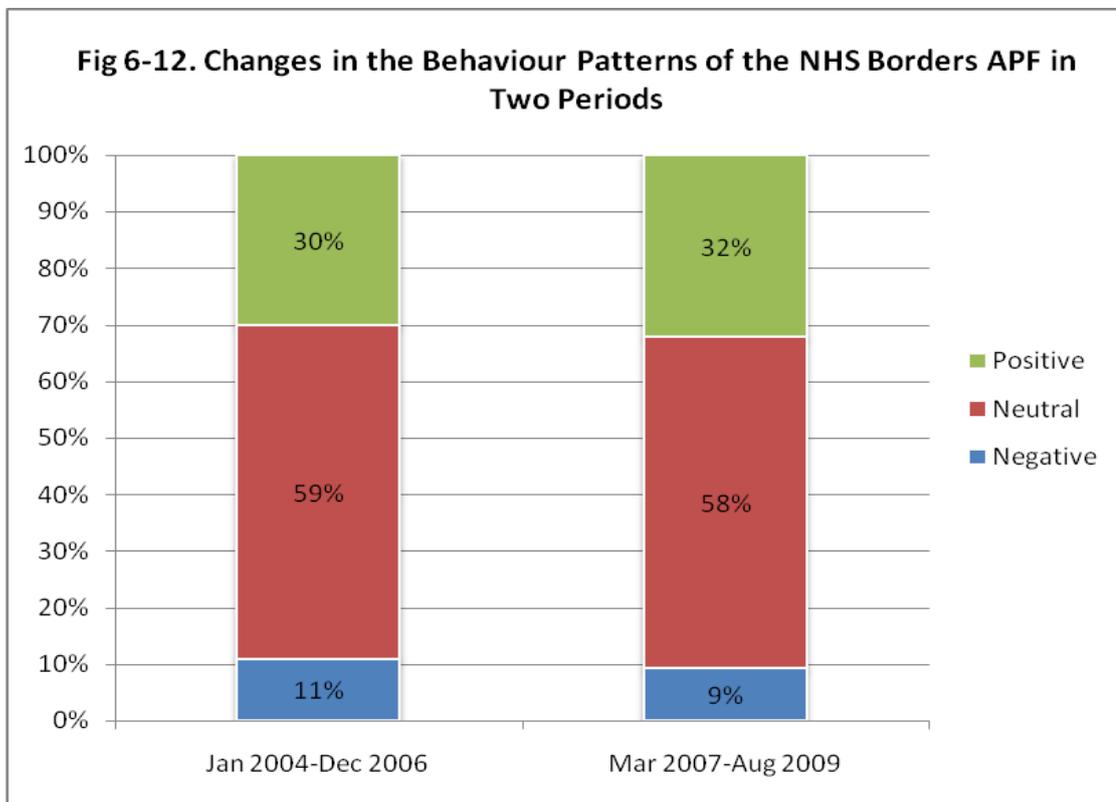
It is noted that information exchanges acutely increased during the period from 2003 to 2004, and gradually declined in the following years. In contrast, positive behaviours sharply decreased from 47% in 2003 to 26% in 2004, then started to increase from 2005 to 2008. The proportion of negative behaviours was relatively stable in the Forum, fluctuating around the 10% level every year (see Table 6-11).

**Table 6-11. Proportion of Behaviours in the NHS GG&C APF from Feb 2003 to Nov 2009 (column %, word count)**

	2003	2004	2005	2006	2007	2008	2009
Negative	13%	8%	10%	9%	8%	10%	12%
Neutral	40%	65%	59%	58%	59%	46%	54%
Positive	47%	26%	31%	34%	33%	44%	34%

### 6.5.3 NHS Borders

As with NHS Borders, no substantial changes occurred in participants' behaviour patterns after the Forum was restructured in NHS Borders (see Fig 6-12).



Basically, information exchange was the predominate activity in the Forum, reaching 73% in 2005. However, such behaviour slightly decreased after the Forum was restructured. It is important to note that cooperative behaviours had steadily increased in the Forum since 2004, but at a very marginal growth rate. The percentage of negative behaviours was relatively low and remained stable in the Forum. However, negative behaviours increased in some particular meetings, for example, the

percentage of negative behaviours increased to 20% in the meetings held on 2<sup>nd</sup> Nov 2007 and 12<sup>th</sup> Mar 2009.

**Table 6-12. Proportion of Behaviours in the NHS Borders APF from Jan-2004 to Aug-2009 (column %, word count)**

	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Negative	15%	1%	11%	16%	6%	10%
Neutral	61%	73%	51%	56%	61%	56%
Positive	24%	26%	39%	28%	34%	33%

#### **6.5.4 Three Cases Compared**

In summary, the behaviour patterns changed in NHS Highland APF after restructuring, while the behaviour patterns in NHS GG&C APF and NHS Borders APF did not change. In NHS Highland it is significant to see that the Forum had more information exchange after restructuring and positive behaviours reduced from 44% to 28%. This is not surprising because the Forum was concentrating more on strategic issues like Modernisation and Workforce Planning after restructuring. Considering the fact that most of the strategic issues included in the NHS modernisation agendas were made by national authorities and local committees had only limited influence on these issues (Bach, 2004), this therefore indicates that a stronger focus on strategic issues without enough empowerment to local committees may result in giving trade unions a sense of participation rather than real influence (Danford et al., 2005).

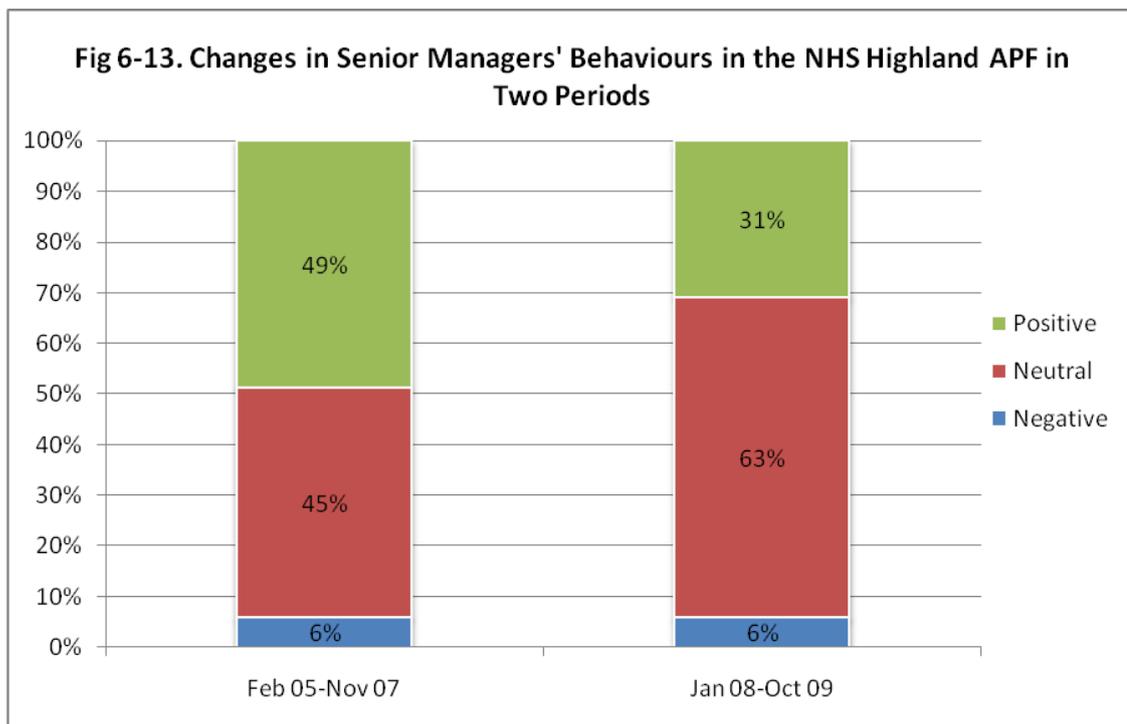
It is also noted that in both NHS GG&C and NHS Borders no significant changes had occurred to the behaviour patterns of the two APFs, suggesting that partnership arrangements did not necessarily lead to behaviour changes. Changes in behaviour were more likely to depend on the specific issues discussed, the training that participants received and on a changing culture (Eaton et al., 2008).

## 6.6 Changes in Participants' Behaviours

This section will examine changes in the behaviours of different groups of participants in the three APFs.

### 6.6.1 NHS Highland

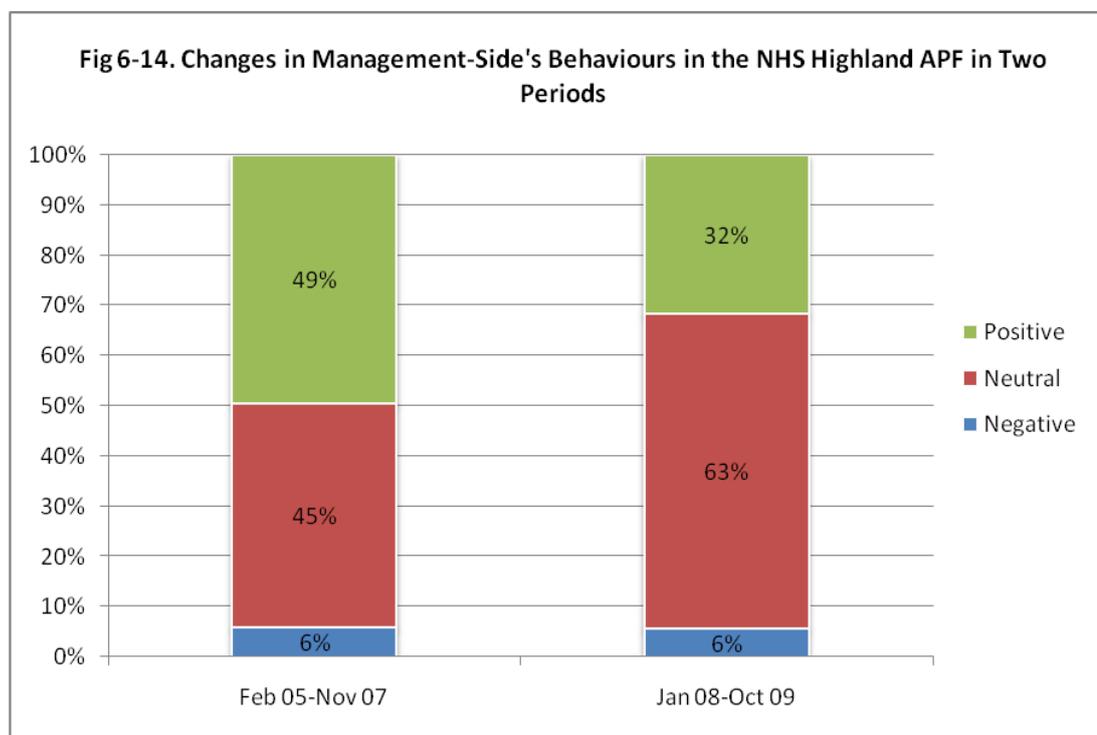
Fig 6-13 shows the changes to senior managers' behaviours in the NHS Highland APF in the two periods. It is noted that after restructuring, senior managers shared more information in the Forum, while the proportion of positive behaviours reduced from 49% to 31%. Challenging behaviours from senior managers still remained at a relatively low level, and no significant changes occurred in this area.



**Table 6-13. Senior Managers' Behaviour Change over Time in the NHS Highland APF (Column %, word count)**

	2005	2006	2007	2008	2009
Negative	2%	4%	11%	5%	8%
Neutral	35%	46%	56%	70%	51%
Positive	63%	50%	34%	26%	41%

Fig 6-14 reveals changes to management-side's behaviours in the Forum after restructuring. It is noted that the management-side also shared more information in the Forum, increasing from 45% to 63%. Positive behaviours had declined from 49% to 32%, and challenging behaviours remained at a relatively low level. It is also important to note that on the management-side, no significant changes occurred to the behaviour pattern of HR managers, but other management representatives had shared more information in the Forum after restructuring.



**Table 6-14. Management Representatives' Behaviour Change over Time in the NHS Highland APF (Column %, word count)**

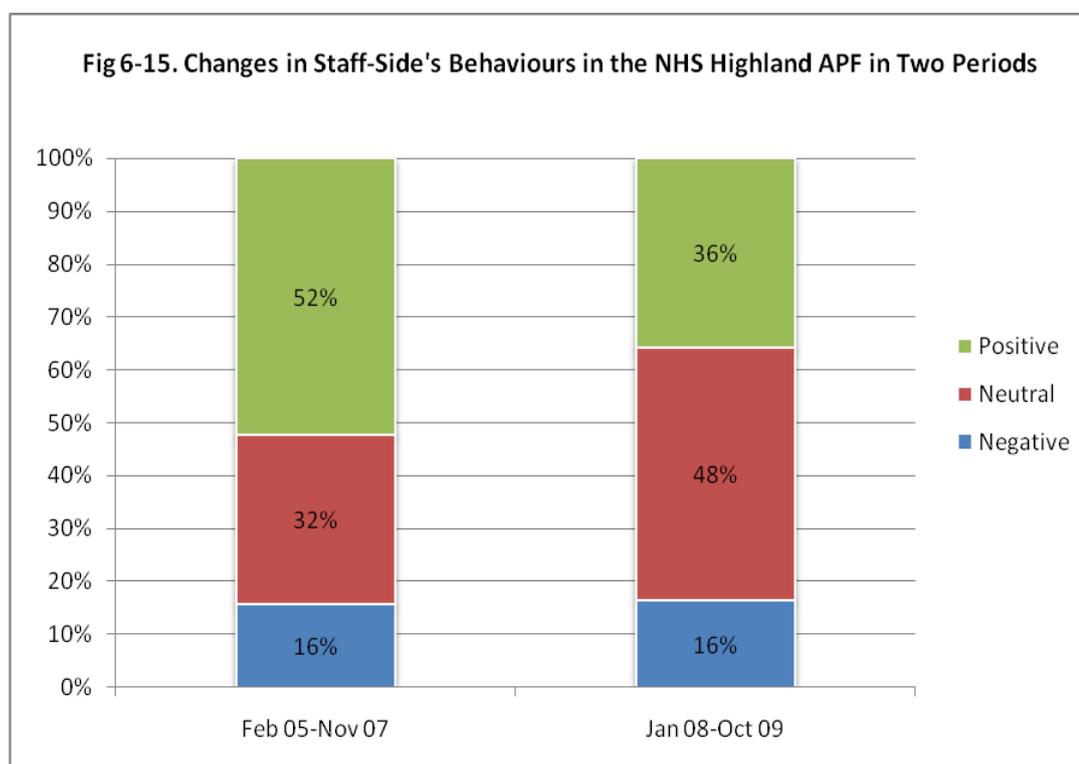
	2005	2006	2007	2008	2009
Negative	2%	6%	8%	8%	3%
Neutral	26%	39%	59%	60%	66%
Positive	72%	55%	33%	32 %	31%

**Table 6-15. HR Managers' Behaviour Change over Time in the NHS Highland**

**APF (Column %, word count)**

	2005	2006	2007	2008	2009
Negative	7%	6%	6%	6%	5%
Neutral	42%	53%	49%	60%	66%
Positive	51%	41%	46%	34%	29%

Fig 6-15 indicates staff-side's behaviour changes in the APF after restructuring. It is noted that they also shared more information in the Forum, as the proportion of information exchange increased from 32% to 48%. Positive behaviours declined from 52% to 36% and negative behaviours remained stable.



**Table 6-16. Employee Directors' Behaviour Change over Time in the NHS**

**Highland APF (Column %, word count)**

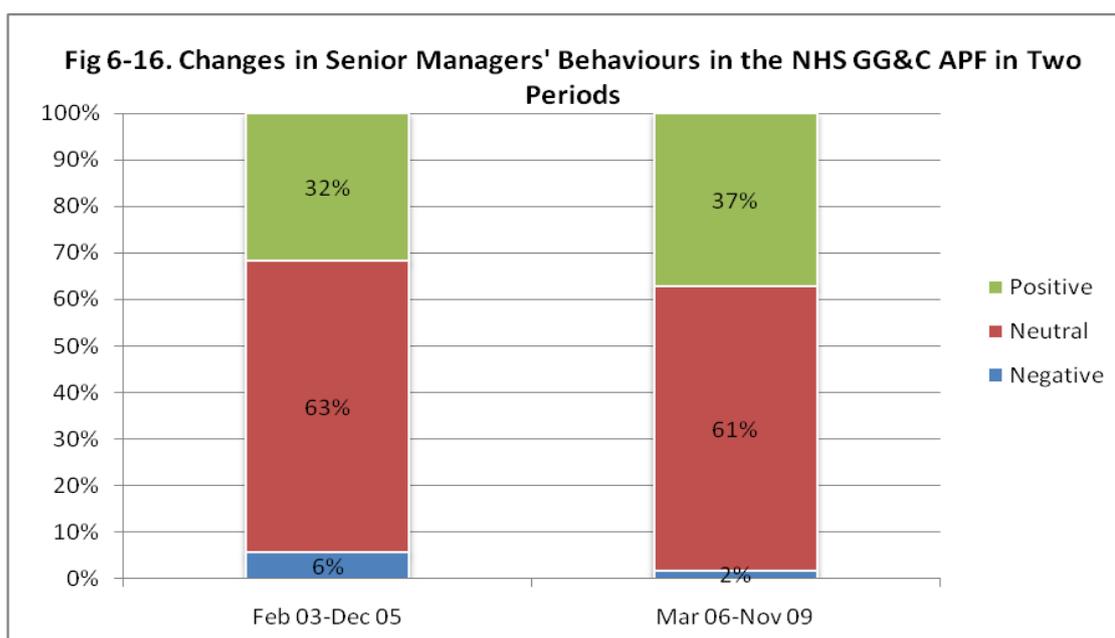
	2005	2006	2007	2008	2009
Negative	9%	6%	12%	13%	11%
Neutral	22%	47%	44%	50%	52%
Positive	69%	47%	44%	37%	36%

**Table 6-17. Trade Union Representatives' Behaviour Change over Time in the NHS Highland APF (Column %, word count)**

	2005	2006	2007	2008	2009
Negative	23%	27%	25%	27%	22%
Neutral	12%	29%	29%	38%	44%
Positive	64%	45%	46%	35%	34%

### 6.6.2 NHS GG&C

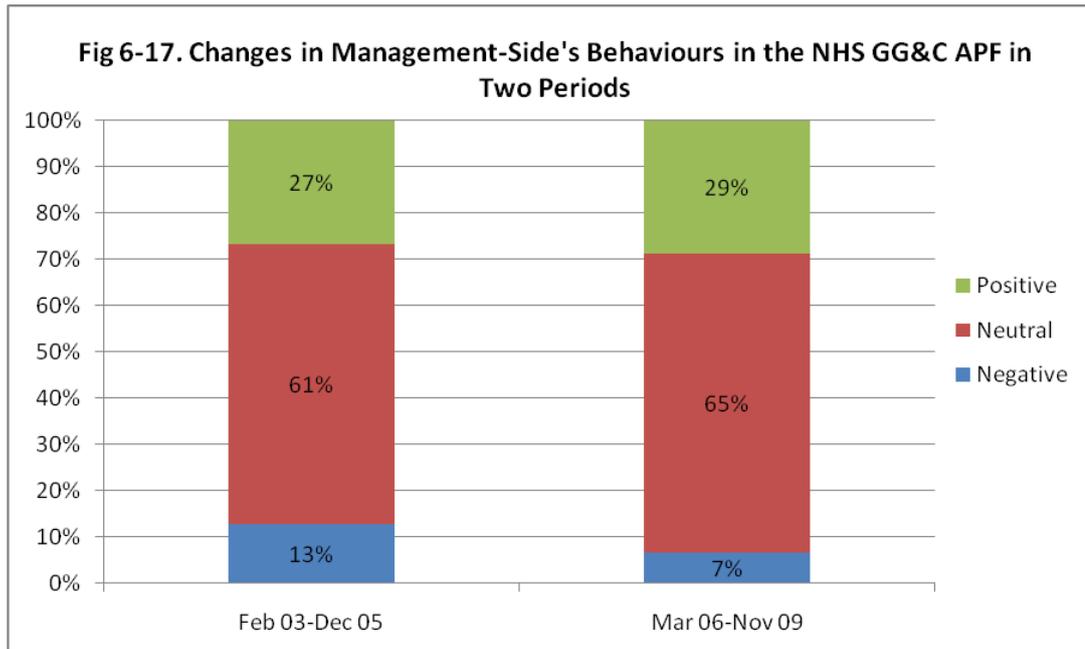
Fig 6-16 indicates senior managers' behaviour changes in NHS GG&C APF after restructuring. It is noted that senior managers had become more positive after the Forum was restructured, with the proportion of positive behaviours increased from 32% to 37%. During the same period, it is important to see that challenging behaviours from senior managers had declined from 6% to 2%.



**Table 6-18. Senior Managers' Behaviour Change over Time in the NHS GG&C APF (Column %, word count)**

	2003	2004	2005	2006	2007	2008	2009
Negative	4%	0%	8%	1%	0%	0%	8%
Neutral	83%	37%	63%	59%	77%	59%	50%
Positive	13%	63%	30%	40%	23%	41%	42%

Fig 6-17 indicates the management-side behaviour changes in NHS GG&C APF in two periods which had become more positive and shared more information in the Forum, although the growth rate was marginal. Challenging behaviours had declined from 13% to 7%, reflecting an improvement of the management-side behaviour pattern.



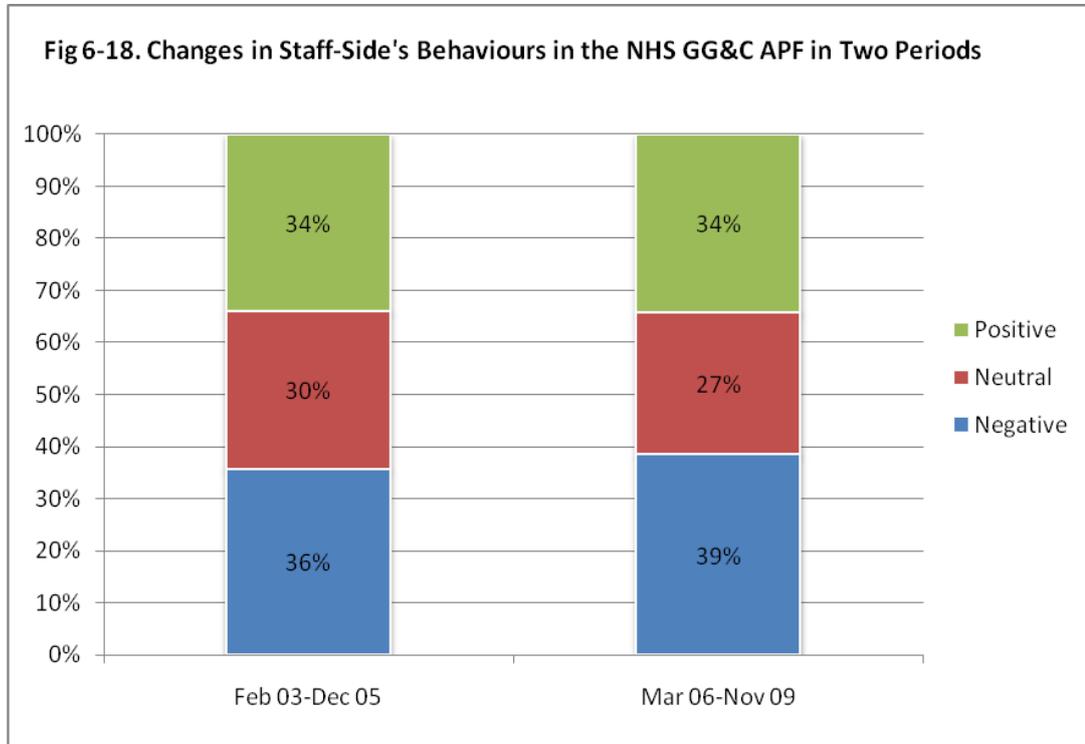
**Table 6-19. Management Representatives' Behaviour Change over Time in the NHS GG&C APF (Column %, word count)**

	2003	2004	2005	2006	2007	2008	2009
Positive	31%	8%	15%	34%	21%	54%	34%
Neutral	69%	74%	76%	66%	75%	38%	62%
Negative	0%	19%	9%	0%	4%	8%	3%

**Table 6-20. HR Managers' Behaviour Change over Time in the NHS GG&C APF (Column %, word count)**

	2003	2004	2005	2006	2007	2008	2009
Positive	60%	0%	53%	21%	25%	25%	35%
Neutral	14%	100%	35%	75%	63%	64%	61%
Negative	26%	0%	12%	5%	13%	12%	4%

Fig 6-18 reveals staff-side behaviour changes in the Forum after restructuring. It is noted that no significant changes had occurred, with challenging behaviours slightly increased and information sharing accounting for less.



**Table 6-21. Employee Directors' Behaviour Change Over Time in the NHS GG&C APF (Column %, word count)**

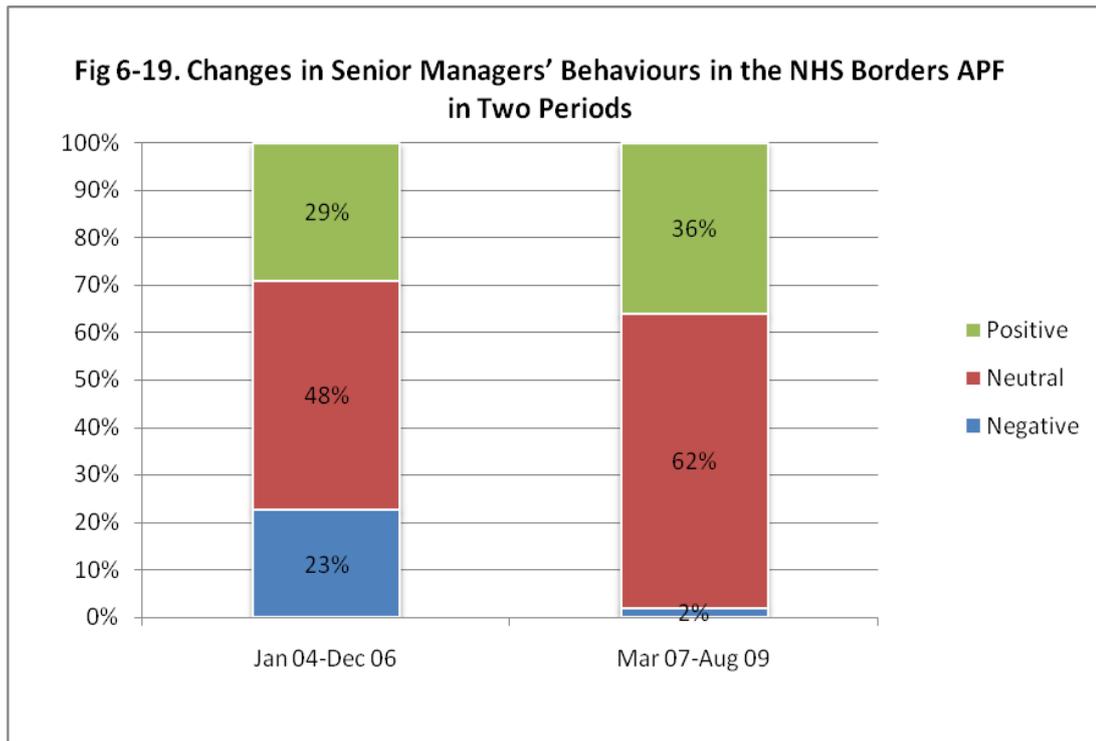
	2003	2004	2005	2006	2007	2008	2009
Positive	84%	0%	23%	10%	52%	60%	22%
Neutral	16%	0%	46%	74%	48%	40%	36%
Negative	0%	0%	30%	16%	0%	0%	42%

**Table 6-22. Trade Union Representatives' Behaviour Change Over Time in the NHS GG&C APF (Column %, word count)**

	2003	2004	2005	2006	2007	2008	2009
Positive	0%	63%	21%	29%	45%	37%	27%
Neutral	100%	10%	24%	25%	21%	23%	26%
Negative	0%	27%	55%	46%	33%	40%	47%

### 6.6.3 NHS Borders

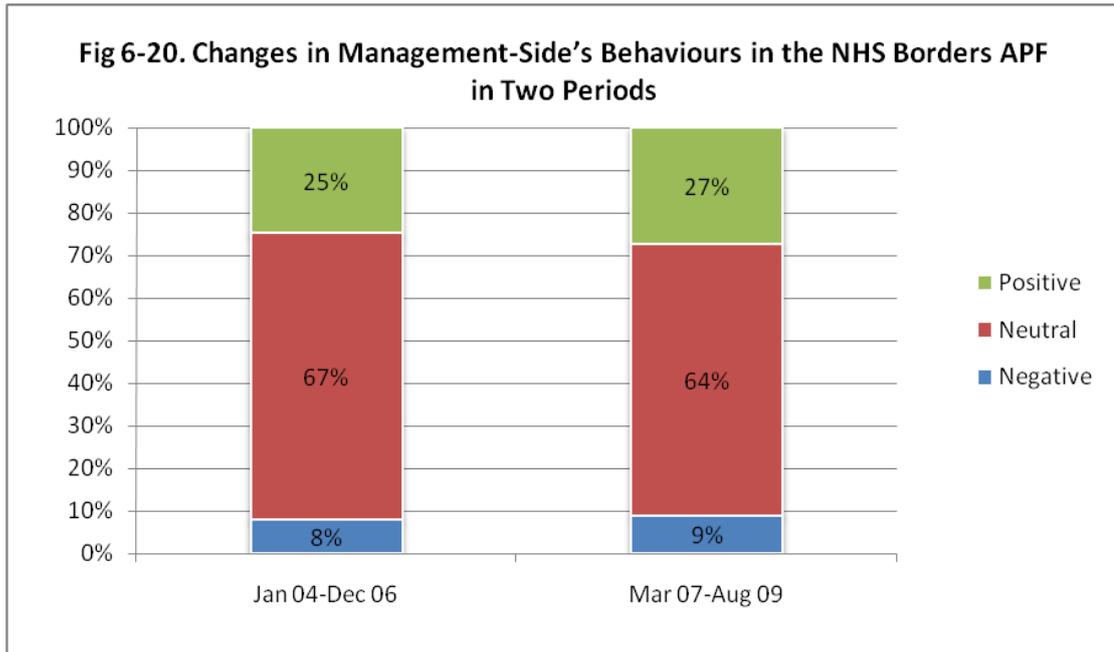
Fig 6-19 reveals senior managers' behaviour changes in the NHS Borders APF after restructuring. It is highly significant to see that senior managers had shared more information and been more positive in the Forum, while challenging behaviours had dramatically declined from 23% to 2%.



**Table 6-23. Senior Managers' Behaviour Change Over Time in the NHS Borders APF (Column %, word count)**

	2004	2005	2006	2007	2008	2009
Negative	50%	0%	3%	0%	3%	0%
Neutral	35%	100%	56%	0%	57%	75%
Positive	15%	0%	41%	0%	40%	25%

Fig 6-20 indicates management-side's behaviour changes in the APF in two periods. It is notable that no significant changes had occurred to the management-side behaviour pattern, as information exchange was still the main activity.



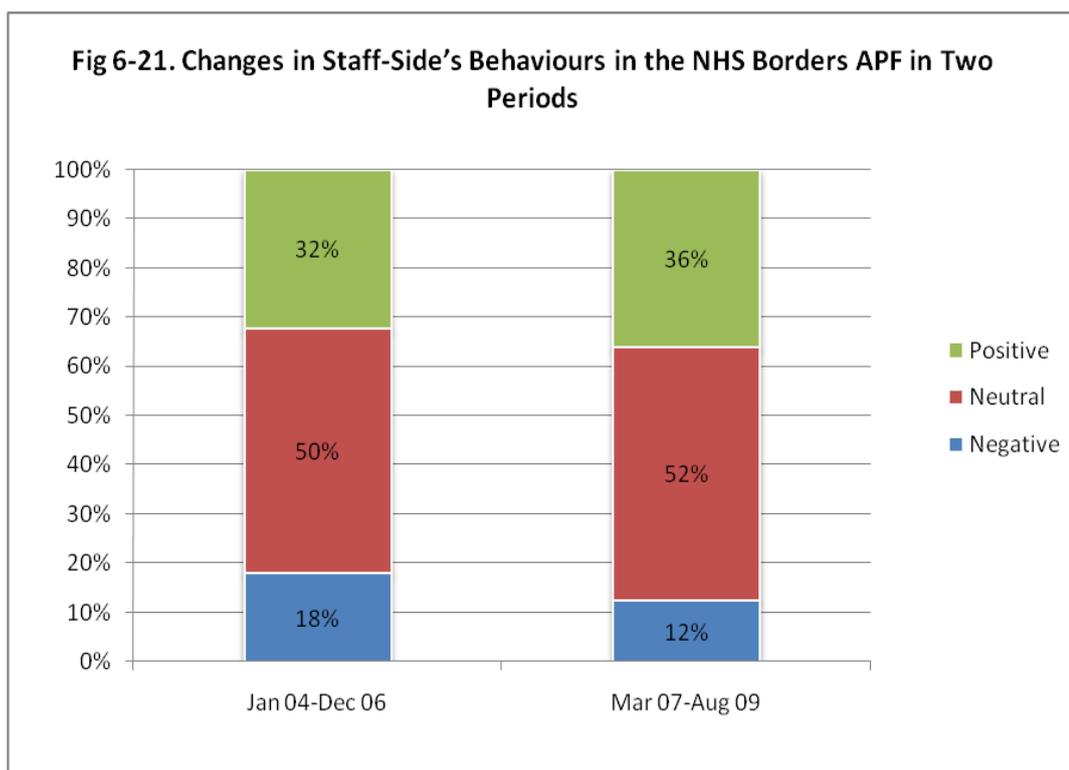
**Table 6-24. Management Representatives' Behaviour Change over Time in the NHS Borders APF (Column %, word count)**

	2004	2005	2006	2007	2008	2009
Negative	5%	2%	9%	14%	5%	16%
Neutral	72%	70%	63%	61%	67%	54%
Positive	23%	28%	28%	25%	29%	29%

**Table 6-25. HR Managers' Behaviour Change over Time in the NHS Borders APF (Column %, word count)**

	2004	2005	2006	2007	2008	2009
Negative	8%	0.00%	52%	9%	7%	0.00%
Neutral	72%	63%	34%	66%	66%	74%
Positive	20%	37%	15%	26%	28%	26%

Fig 6-21 indicates staff-side behaviour changes in the Forum after restructuring which had become more positive and shared more information in the Forum, with challenging behaviours reduced from 18% to 12%.



**Table 6-26. Employee director's Behaviour Change over Time in the NHS Borders APF (Column %, word count)**

	2004	2005	2006	2007	2008	2009
Negative	17%	0%	17%	25%	5%	13%
Neutral	50%	100%	43%	58%	55%	50%
Positive	32%	0%	39%	17%	40%	37%

**Table 6-27. Trade Union Representatives' Behaviour Change over Time in the NHS Borders APF (Column %, word count)**

	2004	2005	2006	2007	2008	2009
Negative	22%	0%	32%	22%	31%	3%
Neutral	38%	100%	37%	40%	29%	57%
Positive	40%	0%	30%	38%	40%	39%

#### 6.6.4 Three Cases Compared

In NHS Highland it is noted that the behaviours of all three groups were changing towards a similar pattern, with more information exchanging and less positive behaviours. By comparison, in NHS GG&C it is noted that both senior managers and

management-side were more positive and less negative, and staff-side behaviour patterns remained stable as they kept challenging management all of the time. In NHS Borders it is likely that senior managers have been more positive and have started sharing more information. However, it should be kept in mind that senior managers only contributed 3% of the total discussions in the Forum after restructuring. There are no significant changes to behaviours on the management-side and the staff side has been less challenging.

## **6.7 Summary and Conclusions**

This chapter has analysed changes that have occurred in terms of structures, agendas, participants' voice and behaviours in all three of the APFs. Table 6-28 outlines the key features with regard to these dynamics.

There are several similarities and differences among the three APFs. The first similarity concerns the structural changes. It was in the context of structural changes to the Scottish Partnership Forum (SPF) and a national strategy to establish Community Health Partnerships (CHPs) at local levels that all three health boards were required to facilitate changes in APFs and to propagate partnership structures to the CHPs. As a result, each of the organisations carried out significant structural changes between 2006 and 2008. The second similarity concerned the changes in frequency of partnership meetings and proportion of trade union attendees in the APFs. Analysis has shown that the frequency of partnership meetings increased in all three APFs and the proportion of trade union attendees in the three APFs has also increased.

However, there are also several differences between the three cases. Firstly, it is important to note that the rationale and management attitudes towards restructuring are distinct between the three health boards. In NHS Highland, although a few middle managers were reluctant to establish partnership infrastructures in their departments,

senior managers and trade union officials shared a strong commitment to developing long-term partnership relationships. The APF held several meetings prior to the restructuring. Managers and union officials openly exchanged their opinions and clearly set up the aims of restructuring. At the same time, in NHS GG&C, the restructuring has met with no resistance from managers due to trade union strength within the organisation. Trade unions put forward a proposal for restructuring that aimed to separate strategic and operational issues from the overall partnership agenda. The proposal gained full support from the management-side. In contrast, the process of restructuring in NHS Borders did not go as well as its counterparts in NHS Highland and NHS GG&C. There was a lack of commitment from senior managers, and managers generally felt that there was no need to develop further partnership arrangements, given the fact that the Employee Director's proposal on restructuring was denied by the APF.

Secondly, the evolving trajectories of the three APFs in terms of agendas, voice and behaviours are distinct from each other. In NHS Highland, the scope of partnership agendas has been more strategic-focused since restructuring. The Chief Executive consistently attended the Forum and voice by senior managers increased since restructuring. Challenging behaviours remained at a low level, and both the management and staff sides shared more information with each other. In NHS GG&C, the size of the APF has expanded since restructuring, involving more and more participants in the Forum. Staff-side continued to be the largest group in the APF, and the proportion of union attendees slightly increased after restructuring. Strategic issues like Modernisation and Workforce Planning continued to be the most popular topics in the Forum, however it is also important to note that discussions on operational issues of Pay and Equality and Training were increased after restructuring. Voice by senior

managers declined after restructuring, and this is mainly because senior managers chose only to attend the strategic meetings and generally missed all of the meetings that discussed operational issues. Both senior managers and the management-side have been less aggressive and provided more information in the Forum, while in contrast trade union representatives continued to challenge managers all the time. In NHS Borders, the Forum has been expanded to get more participants involved. It is significant to see that the proportion of trade union attendees has increased from 20% to 30% since restructuring. However, discussions in the Forum were still dominated by the management-side, and voice by both senior managers and staff-side had declined after restructuring, reflecting strong control of the Forum by the former group. It is also noted that there are no significant changes in the partnership agendas and participants' behaviours in the Forum.

**Table 6-28. Comparison of Changes in the Three APFs before and after Restructuring**

<b>Features</b>	<b>NHS Highland</b>	<b>NHS GG&amp;C</b>	<b>NHS Borders</b>
Rationale for APF Restructuring	<ul style="list-style-type: none"> <li>• Response to national instruction</li> <li>• To develop long term partnership relations between management and unions</li> <li>• Clear expectations jointly developed by management and trade unions</li> </ul>	<ul style="list-style-type: none"> <li>• Response to National Instruction</li> <li>• Clear expectations proposed by trade unions</li> </ul>	<ul style="list-style-type: none"> <li>• Response to National Instruction</li> <li>• Employee Director's proposal on restructuring was denied</li> </ul>
Management Attitudes on Restructuring	<ul style="list-style-type: none"> <li>• Strong commitment from senior managers</li> <li>• Resistance from some middle-level managers</li> </ul>	<ul style="list-style-type: none"> <li>• Support from senior managers</li> <li>• No resistance</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of Involvement from Senior Managers</li> <li>• Strong resistance from most middle-level managers</li> </ul>
Frequency of Meetings	<ul style="list-style-type: none"> <li>• 6 meetings before restructuring</li> <li>• Increased to 10 meetings after restructuring</li> </ul>	<ul style="list-style-type: none"> <li>• 6 meetings before restructuring</li> <li>• Increased to 10 meetings after restructuring</li> </ul>	<ul style="list-style-type: none"> <li>• 4 meetings before restructuring</li> <li>• Increased to 7 meetings after restructuring</li> </ul>
Proportion of Trade Union Representatives in the APF	<ul style="list-style-type: none"> <li>• Increased from 32% to 36% after restructuring</li> </ul>	<ul style="list-style-type: none"> <li>• Increased from 54% to 60% after restructuring</li> </ul>	<ul style="list-style-type: none"> <li>• Increased from 20% to 30% after restructuring</li> </ul>
The Scope of Partnership Agendas	<ul style="list-style-type: none"> <li>• More strategic-focused</li> </ul>	<ul style="list-style-type: none"> <li>• Strategic issues remained predominant</li> <li>• Operational issues slightly increased</li> </ul>	<ul style="list-style-type: none"> <li>• No significant changes</li> </ul>
Participants' Voice	<ul style="list-style-type: none"> <li>• Voice by senior managers has significantly increased</li> <li>• Voice by management-side has decreased</li> <li>• Voice by staff-side remained stable</li> </ul>	<ul style="list-style-type: none"> <li>• Voice by senior managers has decreased</li> <li>• Voice by management-side has increased</li> <li>• Voice by staff-side has slightly increased</li> </ul>	<ul style="list-style-type: none"> <li>• Voice by senior managers has sharply decreased</li> <li>• Voice by management-side has significantly increased</li> <li>• Voice by staff-side has decreased</li> </ul>
Behaviour Pattern of the APF	<ul style="list-style-type: none"> <li>• A shift from positive behaviours to information exchange</li> </ul>	<ul style="list-style-type: none"> <li>• No significant change</li> </ul>	<ul style="list-style-type: none"> <li>• No Significant Change</li> </ul>

In conclusion, the above findings have several important implications. Firstly, they suggest that the impact of external context on the sustainability of partnerships was significant. In contrast to the assumption that partnership agreement will not last in the institutional context of Britain's liberal market economy (Kelly, 2005; Martínez Lucio and Stuart, 2005; Thompson, 2003; Turnbull, 2003), such agreement appeared to be robust in NHS Scotland and there is no sign that the agreement will decay in the future. Secondly, it also suggests that, although they were facing the same external contexts, partnership arrangements were evolving in different directions for the three cases. Such diversities were shaped by the organisation's own characteristics, including historic industrial climate, traditional behaviour patterns and the chief leaders' perspective on partnership working. However, to this point, we still cannot assert which kinds of partnership arrangements were more effective without knowing the outcomes for stakeholders. The next chapter will therefore examine the outcomes of partnership working in the three health boards.

## **Chapter 7. The Outcomes of Partnership Working**

### **7.1 Introduction**

Previous studies have suggested that a necessary condition for the sustainability of partnership is to deliver tangible, valued and substantive outcomes for stakeholders (Bacon and Storey, 2000; Kochan et al., 2008). Therefore, the final aim of this thesis is to examine the outcomes of partnership working in the three health boards.

This chapter will first assess the outcomes of partnership meetings by dividing the decisions into five main categories. This is followed by analysing some critical issues that were selected from the common agendas of the three APFs. Such method can help to explain how problems were generated, discussed and resolved through partnership arrangements.

### **7.2 The Overall Outcomes of Partnership Meetings**

Researchers have pursued various ways to assess the outcomes of partnership initiatives, for example, using a quantitative method to measure the labour or organisational outcomes (Kelly, 2004), conducting interviews with management, trade union representatives or employees (Guest and Peccei, 2001; Oxenbridge and Brown, 2004), or analysing critical incidences of partnership (Johnstone et al., 2010). However, these researches have overlooked the importance of observing partnership meetings and joint consultation committees which are the central organisations for carrying out partnership initiatives.

This research therefore aims to examine the outcomes of partnership meetings in the three health boards. Drawn from Bacon and Samuel (2010), decisions from partnership meetings are divided into five main categories which are refining, agreeing, involving, revisiting and vetoing. It is suggested that refining decisions can

produce tangible changes or improvement in stakeholders that can eventually increase satisfaction with partnership and commitment to partnership. Agreeing on decisions shows a party's cooperation with another, this can also bring convenience and benefit to one party and therefore, further reinforcing partnership relationships. Involving partners in the decision making process cannot increase satisfaction unless the involvement also leads to changes. Excessive revisiting issues will reduce participants' satisfaction with partnership and commitment to partnership process and vetoing on issues will cause severe damage on partnership relationships.

### 7.2.1 NHS Highland

In NHS Highland, 376 decisions were made in the Forum from Feb 2005 to Sep 2009. Overall, deciding to agree the issue was the most common outcome of discussions, accounting for 36% of all decisions, with refinements made in almost one-fifth (19%) of the total number of decisions made and involvement accounted for 30%. Revisiting issues accounted for 14% and vetoing the policies occurred only in three occasions (see Fig 7-1).

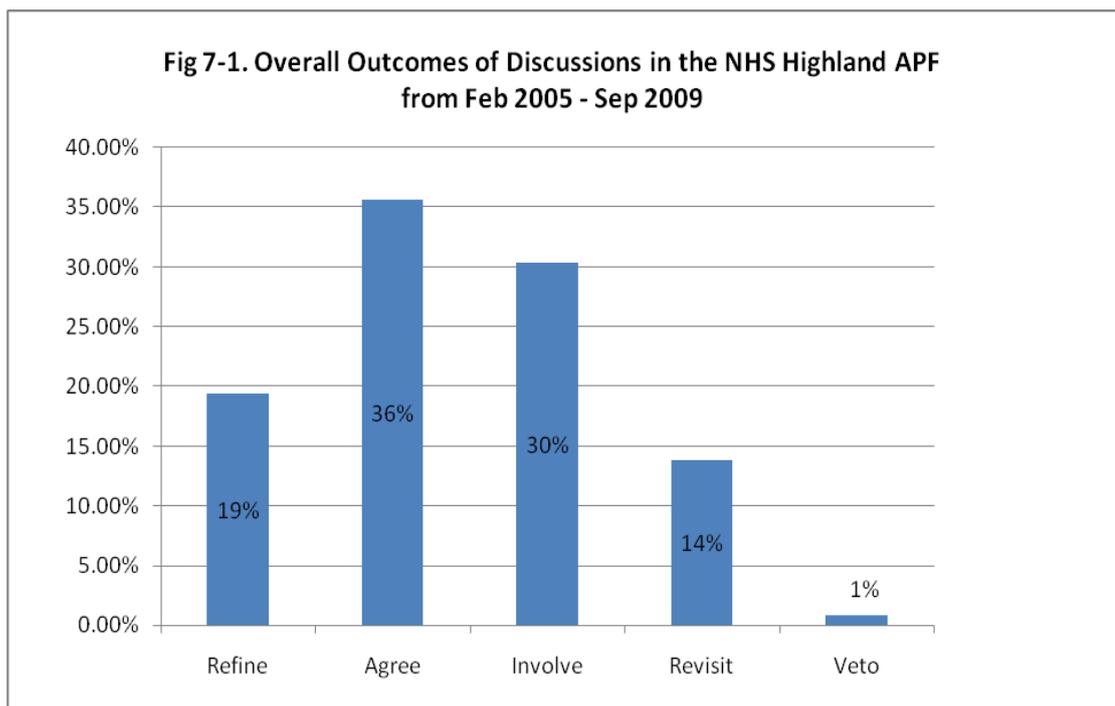
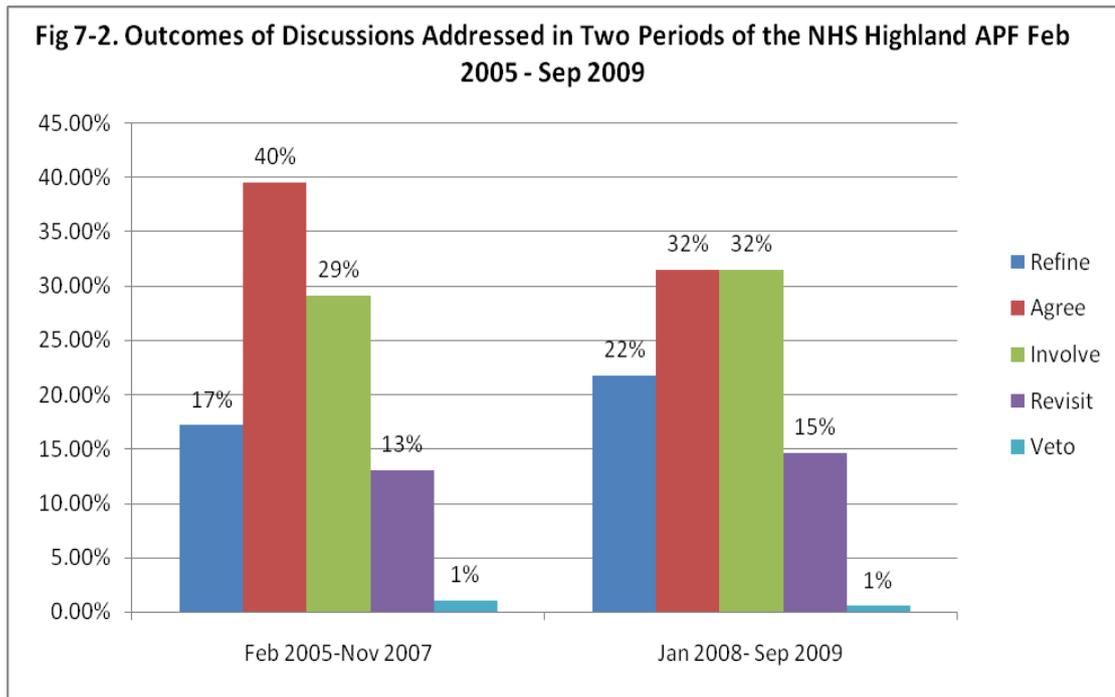


Table 7-1 reveals changes occurred to the outcomes over time. From 2005 to 2007, the number of decisions of refinement, agreement and involvement had all declined, while decisions to revisit issues had significantly increased. The figure suggests that the APF has become ineffective since 2005 and ...echoes the rationale for management and trade unions to restructure the APF (see Section 6.2). However, after the Forum was restructured at the end of 2007, the number of decisions substantially increased in 2008 (113 decisions made in 2008). It is very important to note that the number of decisions to refine and agree a policy or to involve partners in discussions had significantly increased since restructuring, reflecting that the APF had become more central to the management-union relationships, which also implies that trade unions were involved in a broader range of management decision making processes.

**Table 7-1. Number of Decisions Made in the NHS Highland APF from Feb 2005 to Sep 2009**

	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Refine	14	8	11	23	17
Agree	37	21	18	32	26
Involve	30	14	12	41	17
Revisit	4	8	13	16	11
Veto	0	1	1	1	0
In total	85	52	55	113	71

Fig 7-2 compares the changes of outcomes in the two periods. It shows that there was a reduction in agreeing issues and a marginal increase in refining decisions and involving partners after restructuring.



### 7.2.2 NHS GG&C

In NHS GG&C, 242 decisions were made in the APF from Feb 2003 to Nov 2009. Overall, involving partners in discussion of the issues was the most common outcome of APF meetings, accounting for 44% of all decisions, with refinements constituted only 7% and agreeing accounted for 27%. Decisions to revisit issues accounted for 19% and vetoing issues occurred in nine occasions, accounting for 4% of the total number of decisions (see Fig 7-3).

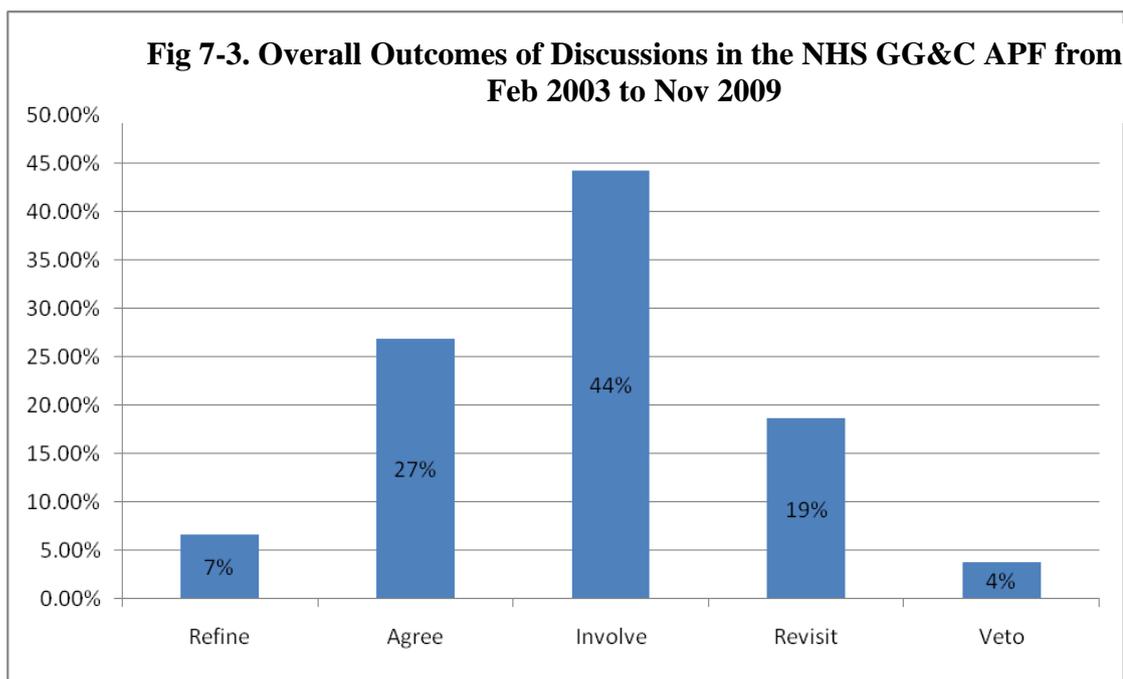
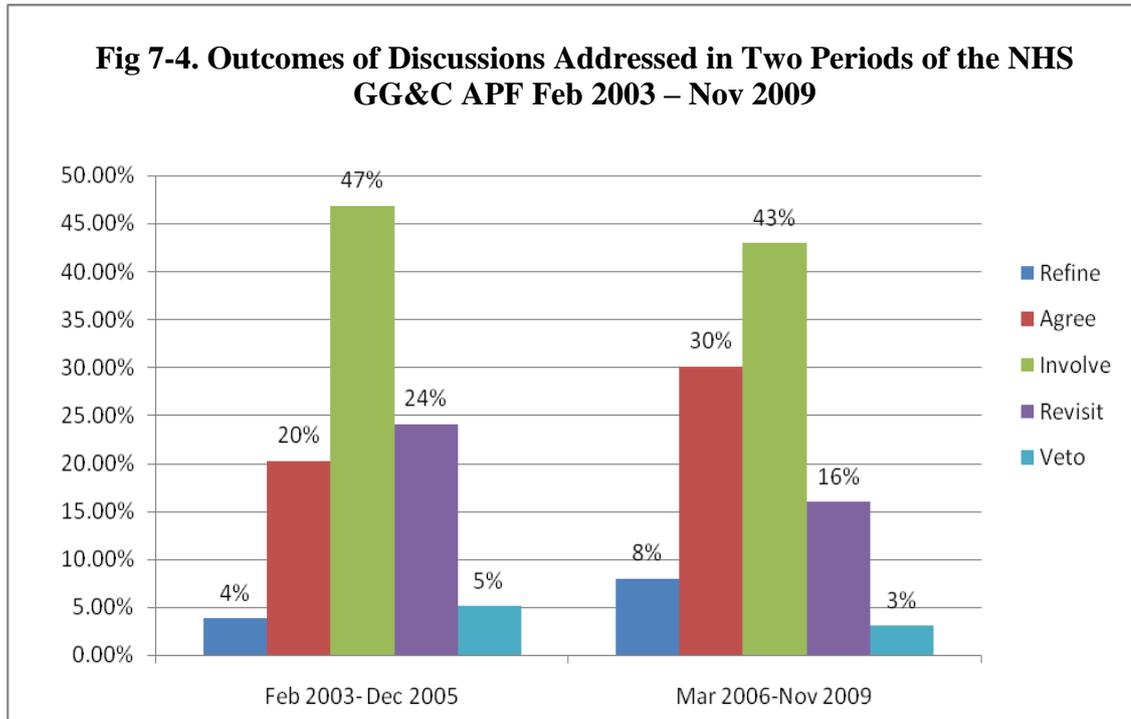


Table 7-2 indicates the changes of outcomes over time in NHS GG&C. From 2003 to 2005, refinement was made only once in each year, while the number of decisions of agreement also declined. After the APF was restructured at the end of 2005 (decisions were made in 25 occasions in 2005), the number of decisions made in the Forum increased in 2006 (36 occasions). The number of decisions of refinement, agreement and involvement had all increased since restructuring.

**Table 7-2. Decisions Made in Each Year in the NHS GG&C APF from Feb 2003 to Nov 2009**

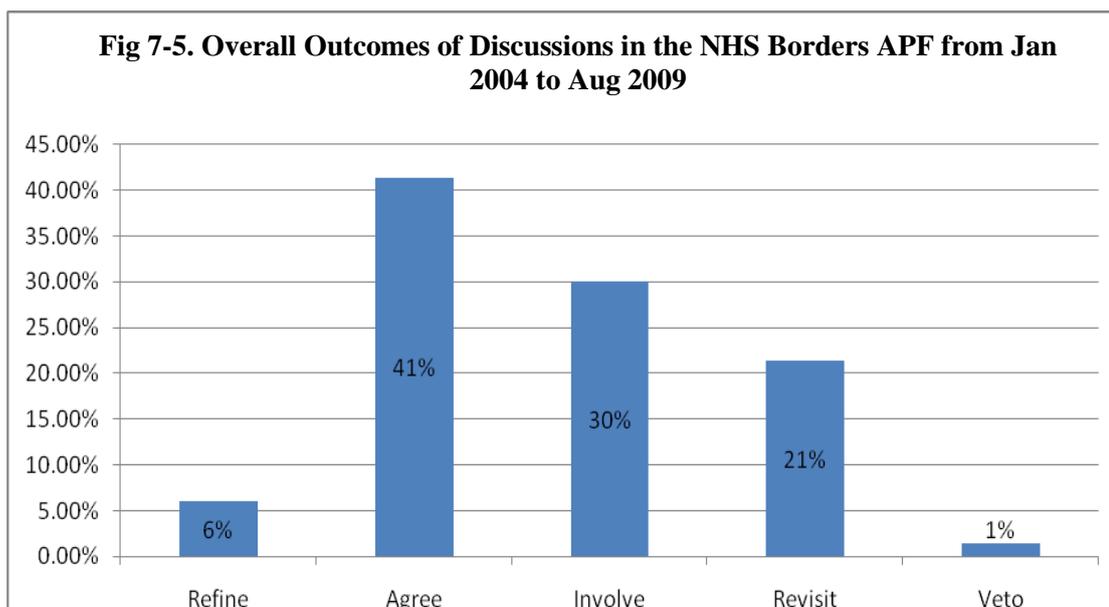
	2003	2004	2005	2006	2007	2008	2009
Refine	1	1	1	5	4	2	2
Agree	7	4	5	12	15	11	11
Involve	15	11	11	15	25	15	15
Revisit	8	4	7	3	6	8	9
Veto	2	1	1	1	2	1	1
In Total	33	21	25	36	52	37	38

Fig 7-4 reveals different outcomes addressed in the two periods, which suggests that the NHS GG&C APF had created more positive outcomes after restructuring in 2006. There was a reduction in involving partners and revisiting issues but a significant increase in refining and agreeing decisions.



### 7.2.3 NHS Borders

From Jan 2004 to Aug 2009, 150 decisions were made in the NHS Borders APF. Overall, deciding to agree on issues was the most common outcome of discussions, accounting for 41% of all decisions, with refinements constituted 6% of the total number of outcomes, involving partners 30%, revisiting issues 21% and vetoes in two occasions (see Fig 7-5).

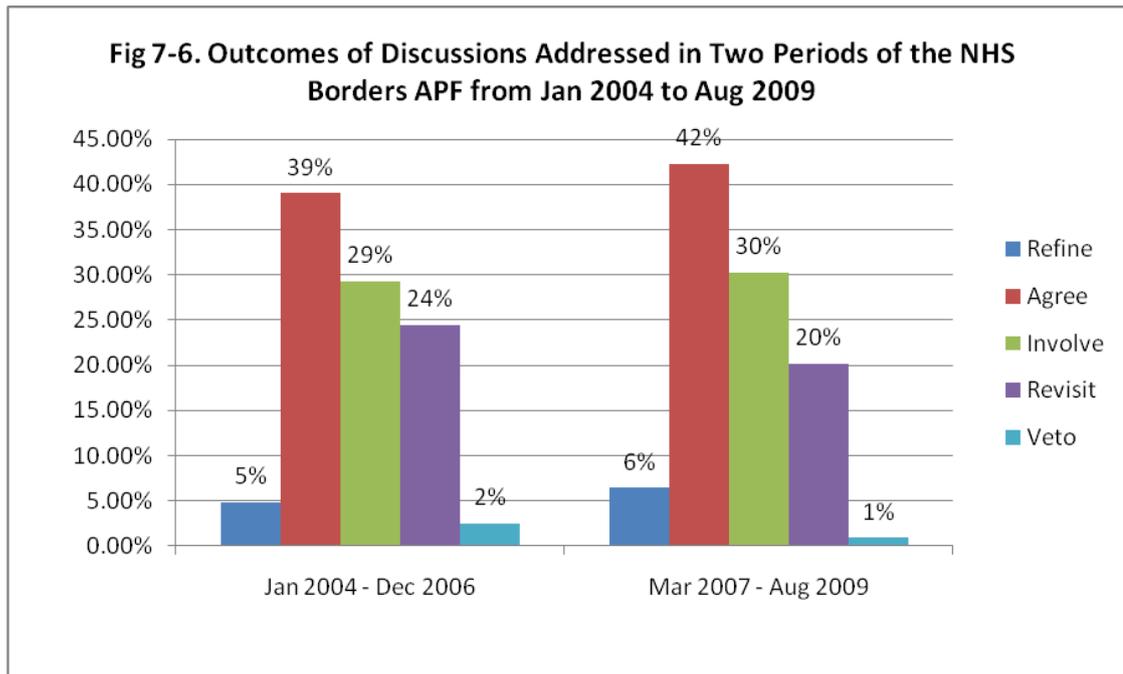


The number of decisions had significantly increased since the APF was restructured at the end of 2006. As Table 7-3 reveals, the Forum made decisions in 46 occasions in 2007, twice more than the 17 decisions made in 2006. It suggests that the APF was generally bypassed in the management decision-making process before restructuring. After restructuring, more items were brought to the APF. However, it is important to note that managers wanted the APF to endorse policies which were handed down from national authorities. The APF was like a policy-endorsement forum rather than a joint policy-making organisation.

**Table 7-3. Number of Decisions Made in the NHS Borders APF from Jan 2004 to Aug 2009**

	2004	2005	2006	2007	2008	2009
Refine	1	0	1	3	4	0
Agree	4	5	7	21	22	3
Involve	5	1	6	15	14	4
Revisit	5	2	3	7	13	2
Veto	1	0	0	0	1	0
In Total	16	8	17	46	54	9

Fig 7-6 compares the outcomes of discussions before and after the restructuring. It can be seen that there was a marginal increase in refining, agreeing and involving in issues and a reduction in revisiting and vetoing issues, suggesting that the Forum was evolving towards a more cooperative pattern and generating more positive outcomes after restructuring, albeit not in a significant way.



### 7.3 Delivery of Benefits

The previous section has analysed the overall outcome of partnership meetings in the three health boards. While in this section, it will continue to examine the outcomes of decisions made on each main category of issues and the distribution of gains for management, trade unions and employees.

#### 7.3.1 NHS Highland

In the aspect of decisions on particular issues, Fig 7-7 shows that more than half of the total number of decisions made in the APF was about Workforce Planning and Development (20%), Modernisation (18%) and Pay (16%). The number of decisions made on issues related to health, safety and well-being (10%) and Equality and

Training (9%) were higher than other issues like Partnership Working and the Forum (7%), Financial Issues (8%) and Staff Governance Process (7%). Decisions on clinical issues contributed the least, only accounting for 5% of total decisions made in the Forum.

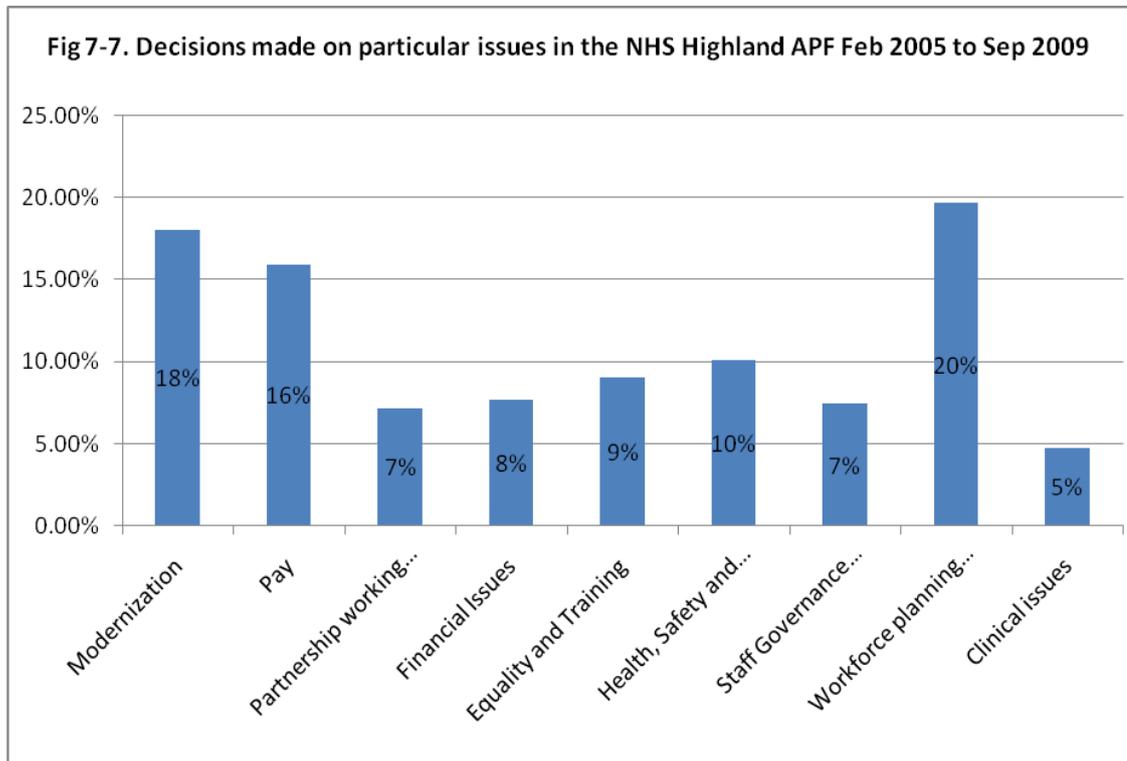


Table 7-4 reveals decisions made on different issues. In detail, decisions were made in 68 occasions on the issue of Modernisation, with agreeing on issues in 24 occasions and involving partners in equal numbers. It is noted that substantial changes to modernisation agendas were made in 11 occasions, suggesting that trade unions were not only involved in the strategic discussions but also can influence strategic decisions to some extent, at least in the implementation stage. Revisiting on modernisation issues occurred in 9 occasions. In some occasions, it was because the Forum was inoperative and they had to postpone the issues. There were also some occasions that agreement could not be achieved because trade unions were concerned that the

interests of their members might be eroded when implementing a particular policy, for example, the National Shared Service (see detailed discussions in Section 7.4.1).

**Table 7-4. Outcomes of Discussion on Nine Issues Addressed in the NHS Highland APF from Feb 2005 to Sep 2009**

	<b>Refine</b>	<b>Agree</b>	<b>Involve</b>	<b>Revisit</b>	<b>Veto</b>	<b>In Total</b>
Modernisation	11	24	24	9	0	68
Pay	16	22	13	7	2	60
Partnership working and the Forum	7	7	6	7	0	27
Financial Issues	3	10	13	3	0	29
Equality and Training	6	20	6	2	0	34
Health, Safety and Well-being	4	17	8	8	1	38
Staff Governance process	6	8	9	5	0	28
Workforce planning and Development	15	22	27	10	0	74
Clinical issues	5	4	8	1	0	18

Decisions were made on the pay issue in 60 occasions. Refinements had been made in 16 occasions, suggesting that substantial benefits were delivered to employees through partnership working. Good examples can be found on many issues like car parking charges, valuing service awards, lease car policy and subsistence rates. It is also noted that vetoing had occurred on pay issues in two occasions. It is not surprising to see this result due to its controversial nature. However, it also implies trade unions' hard-bargaining tactics on the issue while cooperating with managers in other issues.

Decisions were made on Workforce Planning and Development in 74 occasions. It is noted that workforce planning was widely discussed in the Forum and trade union representatives were involved in a very early stage. Refinements were made in 15 occasions which made the workforce strategy more suitable for the organisation and

easier to implement. For example, managers agreed to monitor and review the Nurse Bank Policy in order to adapt to the changing organisational environment and respond to employees' needs after consulting the APF.

On other issues, it is noted that agreeing and involving are the most common outcomes of discussions, which refinements being made in every area discussed in the Forum. It is therefore suggested that partnership working in NHS Highland could bring about substantial benefits.

### 7.3.2 NHS GG&C

Fig 7-8 indicates the outcomes of discussions which addressed nine broad issues. It is suggested that more than three-fifths (71%) of the total number of decisions were related to the issues of Modernisation (25%), Pay (27%) and Workforce Planning and Development (19%). The number of decisions made on other issues was relatively low and Clinical Issues (2%) were the lowest.

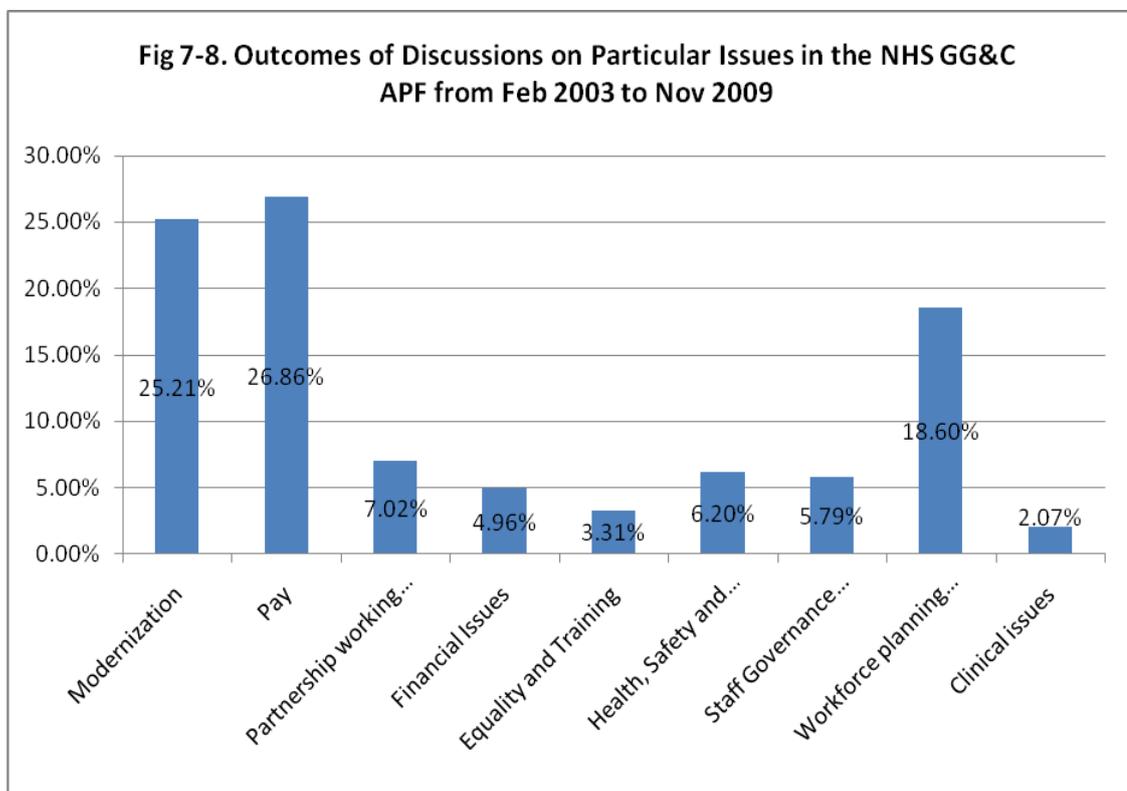


Table 7-5 reports the percentages of different kinds of decisions on particular issues. In detail, decisions were made on the issue of Modernisation in 61 occasions. Deciding to involve partners accounted for more than half of the total number of decisions (33 occasions), with refinements in 2 occasions. This therefore suggests that although trade unions were broadly involved in the strategic issues, the extent to which trade unions can influence the decision-making process was relatively low.

**Table 7-5. Outcomes of Discussion on Nine Issues Addressed in the NHS GG&C APF from Feb 2003 to Nov 2009**

	<b>Refine</b>	<b>Agree</b>	<b>Involve</b>	<b>Revisit</b>	<b>Veto</b>	<b>In Total</b>
Modernisation	2	12	33	12	2	61
Pay	6	18	24	12	5	65
Partnership working and the Forum	1	7	6	3	0	17
Financial Issues	1	3	6	2	0	12
Equality and Training	1	4	2	1	0	8
Health, Safety and Well-being	0	2	7	4	2	15
Staff Governance process	2	2	8	2	0	14
Workforce planning and Development	3	14	19	8	1	45
Clinical issues	0	1	2	2	0	5

Decisions made on the issue of pay accounted for 65 occasions. It suggests that the APF had exerted significant influence on this issue, as refinement on management decisions occurred in 6 occasions. Trade unions' aggressive bargaining behaviours in the Forum, particularly on issues of pay, echo with Bacon and Blyton's (2007) recent findings that consistently hard bargaining behaviors can benefit employees. Deciding to agree on this issue occurred in 18 occasions and deciding to involve partners occurred in 24 occasions. It is also noted that vetoing on pay issues occurred in 5

occasions, and in some occasions it was managers who refused to discuss particular issues such as car parking charges with trade unions,.

Decisions made on the issue of Workforce Planning and Development occurred in 45 occasions. In detail, decision to involve partners happened in 19 occasions, with agreement achieved in 14 occasions.

### 7.3.3 NHS Borders

Fig 7-9 reports the percentages of decisions made on particular issues. It is noted that the percentages of decisions made on the issues of Modernisation (20%) and Pay (23%) were higher than other issues. It appears that Health, Safety and Well-being issues were of special concern to the APF in NHS Borders, with 14% of the total decisions being related to these issues, and more than two-thirds of the decisions made through agreement (see Fig 7-9 and Table 7-6). The percentage of decisions made on Financial issues (3%), Equality and Training (6%), Staff Governance Process (5%) and Clinical Issues (4%) were relatively lower than the other issues.

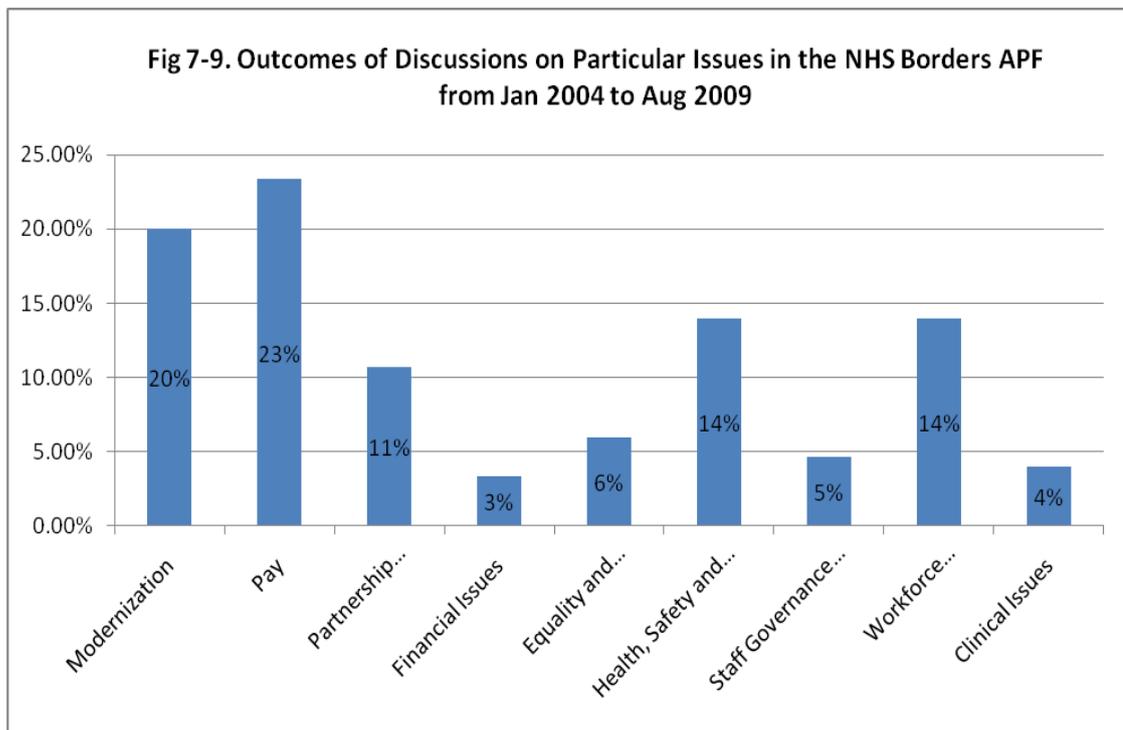


Table 7-6 indicates the decisions on different issues. Although modernisation was a prevailing topic in the Forum which accounted for 20% of the total number of decisions, most decisions were to involve partners or revisit issues in another day and decisions to agree on issues only occurred in 5 occasions. Furthermore, reasons to revisit issues were either due to the shortage of time in the meeting or an absence of participants the Forum. Decisions on the pay issue were made in 35 occasions, with agreeing on issues in 14 occasions and involving partners in 10 occasions.

It is important to note that decisions to revisit the issue of Partnership Working and Development occurred in 9 occasions, accounting for more than half of total decisions made on this issue. It was mainly because the Forum had encountered resistance from middle/front-line managers when discussing the future development of partnership working in their department. It is also noted that decisions made on issue of Health, Safety and Well-being occurred in 21 occasions, and more than half of the total number of decisions on this issue were related to the APF endorsing management proposals or policies.

**Table 7-6. Outcomes of Discussion on Nine Issues Addressed in the NHS Borders APF from Jan 2004 to Aug 2009**

	<b>Refine</b>	<b>Agree</b>	<b>Involve</b>	<b>Revisit</b>	<b>Veto</b>	<b>In Total</b>
Modernisation	1	5	14	10	0	30
Pay	2	14	10	8	1	35
Partnership Working and the Forum	1	4	2	9	0	16
Financial Issues	0	3	1	1	0	5
Equality and Training	1	4	3	1	0	9
Health, Safety and Well-being	1	14	4	1	1	21
Staff Governance Process	1	3	3	0	0	7
Workforce Planning and Development	2	10	7	2	0	21
Clinical Issues	0	5	1	0	0	6

## **7.4 The Outcomes of Critical Issues**

Some critical issues would inevitably arise in partnerships, which, if not resolved successfully, will jeopardise partnership relationships. However, if these challenges could be addressed successfully, the experience would strengthen partners' commitment to the partnership and further reinforce the sustainability of partnership (Leonard and Swap, 1999; Kochan et al., 2008). In the following section, a number of critical issues are selected from the three organisations. By analysing these issues, it will help us to gain a more concrete understanding of the following questions, for example, how do partners jointly work on problems? What are different participants' attitudes towards partnership working? To what extent have mutual gains been delivered?

Four critical issues are selected from the agendas of the three APFs, namely National Shared Service, Tobacco Policy, Car Parking Policy and Financial Deficit. The principles for choosing these critical issues were considered in two aspects. Firstly, the issues must be discussed in all of the APFs, which therefore can allow comparison to be made between the three cases as how issues were proposed, discussed and solved. Secondly, the issues were generally selected from the strategic meetings that aiming to test trade union influence on the strategic decision-makings.

### **7.4.1 National Shared Services**

A central component of Scotland's public sector modernisation agenda was to tackle waste, bureaucracy and duplication. In order to achieve this goal, the Scottish Executive launched the Efficient Government Initiative that contains five key work streams in June 2004. The Shared Service Strategy was developed as one of these five key work streams. By providing some common internal support service functions (e.g. Finance, Procurement, HR, Payroll, ICT, Facilities) and operational process and

systems underpinning common frontline service areas (e.g. Revenues and Benefits, Social Care, Education, Housing, Transportation, Policy and Fire), it was expected that the Shared Service Strategy can release significant efficiency savings or investment in frontline services that can eventually lead to better service quality and consistency (Scottish Executive, 2006).

As the second largest employer in the public sector of Scotland, NHS Scotland has been an early adopter of the strategy. A general background behind this decision was that the NHS Scotland was buying as 47 different organisations before the National Shared Service (NSS) was implemented. It was recognised that there was a lack of consistency between these organisations and resources were wasted in the duplicated operations. Therefore, it was necessary to implement more effective systems across Scotland.

### **NHS Highland**

NHS Highland has been an actively supporter of NSS during its implementation. An initial project group which involved the Director of Finance, management representatives, APF representatives and staff representatives from the Finance Department was set up by the Board in May 2005. The Project Group has set its primary goal at the early stage to communicate with all affected staff and support implementation of the NSS.

Even earlier than the national consultation paper which was published in May 2006, consultations with staff side in Highland had already taken place since January 2006. Members from APF had fully discussed the impact of NSS on NHS Highland and the future actions to be taken. Both of managers and trade unions were sharing the view that the process to implement the NSS should be robust and it also should be supported by local board officers and with involvement from the staff side. More importantly, during the discussions members were well recognised that human

resource issues were not included in the omissions of NSS that employees might concern in the future. Therefore, the HR Director had planned to hold a special workshop with staff-side representatives in order to ensure full engagement of the APF in the programme and set the principle that the action plan would be integrated as part of the Board's Workforce Planning Programme. In addition, managers also joined the staff-side meetings regularly to keep relevant information disseminated to those members of staff affected.

This case represents a good example of partnership working in NHS Highland. Tangible benefits have been created for both managers and trade unions. For managers, they have gained support from trade unions to execute a national policy. As a result, the NSS was implemented in NHS Highland smoothly. Furthermore, it has generated efficiency savings as the programme originally expected that benefiting the whole organisation. As for trade unions, representatives have been involved in the case since the early stage to exert significant influence on the implementation process. In addition, trade unions' concern of their members' job security was taken seriously by managers and finally addressed through a joint problem-solving approach.

### **NHS GG&C**

NHS GG&C established a steering group to support the implementation of NSS in June 2006. The Steering Group was co-chaired by the Board Finance Director and a union officer from Unison. There were also three sub-groups under the governance of the Steering Group to look at HR, communication and a service model to support implementation.

Several workshops were held by the Steering Group to classify issues and a basic agreement to support NSS was achieved. In the meantime, a number of challenges were identified in the APF meetings. The staff side has questioned the accuracy of the figures provided by management and the timescale for implementing such a huge

project. A few technical issues were also raised by trade unions. In particular, the staff side has expressed deep concerns about the redeployment and staffing of employees from the Department of Finance. It was stressed by union representatives that employees from Financial Department had just undergone local reorganisation and were under huge working pressure from implementing Agenda for Change. The new programme had demotivated them and made them feel undervalued. More importantly, the staff was concerned with their future job security. Therefore, the staff side threatened that they could not support progressing with NSS until the HR issues raised were addressed.

In response, managers made efforts to work on this issue in partnership with the trade unions. With support from the Board of NHS GG&C, the managers and trade unions then compiled a report that contained unions' concerns and the report was sent to the NSS Project Team. The team welcomed the partnership approach adopted by the APF and the Board's support of the Forum's review, and as a result they amended the original plan and took a more measured approach.

The above case reveals a typical partnership working approach in NHS GG&C that was being challenged by trade unions during the consultations. While trade unions in this case were successful in influencing management's decision and protecting their members' interest, some essential factors that might have contributed to the successful partnership working on this issue need to be noted, for example, broad involvement of trade unions in early consultations, union representatives' candid and critical views being valued by managers, and the support of the NHS GG&C Board, etc.

### **NHS Borders**

In NHS Borders, the NSS was implemented by a Project Team that included the Employee Director. The team was running outside the APF and reported back to the APF casually. Similar to other boards, employees in NHS Borders were also

concerned about their job security under the implementation of NSS. However, there was evidence suggesting that employees' voice and concerns were not expressed through the APF but through some other informal channels. Managers had expressed the view that they would like to meet with staff to provide them with updates and listen to any concerns. Several meetings were arranged by managers for employees to meet directly with people who were involved in the process. After discussing with the employees, managers could well address their concerns and assured them that no compulsory redundancies would be conducted and there would be protection of current terms and conditions if staff were to be relocated or redeployed. The APF's influence on such issue turned up to be shallow. It appeared that the APF is simply a place where managers inform results to trade unions, rather than a joint forum for partners to resolve problems.

#### **Various ways to address issues**

When implementing the National Shared Service, all the three Boards faced the same challenge that staff's job security was threatened. However, it is noted that the issue was addressed in the three APFs in very distinct ways. The NHS Highland APF appeared to be quite cooperative. Both managers and trade unions showed mutual respect to each other's interest. Trade union's concerns about staff job security were recognised and addressed seriously by managers. In return, trade unions helped managers to implement such strategy more smoothly. In NHS GG&C, the issue was also addressed by managers, but in a different manner. Trade unions in the NHS GG&C APF questioned managers about the rationale of the strategy and technique possibilities. Furthermore, negotiation of staff issues was treated by the trade unions as a precondition to cooperate with managers, and they threatened not to cooperate if managers failed to fulfil these conditions. While in NHS Borders, the issue was

addressed outside the APF. Managers preferred to meet directly with staff rather than through the APF.

#### **7.4.2 Tobacco Policy**

On 30<sup>th</sup> June 2005, the Scottish Parliament passed “The Smoking, Health and Social Care (Scotland) Act 2005” that came into force on 26<sup>th</sup> March 2006. The Act establishes that it is an offence to smoke in any ‘wholly or substantially enclosed public space’ in Scotland, but with a small number of exceptions such as in care homes and psychiatric hospitals. On 21<sup>st</sup> December 2005, some main organisations in the Scottish health sector jointly published a guidance that aimed to enable the NHS, local authorities and other care service providers in Scotland to comply with the smoking free legislation and offer advice on the development of an approach to tobacco which perceived to maximize the benefits of becoming smoke-free. The NHS organisations were expected to play a health leadership role during the implementation of this legislation and there was a desire that NHS organisations should not only comply with the smoke-free legislation, but they need to work towards a completely smoke-free policy. Under such circumstances, the central themes discussed in local NHS boards were how to implement the national policy well and whether to choose a total smoking ban strategy.

#### **NHS Highland**

In NHS Highland, early consultations with trade unions about the draft of a tobacco policy had started within the APF since March 2005. The Forum decided to comply with the national policy and a number of actions to support implementation of the policy were discussed, for example, the smoking cessation programme.

After the national guidance to encourage NHS organisations to extend to a total smoking ban stage was published, the issue of whether NHS Highland should go for a

total ban remained a contentious issue in the Forum. Differing views had been expressed. For example, on one hand, some members felt that NHS Highland should be moving towards a total smoking ban in all its premises as designated smoking areas may send out mixed messages, yet on the other hand, the potential difficulty and stress to patients and staff of a total ban was acknowledged, as were the difficulties in implementing such a policy. The issue were revisited several times but remained unresolved until the NHS Highland Board unilaterally decided to introduce a total smoking ban on all sites at its June 2006 meeting.

Managers then informed the APF that a new total smoking ban policy for NHS Highland would come into effect from 1<sup>st</sup> April 2007 and it was expected that positive support was to be sought from the staff side. However, the staff side objected to the implementation of the extended policy. Some trade unions expressed deep concerns over the principle of staff-side consultation and the practicality of introducing a total smoking ban that exceeded the current legislation. For example, Unison criticised that the policy was formulated centrally by the Board without consulting trade unions and indicated that they could not support such a policy without further consultation. In the APF meeting held on 16<sup>th</sup> March 2007, the Director of Public Health attended the APF meeting and reiterated that there was a desire for the Board to extend to a total smoking ban, as most of other NHS Boards had already introduced. But again, the staff side emphasised that they were opposed to the implementation of the extended policy and a letter was written to the Chief Executive advising that there would be no participation in the implementation.

Despite the lack of trade unions' support, managers still decided to implement the extended policy, but they were quick to find out that this matter could not proceed without staff-side commitment. Therefore, the issue was revisited again in the APF

meeting held on 20<sup>th</sup> July 2007. During the meeting, the Chief Executive pointed out the political pressure for NHS Highland not to implement an extended no-smoking policy and urged the staff side to reflect on their decision not to participate in the process. Eventually, the staff side made a concession and agreed to re-engage and participate within the process. A finalised NHS Highland Tobacco Policy was proved by the APF and came into force on 1<sup>st</sup> September 2007.

### **NHS GG&C**

In NHS GG&C, the No Smoking Policy was discussed in the Board meetings. At its meeting on 22<sup>nd</sup> February 2005, the Board approved to send a draft to the public for consultation. On the whole, the respondents supported the rationales and aims of the policy, but feared that it might be too ambitious and as a result it would not be implemented effectively. Following the comprehensive consultations, the No Smoking Policy in NHS GG&C came into force on 26<sup>th</sup> March 2006. The policy was then revised and extended to a total smoking ban that was in effect from 1<sup>st</sup> March 2007.

The APF was bypassed during the consultation and implementation process of this policy. No substantial discussions on this issue had occurred in the APF meetings. Furthermore, the Board had chosen the strategy to directly consult with the staff, the public and representative groups rather than the trade unions. Although concerns about why this policy had bypassed the APF and gone straight to the Corporate Management Team were raised in the APF meeting, the Employee Director replied that there were different ways of working in partnership and some groups produced documents which did not have to be brought to the APF. This therefore suggests that the APF was not the only place where partnership working would take place and sometimes partnership would operate informally in NHS GG&C.

### **NHS Borders**

Since 2002 NHS Borders has adopted a Tobacco Policy which is committed to bringing the community towards a smoke-free environment. In 2004, the policy was reviewed by the Occupational Health & Safety Forum (OH&S) that decided to extend the extant policy for another two years. The APF approved the revised policy at its meeting held on 29<sup>th</sup> January 2004 and allow staff to smoke only in designated areas. The current policy has been in situ since 2006 and complies with the national no-smoking legislation and the national guidance on smoking policies for the NHS, local authorities and care services providers 2005 which directs NHS to move towards a total smoking ban environment.

The Board has set up a special Tobacco Policy group to look into the smoking issue. The Tobacco Policy group consists of all members of the OH&S Forum and other representatives from Clinical Boards, Support Services, Health Improvement and a seat was reserved for the Employee Director. It was noted that, from 2004 to 2009, the Tobacco Policy in NHS Borders had been revised for three times, but no substantial discussions occurred in the APF meetings. The decision making power was assigned to the Tobacco Policy group which reported directly to the Board.

#### **Various ways to address issues**

Although all the three Boards were eventually in a total free smoking environment, the consultation and implementation processes were different. In NHS Highland, managers opened a consultation procedure in the APF and confronted objection from trade unions. Under such situation, managers tried to implement the policy unilaterally without the involvement of trade unions but found it very difficult to achieve success. The intervention of Chief Executive helped to settle the dispute and trade unions finally made a concession recognising the great political pressure the management team were facing. In NHS GG&C, managers conducted a more comprehensive consultation with staff, the public and other professional groups. The issue was

perceived as a need to comply with the law and was discussed in the Board meeting. The APF was therefore excluded from this issue. In NHS Borders, the issue was mainly discussed in the Occupational Health & Safety Forum and the APF was excluded.

### **7.4.3 Car Parking Charges**

In April 2004, the Scottish Government published a guidance that defined the car parking charges as a local decision and authorised the NHS Boards to decide the level to charge in partnership with trade unions. In response, many boards showed a strong willingness to charge on car parking. For example, just one month after the release of the national guidance, NHS GG&C announced to phase in the charges for staff, patients and public visitors with effect from April 2005. For the management side, the main reasons behind this move included the need to respond to the government guidelines to promote green travel and reduce car travel, in view of the lack of car parking spaces and the financial pressure to sustain and manage the car parking system. The management team expected that the parking charges could be used to offset initiatives such as subsidised public transport for staff and improved public transport links. However, such policy met strong resistance from the trade unions. For example, Unison and RCN claimed that it was an unfair burden added on staff, patients and visitors. Furthermore, radical industrial actions were taken by trade unions in some NHS sites, for example, the 'No to parking charges' campaign organised by RCN Scotland and employees' strike actions over car parking charges run by Unison.

It was noted that car parking charges has long been a typical contentious issue between management and trade unions that may jeopardize the future of partnership working in NHS Scotland. As summarised in Table 7-7, from 2004 to 2008, two

national reviews were held by the Scottish Executive that directed to management's concession on the charging issue after each national review. As the car parking charges were eventually abolished, it can be seen that trade unions had succeeded in this dispute in protecting their members' economic interest. It is worth assessing carefully whether the issue was addressed with the remit of partnership working or purely by traditional radical industrial actions at the Board level.

**Table 7-7. Developmental Milestones of Car Parking Charges in NHS Scotland**

Years	Main Events
2004	On 1 <sup>st</sup> April 2004, the Scottish Executive published new guidelines HDL(2004)19 on car parking issues that replaced the original ones which were issued to NHS Scotland on 17th March 2000 in MEL(2000)13. The guidance defined that the car parking issue is a matter for local determination by the local NHS board responsible for the NHS site. It sets up the basic principles for NHS boards to charge on car parking, for example, the necessity to consult staff before introducing or substantially revising car park charges and the use of income generated from car parking charges.
2007	In February, the first national review on car parking charges was called by the then Minister. The charge was reduced from £12 per day to £7 afterwards.
2007	On 14 <sup>th</sup> March, a new guidance on hospital car parking charging HDL(2007)14 was launched. It replaces the guidance which was issued to NHS Scotland on 1 <sup>st</sup> April 2004 in HDL(2004)19. It indicates that the introduction of car park charging, or the revision of existing car parking arrangements, remains a local issue by the correspond in NHS board responsible for the NHS site. In addition, it sets up the level of charging and the minimum concessions given to patients, staff and visitors.
2007	On 14 <sup>th</sup> September, a national review group was set up with the remit to review existing guidance on car parking and charges, with an emphasis on the impact on staff, particularly lower paid staff. The review group was made up of representatives from SPF, the Scottish Health Council, a voluntary organisation, the NHS Board Chair and HR Director. It was the second time that hospital parking charges came under top-level scrutiny.
2008	The result of the second national-wide review has led to a further reduction of car parking charges from a maximum of £7 per day to £3 capped that came into effect in Jan 2008.
2008	On 11 <sup>th</sup> September, the Scottish Government announced that car parking charges were to be abolished at most of the NHS hospitals across Scotland with effect from 31 <sup>st</sup> December 2008 (Scottish Government, CEL 38(2008)).

## **NHS Highland**

In NHS Highland, a car parking review group was set up in September 2006 with the remit to deal with congestion around Assynt House and John Dewar Building and to develop a sustainable travel plan for those sites managed by the Board. Staff-side representatives were involved and consulted in the early stage. In order to reduce reliance on single occupancy car travel, various options were given during the consultation, including car sharing, the use of public transport, cycling and walking. Subsequently, the Travel Planning Steering Group was set up to take the process forward and hold extensive consultations with staff regarding the plan. On 19<sup>th</sup> January 2007, in view of the fact that demand for car parking spaces was likely to exceed the number of spaces available, the management side proposed a scheme to charge staff on car parking. Not surprisingly, union representatives stated that the staff side could not accept the proposal. However, they recognised that there was a need to ease the pressure at key sites, and they were happy to discuss with the management side to explore alternative options. On 16<sup>th</sup> March 2007, two days after the second national guidance on car parking charging HDL(2007)14 was issued, the management side reiterated the proposals to charge car parking at Assynt House and John Dewar. In the meantime, managers and unions jointly developed a bicycle lease scheme that provides financial support for staff that was willing to cycle to work. The scheme was positively welcomed. However, unions were still against the charge. As a result, on 16<sup>th</sup> November 2007, the APF announced management's concession not to proceed with the car parking charge at John Dewar Building. However, unions and managers would keep on exploring workable solutions to resolve the car parking issues at Assynt House. It is noted that the Chief Executive played a leading role in this matter, and several consultations were organised to investigate some other possible options. Eventually, in response to the decisions by the Scottish Government to abolish car

parking charges at NHS sites from 1<sup>st</sup> January 2009, proposals to charge on car parking at Assynt House were suspended in NHS Highland. However, unions and managers still worked together to manage the car parking system, for example, cost implication of monitoring the system and the promotion of alternative modes of transport.

### **NHS GG&C**

Complying with the national guidance on car parking charges in HDL(2004)19, the NHS GG&C Board unveiled its plans to introduce car parking charges at eight hospitals in the Glasgow area on 18<sup>th</sup> May 2004. After several consultations with staff side, the car parking policy was approved by the APF in difficult with effect from April 2005. On 8<sup>th</sup> February 2007, the NHS GG&C decided to take a further step to introduce car parking charges to most of the main hospitals in the Glasgow area. The trade unions had expressed deep concerns about this action. In the APF meeting held on 29<sup>th</sup> March 2007, the staff side proposed a moratorium on the current Car Parking Policy in response to complaints from their members. However, the management side argued that the policy applied to NHS GG&C was legitimate according to the recent national guidance on car parking charges in HDL(2007)14. Although they agreed to undertake a review of certain implementation issues such as the level of charging, impact on regular hospital attendees and out-of-hours staff, there was a view that it was unlikely for trade unions and the Board to reach a consensus on the principle of charging. The issue was then put on the agenda of the strategy meetings of the Forum. However, the result turned out that the trade unions were excluded from the review process and informed the results of the review by a core brief. The manner in which managers handled this matter had therefore triggered severe conflicts.

On 11<sup>th</sup> June 2007, the NHS GG&C Board decided to reduce parking charges at some major hospitals under great political pressure and in response to complaints from

patients and low-paid staff. The original maximum £12 daily parking charge was reduced to £7 after a detailed review. However, trade unions were not satisfied with the concession made by the Board. In the APF meeting held on 21<sup>st</sup> June 2007, the staff side again expressed their deep concern about not being involved in the car parking review process and questioned the Board's commitment to partnership working. In addition, they had made an effort to discuss with managers whether it would be flexible to apply charges for car parking throughout the Board's area. However, the management side held an assertive attitude and the Chief Executive made it very clear that "the principle of charging was not up for review or debate". The HR Director also expressed the view that the review of the implementation of the policy need not return to the APF for discussion, as stated by the HR Director:

*"It would not have been productive or appropriate therefore, to expect agreement in partnership to levels of charging and other implementation issues which might be seen to indicate acceptance of the principle." (HR Director, NHS GG&C)*

More disappointing for trade unions, the management side held an informal meeting with a group of staff outside the trade union structure which involved staff members, the local community and local traders to discuss the issue and submitted a report to the Scottish Government. Such a tactic was perceived to limit the influence of the trade union and to increase management discretion (Oxenbridge and Brown, 2002).

Facing the situation, the trade unions reiterated that it was unacceptable for the NHS GG&C Board to charge staff on car parking and they had no choice but resorted to radical industrial actions. On 24<sup>th</sup> August 2007, RCN Scotland launched a 'No to parking charges' campaign, calling on NHS Boards to end charging at all NHS premises in their areas and urging the Scottish government to abolish the charges. On

12<sup>th</sup> September 2007, Unison threatened that it was planning to ballot staff employed by NHS GG&C on strike action over the car parking charges. As stated by one Unison officer:

*“... members are very angry over these charges and they are even angrier that their employer has refused to listen to them.” (Trade Union Representative, NHS GG&C)*

Another union representative stated that:

*“... it was unacceptable that the NHS GG&C Board charging staff on car parking, while it was even more disappointing that unions’ attitude on this issue was largely ignored by management-side and there was a lack of union engagement in the decision-making process.” (Trade Union Representative, NHS GG&C)*

In view of the trade unions’ tough attitude and a number of parliamentary and public concerns<sup>8</sup>, on 22<sup>nd</sup> September 2007, NHS GG&C decided to delay the introduction of car parking charges at hospitals which was due to occur in December 2007. However, the Board stressed that it was still committed to the “full implementation” of the policy in the future. Even so, the decision was welcomed by the unions and it was perceived to be a breaking point for managers to have open talks with unions on this problem.

After the second national review on car parking charges, the Scottish Government decided to cap the daily charge at £3 across most hospitals in Scotland with effect from Jan 2008 as a last resort. The trade unions issued a “cautious welcome” on the decision, but still perceived the £3 charge was a “tax on the sick” which could not be

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<sup>8</sup> A typical event was the review of car parking charges at NHS hospitals that ordered by the Scottish Government on 14<sup>th</sup> September 2007.

accepted. Eventually, car parking charges were abolished at NHS healthcare sites from 31<sup>st</sup> December 2008.

### **NHS Borders**

Unlike NHS Highland and GG&C, NHS Borders do not currently charge for car parking at any of its sites. The Board set up a car parking group with the remit to assess the parking needs of the organisation, specifically at Borders General Hospital. Any proposals from the will group directly go to the Board, and therefore there are no discussions on the car parking issue in the APF.

### **Various ways to address issues**

The car parking charges was one of the most controversial issues that could jeopardise the future of partnership in NHS Scotland if not addressed appropriately. The results indicate that trade unions in NHS Scotland did have great influence on the management decision making process, as the policy was eventually abolished by the Scottish Government. The question is: was the decision to change the policy actually shaped by partnership working or by the traditional adversarial industrial actions? The way how NHS Highland and NHS GG&C addressed this issue gives an answer to this question.

It is noted that both NHS Highland and NHS GG&C had confronted severe objection from trade unions when the car parking charges were implemented. However, in NHS Highland, managers and trade unions were regularly involved in the discussions and openly discussed alternative ways to address the issue. Although bargaining behaviours on this issue appeared to be more aggressive and harder than many other issues, no party left the table. Finally, the trade unions were successful in slowing down the management side's decision making process and made managers give up the original plan till the policy was called off by the Scottish Government. In contrast, in NHS GG&C, the trade unions had tried to negotiate the policy in the APF, but in a

very aggressive and challenging manner. Despite this, managers insisted on implementing the policy. Partnership approach was abandoned because managers kept the trade unions out of the issue and refused to discuss the issue in the APF. As a result, trade unions decided to take industrial actions which alerted the Scottish Health Minister. The policy was eventually abolished due to political pressure suggesting that the traditional industrial actions were more likely to generate substantive gains for trade unions and their members when partnership working did not work.

#### **7.4.4 Financial deficit**

The Scottish Government sets three financial targets for all health boards: to operate within the given revenue budget; to operate within the given capital budget; and to operate within the given cash allocation. As discussed in Section 4.3, the financial environment has been changing among the NHS boards in Scotland as budget was cut down since 2007. Therefore, regional NHS boards are required to cut expenses and find savings in order to reach a break-even point. This section will analyse how trade unions were cooperating with managers to address the financial deficit through partnership arrangements.

##### **NHS Highland**

In 2005/06, the Board encountered a number of financial problems and its financial position dropped from an anticipated surplus of £4 million to a deficit of £1 million. In order to manage the financial deficit, managers had to cut expenses in areas that had minimal impact on frontline patient services. In such a case, managers appreciated the great value of partnership working with trade unions and they proposed to put the financial saving issue on the APF agenda as a standing item hoping that the staff side can participate in this process. As the Chief Operating Officer indicated:

*“... the APF would be the correct Forum for detailed discussion to take place on such issue once more detailed proposals had been established and staff at all levels and in all locations would have a role to play.”(Chief Operating Officer, NHS Highland)*

In response, the Forum agreed to consider the information and put forward suggestions to improve the situation. Further discussions were then taken place in the Forum, and members have reached a consensus that there was a need to get the message out that staff could make a huge contribution. Various means had been used to disseminate the financial information to staff, for example, by team update, briefing sessions, roadshow and workshops with trade union representatives. Eventually, relying on non-recurrent savings, NHS Highland has succeeded in balancing the budget for the financial year 2005/06. However, the financial challenge went greater for NHS Highland for 2006/07, as a budget deficit of £15.4 million was projected. The Board realised that there would be far less non-recurrent resources available for appropriate allocation. Therefore, there was a need to identify recurrent savings that would mean unavoidable pressure for the operational units and corporate services. The Financial Department proposed to deal with the financial deficit by three strands, involving technical accounting aspects, Non-Recurrent savings and a saving plan that would give consideration of service redesign and whole operation system changes. In order to implement the saving plan, managers recognised that a cultural change would be needed and the engagement of staff in the process would be crucial. As the Director of Finance stated that:

*“... any financial plan could only work using partnership principles and would require to draw upon the detailed knowledge and suggestion of staff.” (Director of Finance, NHS Highland)*

Finally, depending on the successful implementation of the financial saving plan, NHS Highland had reached a break even by year end for 2006/07. There was evidence suggesting that staff had contributed a lot of valuable suggestions for achieving the financial targets in NHS Highland. For example, in relation to service redesign, a number of areas which include procurement, delayed discharges and closure of the short stay facility in Accident and Emergency were identified in staff-side meeting. Staff had also suggested considering changes to the non-patient impact areas, for example, transfer of the financial grouping of digital hearing aids from revenue to capital. Furthermore, an energy efficiency campaign was raised by staff who suggested turning off computer monitors at night.

### **NHS GG&C**

Financial issues have been regularly reported in the APF since 2003. It was noted that the financial position in NHS GG&C has changed since the application of Arbutnott Formula<sup>9</sup>. As a result, NHS GG&C is no longer a “gainer”, but they lose considerably. For example, the financial funding for NHS GG&C was £11 million less than the anticipated amount in the financial year 2003/4. Considering the financial challenge, both the managers and trade union representatives agreed that there was a need to inform staff the financial situation the Board was facing. Different options were considered as to the best means of disseminating the financial position to staff, which includes briefing sessions by the Chief Executive, video presentations and staff briefs.

Although managers did recognise the importance of informing the financial position to staff, the staff side was not informed of the problem. In view of the emerging costs for many new initiatives driven by the Scottish Executive, the Board decided to use

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<sup>9</sup> Arbutnott Formula is a calculation used to allocate central funds for Hospital and Community Health Services (HCHS) and Prescribing by assessing key indicators of population, inequality and deprivation of the areas covered by each of the NHS Boards.

non-recurring funding to reach a breakeven position. The decision was announced in an APF meeting without consulting the trade unions. Later on, in the APF meeting held on 1<sup>st</sup> December 2003, the staff side was informed that managers had decided to modify the Parental Leave Policy to a more compromising position. And again, prior consultation with trade unions did not take place.

The issue of financial deficit was not raised in the APF for 2004/5 and 2005/6. In the financial year 2006/7, the Board had a financial deficit amounting to £31 million after merging part of NHS Argyll and Clyde. In order to address the issue, a paper “Development of Cost Saving Plan for Clyde” was proposed by the Financial Department. The saving plan was presented to the Forum and staff side was invited to involve in the process. However, it appeared that no substantial discussions with trade unions had occurred in the Forum and the decision-making process generally followed the route that managers informing the APF decisions that had already been made.

### **NHS Borders**

In view of the tighter financial climate and continued challenges relating to increased initiatives driven by central authority of NHS Scotland, NHS Borders has introduced a 3-year Strategic Change Programme since 2008. A central theme of the programme was to provide value for money services within a financial framework that emphasises the need to make significant savings. The programme contained six work streams<sup>10</sup>, with each stream managed as a project in its own right. It is noted that the Employee Director was leading the Improving Efficiency, Reducing Waste strand. Such strand was a one-year campaign that enables all staff to have involvement by providing suggestions on how saving can be made within the workplace. However, it turned out

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<sup>10</sup> The Six work streams are: Improving Efficiency, Reducing Waste; Productivity and Benchmarking; Operational Budget Savings; Integrated Health Strategy; Continuous Improvement; Sustainable Workforce.

that most of the work around this strand was done outside the APF. No further reports were handed over to the Forum and no substantial discussions around this issue occurred in the APF.

Among the six work streams, only Operational Budget Savings were regularly reported to the APF. This work stream aimed to seek all opportunities to reduce costs and achieve efficiency savings by setting recurring and non-recurring targets for each clinical board and corporate services in NHS Borders. However, there was no evidence suggesting that managers involved staff or consulted trade union representatives, at least not through the APF.

In general, the APF appeared to be immobilised when strategic issues like financial planning and savings were discussed. Furthermore, some issues that would apparently have great impact on staff were not discussed in the Forum. For example, one of the main objectives of the Strategic Change Programme was to review the staffing models and to redesign the recruit processes in order to retain the highly skilled workforce. Without consulting the staff side in the APF, actions were taken by managers to reduce recruitment advertising costs and utilise new workload planning tools in hospitals.

### **Various ways to address issues**

In view of the tightening financial environment, all three health boards were under great pressure to meet their financial targets, and managers were seeking trade unions' cooperation to address this issue. However, the process of joint working and eventual outcomes differed between these three health boards. In NHS Highland, managers disseminated the financial problems to employees and openly discussed the issue in the APF. Multi-methods were used by managers to communicate with staff, including communication through the intranet, magazines and newsletters. In addition, managers valued the ownership of good ideas from staff that in turn motivated them to

contribute more. The openness of managers received full respect from the trade unions. The APF was actively involved in the process to deal with financial problems and played an important role in dealing with issues related to communications, contribution of ideas and staff governance. The way how managers and trade unions jointly addressed organisational challenges has contributed to the success of the organisation which in turn reinforced each party's commitment to partnership working. Furthermore, a potential gain for the employees was that managers chose to resolve financial deficit by saving plans or service redesign rather than by laying off staff. As stated by the Employee Director, "the Board was not going down the route of introducing redundancies".

The case of NHS Highland therefore presents a very good example of partnership working that illustrates how managers and trade unions work together to secure organisational success. It is noted that good communication and mutual respect are essential in maintaining good management and union cooperation. In contrast, managers in NHS GG&C perceived the financial issue as a managerial prerogative and trade unions were not substantively involved in the decision making process. In NHS Borders, managers recognised that trade union and employees can make great contributions if they could discuss the financial issues together. However, discussions and actions on the financial issues were not taken through the APF. Partnership working in NHS Borders appeared to be more informal than the other two Boards.

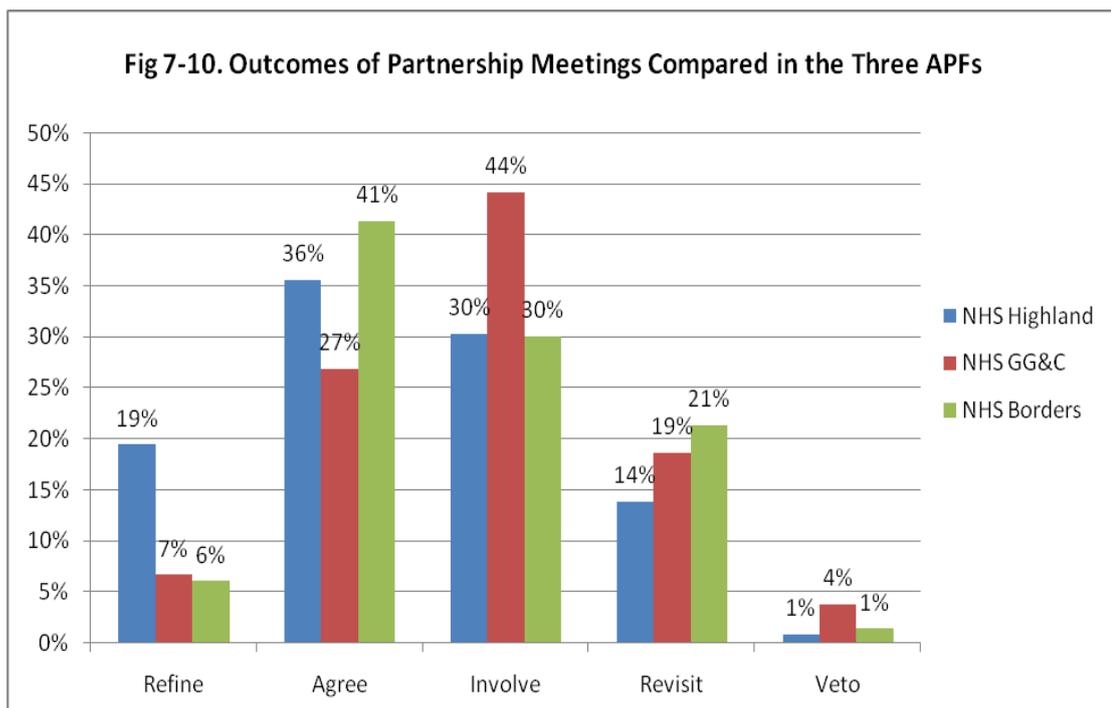
## **7.5 Summary and conclusions**

Advocates of partnership have argued that working in partnership can result in mutual gains for both management and trade unions. It has been suggested that management can benefit from partnership working by gaining higher employee contribution to facilitate organisational change to implement quality initiatives that

may eventually link to higher performance (Guest Peccei, 2001; Marchington and Wilkinson, 2005; Oxenbridge and Brown, 2004). From the trade union perspective, it was perceived that partnership agreements help develop consultation procedures that can increase the opportunity for trade unions to get involved in decision-making process. In addition, it may also provide more chance for trade unions to exert influence on the management decision-making process and gain substantive benefits for their members, for example, better employee relations and harmonisation of terms and conditions, greater voice and job security (Guest and Peccei, 2001; Oxenbridge and Brown, 2004) .

In this study, the above analysis suggests that substantial benefits have been generated in the process of partnership working in the three cases. However, the level to which substantive benefits have been generated and the extent to which mutual gains had been delivered between management and trade unions differed between the three APFs. The NHS Highland APF was relatively more involved in the management decision-making processes and has greater efficiency than the other two boards, as the Forum had made 376 decisions in 35 partnership meetings from Feb 2005 to Sep 2009 (on average 12 decisions per meeting). In contrast, the NHS GG&C APF had made 242 decisions in 53 partnership meetings from Feb 2003 to Nov 2009 (on average 5 decisions per meeting) and the NHS Borders APF had made 150 decisions in 26 partnership meetings from Jan 2004 to Aug 2009 (on average 5 decisions per meeting). In addition, as Fig 7-10 indicates, almost one-fifth of the total number of decisions in NHS Highland were to refine policies which produced tangible changes and improvements for both management and trade unions, suggesting that the NHS Highland APF has greater influence on management decision-making than the other two APFs. While in NHS GG&C, more than two-fifths (44%) of the total number

decisions were to involve partners in the discussion, but they rarely generated positive outcomes for both parties (only 7% of total decisions were refinement). This suggests that trade unions in NHS GG&C were more involved in a wider range of discussions on various issues, but they have less influence on management decision-making process than its counterparts in NHS Highland. In NHS Borders, the APF was a better place for managers to share information and seek endorsement from the APF, given that two-fifths (41%) of total decisions in the APF were about agreeing management proposals or endorsing policies handed down by national authorities. Trade unions were not involved in big issues and can rarely exercise influence on management decisions.



In terms of the delivery of benefits for management, trade unions and employees, it is fairly to conclude that substantial benefits have been generated under partnership agreements in the three health boards. However, some boards have achieved more positive outcomes than the others and the distribution of gains varied between the three cases. The NHS Highland APF has achieved the most robust outcomes among

the three APFs. The NHS GG&C APF came in second, while the NHS Borders APF achieved the least benefits for partners. Managers in NHS Highland had gained trade unions' support when facilitating the organisational change, implementing national policy and achieving performance targets. For trade unions, they were involved in the management decision making process at an early stage and exerted greater influence over a broader range of issues. For employees, they could gain better terms and conditions and most importantly, greater job security.

In light of the internal context issues and operational features associated with these three health boards, the findings of this chapter have several important implications. By comparing the NHS Highland APF and NHS GG&C APF to the NHS Borders APF, the findings suggest that strong trade union organisations in the workplace is indeed a precondition for partnership relationships to thrive (Oxenbridge and Brown, 2004). However, by comparing the NHS Highland APF to the NHS GG&C APF, it also suggests that strong trade union organisations may not necessarily lead to robust outcomes delivered to partners. Although trade unions strength in NHS GG&C was stronger than unions in NHS Highland, the adversarial industrial relations tradition in NHS GG&C and challenging behaviours of trade union representatives during partnership consultations has slowed down decision making and placed constraints for partnership to operate effectively so as to generate positive outcomes. In contrast, the case of NHS Highland APF suggests that, in the context of good industrial relations tradition, with strong management commitment and union-management cooperation in an open environment, can generate substantial benefits for both parties.

## **Chapter 8. Discussions and Conclusions**

### **8.1 Introduction**

This thesis has provided a review of the experience of partnership arrangements in NHS Scotland with the following characteristics. Firstly, the study has focused on one sector with similar external contexts, allowing comparisons to be made between organisations operating within different constraints. Secondly, partnership agreements in NHS Scotland were distinct from partnership agreements in the private sector and those in NHS England, given the stronger political commitment and support by the Scottish government. Thirdly, the study has provided a multi-faceted account of partnership arrangements in the three health boards and an analysis of their external and internal context, operation, evolution and outcomes for partners. Fourthly, the study has presented comparative case studies based on a longitudinal research method, which are relatively scarce in Britain's partnership literature (Guest and Peccei, 2001; Kelly, 2004).

The purpose of this chapter is to present the conclusions of the study and indicate how they are related to the wider literature on partnership. In the second section, a summary of the findings is presented to address the research questions raised in Chapter 2. The third section considers the significance of the findings for the partnership debate. Finally, the thesis closes with some suggestions for practice and implications for future study in this area.

### **8.2 Summary of Findings**

The overall purpose of this thesis is to examine labour-management partnership in NHS Scotland. Guided by the existing partnership literature, it attempts to address this

issue by developing four main themes, including the context, operation, evolution and outcomes. The purpose of this section is to report the findings and conclusions in the same sequence as the empirical chapters of this thesis.

### **8.2.1 The Contexts of Partnership**

The first aim of this thesis is concerned with the contexts surrounding partnership arrangements in the three health boards and their potential impacts on the partnership dynamics. The analyses are conducted along two paths. First of all, the external contexts affecting the adoption and development of partnership are analysed in depth. These include the political context, financial environment, the NHS policy and modernisation agenda. Secondly, the internal organisational contexts of the three health boards are systematically compared to highlight the diversities and establish the characteristics that may have promoted or restricted the development of partnership arrangements. These include the geographic and demographic contexts, their organisation structure and size, the history of industrial relations and trade union organisations and their strength.

The key findings of the first part of the analysis show the importance of political devolution on the development of partnership in NHS Scotland. It suggests that the origins of partnership arrangements in NHS Scotland were rooted in the unique circumstances following the Scottish devolution, when the Scottish Executive Health Department (SEHD) developed industrial relations arrangements which are more commonly found in mainland Europe (Bacon and Samuel, 2010). The political devolution has triggered an unexpected and now an atypical approach to employee participation in NHS Scotland, and an industrial relations approach in sharp contrast to the health service reforms in England (Bacon and Samuel, 2010). Furthermore, the political devolution has also created a comparatively relaxed environment nurturing

partnership initiatives in NHS Scotland through a greater degree of political autonomy and financial flexibility for the operation of NHS in Scotland. With these arrangements, the Scottish government can work closely with the health boards and trade unions to improve health services through a shared commitment to coordinating services rather than market-driven reforms (Greer and Trench, 2008). Following political devolution, the NHS Scotland have created a distinct modernisation agenda that indeed requires trade union engagements in the organisational restructuring and HR reforms. It is in these contexts that the NHS Scotland has created a unique partnership approach to NHS modernisation combining a broader political consensus, more legislated employee participation and cooperative industrial relations that is distinct from most other British partnership arrangements (Bacon and Samuel, 2012).

The findings from the second stage of the analysis suggest that the internal organisation varied between the three health boards. Features associated with NHS Highland include a medium demographic and organisation size, a strong trade union organisation and a good tradition of cooperative industrial relations. The NHS GG&C has the most complicated organisation structure and the largest size as it serves the largest population in the Glasgow area. The industrial relations in the board can be described as ‘conflictual’ based on its tradition. In addition, the trade unions were well embedded in the board and union power appeared to be the strongest among the three cases. NHS Borders is the smallest board. The organisation and strength of the trade unions in NHS Borders is the weakest among all. Under such circumstances, managers felt there is no need to work with trade unions.

### **8.2.2 The Operation of Partnership**

The second aim of this research is to examine the operation of partnership in the three health boards. To address this issue, the research focuses on four key facets, including the partnership structures, agendas, as well as participants' voice and behaviour.

The first facet concerns the partnership structures. In NHS Scotland, partnership arrangements are legally mandated at national, regional/board and local/CHP levels. Within the three health boards studied in this research, each health board reproduces the national partnership structure on a local bi-partite basis (employer-union), with Area Partnership Forum (APF) and Staff Governance Committees, and Employee Directors being elected to each health board. The key findings of this part suggest that, albeit established in a similar external environment, the composition of APFs and the frequency of partnership meetings varied between the three health boards based on each board's particular industrial relations tradition. In NHS Highland where managers and trade unions have a good relationship in history, the frequency of partnership meeting is the highest among the three and trade union representatives account for one-third of the overall attendees in the APF. The NHS GG&C APF is the largest in size and trade union representatives account for nearly three-fifth of the total attendees in the APF. This is associated with the largest demographic size that the board serve and strong trade unions within the organisation. In contrast, NHS Borders APF is the smallest in size and trade union representatives hold the lowest proportion of the overall attendees. In addition, the frequency of partnership meetings was also the lowest among the three APFs. This is linked with the smallest size of the board and managers' unwillingness to work with the trade unions.

The second facet concerns the scope of partnership agendas. Commentators have argued that a broader range of agenda items, combining with well-embedded

structures at both operational and strategic levels is likely to produce more positive outcomes (O'Dowd and Roche, 2009). The key findings of this section suggests that the NHS Highland APF has a broader partnership agenda that evenly covered both strategic and operational issues, while the NHS GG&C APF has shown a stronger focus on strategic issues and pay issues appear to be the primary concern for the APF of NHS Borders.

The third facet concerns participants' voice. It is assumed that the distribution of voice between different parties in the partnership consultation meetings may imply some balance of power in partnership working which would eventually influence the flow of potential gains (Katz et al., 2008; Kelly, 2004). The findings in this section suggest that trade unions in NHS GG&C have the strongest voice among the three APFs, given the strongest trade union power in the board. In NHS Highland, voice was evenly distributed across the senior managers, management-side and staff-side. In addition, senior managers in NHS Highland were actively involved in the APF and led discussions on many issues. In stark contrast to these to boards, the voice of trade unions in the NHS Borders APF was the weakest. It appeared that the NHS Borders APF was in lack of senior managers' buy-in and discussions were dominated by the management-side.

The fourth facet concerns participants' behaviour. Advocates for partnership have suggested that interactions need to be positive from all participants to sustain partnership relationships. Moreover, cooperative behaviours like sharing information, planning and resolving problems in an open and honest manner are likely to associate with a more robust partnership relationship which helps create positive outcomes for both management and trade unions (Kochan and Osterman, 1994; Oxenbridge and Brown, 2002). The key findings in this part suggest that behaviour patterns varied

between the three APFs. The NHS Highland APF was very cooperative, with cooperative behaviours accounting for more than two-fifths of the total behaviours. The NHS GG&C APF appeared to be the most aggressive forum, with challenging and conflicting behaviours accounting for nearly one-fifth of the total behaviours. It is important to note that staff-side in NHS GG&C contributed more than three-fifths of the total negative behaviours. In NHS Borders, an important function of the forum is to share information, with three-fifths of the total behaviours seeking and offering information.

### **8.2.3 The Evolution of Partnership**

The third aim of this research is concerned with the evolution of partnership arrangements in the three health boards in a context of profound organisational restructuring and the launching of modernisation agendas in NHS Scotland. To address this issue, Chapter 6 observes the changes in partnership structures, agendas, participants' voice and behaviours in the three APFs overtime.

In terms of the partnership structures, the key findings suggest that all the three APFs have facilitated restructuring under the same external context of national instruction. After restructuring, the frequency of partnership meeting and the proportion of trade union representatives represented in the APFs have increased in all the three APFs. However, it is important to note that the process of restructuring varied within the three cases. In NHS Highland, the development of partnership arrangements was a prevailing issue in the Forum. Both the senior managers and trade union officials shared the same view that it is necessary to develop a long-term partnership relationship with each other. Although the Forum confronted resistance from a few middle-level managers when propagating partnership infrastructure into the newly established CHPs, managers and trade union representatives had worked together in

an open manner to deal with the issue successfully. In NHS GG&C, the restructuring confronted with no resistance from middle-level managers due to the strong trade union strength within the organisation. Trade Unions' proposal of partnership restructuring had gained fully support from senior managers and was implemented smoothly. In stark contrast, the restructuring of partnership confronted with strong resistance from the middle-level managers in NHS Borders. The Employee Director's proposal on partnership restructuring was rejected by the APF, and managers generally felt that there was no need to have further partnership arrangements.

In terms of partnership agendas, the evolution of agendas has reflected the goal of restructuring in each board. In NHS Highland, a central aim of the restructuring of partnership arrangements was to make the Forum more strategically focused. The results indicate that the aim was successfully achieved, as strategic issues like Modernisation and Workforce Planning have been given more attention since restructuring. In NHS GG&C, one aim of restructuring was to discuss different kinds of issues in the APF meetings, with one meeting focusing on strategic issues and other meetings on operational issues. The results suggest that the aim could also be achieved, as operational issues have increased since restructuring. In contrast, there was no clear expectation on reforming agendas from the restructuring in NHS Borders. As a result, there were no significant changes to partnership agendas after restructuring.

In terms of participants' voice, it is found that views from senior managers have significantly increased in NHS Highland, as the APF has been more strategy focused since restructuring. In the meantime, the voice of staff-side representatives remained stable in the forum. In NHS GG&C, the voice of management representatives has increased, as the APF emphasised the equal importance of both strategic and operational issues after restructuring. In the meantime, while opinions from staff-side

representatives had slightly increased over time, those from staff-side and senior managers had decreased in the NHS Borders APF since restructuring. This suggests that the NHS Borders APF was continued to be controlled by the management-side in NHS Borders after restructuring.

Finally, in terms of participants' behaviours, the key findings of this part of analysis suggest that the behaviour patterns of NHS Highland APF had changed after restructuring, while those of NHS GG&C APF and NHS Borders APF did not change much. It is worthy to note that there is a clear tendency for NHS Highland to shift its operation from a positive joint problem-solving approach to one that focuses more on information exchange in the Forum.

#### **8.2.4 The Outcomes of Partnership**

Finally, the fourth aim of this research is concerned with the outcomes of partnership agreements for management, trade unions and employees. The analysis is conducted along three paths. Firstly, it has examined the overall outcomes of partnership meetings in the three APFs by utilising the framework drawn from Bacon and Samuel (2010; 2012). The key findings of the first part of the analysis suggest that the outcomes of partnership meetings in the NHS Highland APF were more positive than the other two APFs. Almost one-fifth of the total number of decisions in NHS Highland were to refine policies which produced tangible changes and improvements for both management and trade unions, suggesting that the NHS Highland APF has greater influence on management decision-making than the other two APFs. In NHS GG&C, more than two-fifths of the total number of decisions was to involve partners in the discussion, but they rarely generated positive outcomes for both parties. In NHS Borders, the APF appeared to be a place for managers to share information and seek

endorsement from the APF rather than a place for management consulting trade unions or involving trade unions in decision-making processes.

Secondly, it has examined the outcomes of specific categories of agendas and the delivery of gains for management, trade unions and employees. The result of analysis indicates that NHS Highland APF had exerted great influence on management decision-making over a number of issues covering modernisation, pay and workforce planning. It had also generated more substantial benefits than the other two boards. In detail, the managers in NHS Highland had gained trade unions' support in facilitating the organisational change, implementing the national policy and achieving performance targets. For trade unions, they were involved in the management decision-making process at an early stage and exerted greater influence on a broader range of issues. For employees, they could gain better terms and conditions and most importantly, greater job security. The NHS GG&C has a strong focus on strategic issues including modernisation and workforce planning, over seven tenth of the total number of decisions were concerned with these issues. However, the results suggest that trade unions were only involved in the discussions of these issues rather than truly influence the strategic management decision-making. Among the three boards, the NHS Borders APF delivered the least gain for trade unions and employees.

Finally, this study has focused on four critical issues selected from some common agendas of the three APFs and observed how issues were raised, discussed, resolved and delivered gains for all partners through partnership arrangements. The findings suggest that, in NHS Highland where substantial benefits were delivered for all partners, all of the issues were raised and discussed in an open manner, with trade union representatives being involved in an early stage. In NHS GG&C, trade unions challenged management on almost every issue. The case of car parking charges in

NHS GG&C indicates the risk and instability of partnership working in the board, as partnership approach was abandoned when management and trade unions could not reach an agreement. In NHS Borders where outcomes of partnership appeared to be shallow, most of the issues remained management prerogatives. Basically the APF was bypassed in the discussion of certain issues and was only informed of the results.

### **8.3 Discussions**

Recent literature on partnership has suggested the importance of partnership process (Boxall and Purcell, 2003; Guest and Peccei, 2001; Johnstone et al., 2009; Martinez-Lucio and Stuart, 2004; Oxenbridge and Brown, 2004). Researchers have identified some key partnership practices that are perceived to be associated with ‘robust’ or ‘shallow’ partnership agreements, including the aspects of partnership structures, agendas, voice and participation and behaviours (see table 2-3). Some good practices are found to have contributed to the establishment of an effective partnership model, for example, senior managers’ involvement and commitment to partnership working (Samuel, 2007), regular and high frequency of consultation meetings (Oxenbridge and Brown, 2004), early involvement of trade unions in a broader range of agendas covering strategic and workplace issues (Oxenbridge and Brown, 2004; Samuel, 2007), and sharing information, plans and problems to a greater degree (Bacon and Samuel, 2010). However, these points were generated in single-case studies within different sector and organisation contexts. There is a need for more comparative ‘firm-in-sector’ case studies to systematically assess partnership processes as well as outcomes (Johnstone et al., 2009). Therefore, this research has selected three boards from the health service sector in Scotland and examined their operation, evolution and outcomes of partnership in the context of political devolution. Several importance implications for partnership processes can be drawn from the study.

### **8.3.1 Can Mutual Gains be Achieved?**

At the heart of the partnership debate in Britain is whether the perceived benefits of mutual gains are realisable (Guest and Peccei, 2001; Kelly, 2004). Recent empirical studies have indicated that the delivery of mutual gains can be secured, but shaped by some distinct forces, including the political and regulatory context, the economic and organisational factors, management and trade unions' rationale for partnership, and the way in which partnership arrangement is implemented (Heery, 2002; Heery et al., 2005; Stuart and Martinez-Luico, 2005; Samuel, 2007; Wills, 2004;). Furthermore, scholars have argued that those partnership agreements initiated in more positive circumstances are more likely to deliver mutual gains for both management and trade unions than partnership agreements arisen out of industrial relations crisis (Kelly, 2004; Oxenbridge and Brown, 2004; Samuel, 2007). Bacon and Samuel's (2012) study on partnership agreements in NHS Scotland at the national level echoes this point of view, given the context that partnership agreement in NHS Scotland was generated in a more favourable environment and has delivered substantial gains for the Scottish Government, the NHS employers and trade unions at the national level. After an overall evaluation of the operation and outcomes of partnership in NHS Scotland at national level, Bacon and Samuel (2012) suggest that while Britain has stood on the opposite neoliberal side in the past two decades, NHS Scotland presents a case of established social partnership under pressure from a devolved Scottish Parliament. The political devolution in Scotland has created a unique partnership approach to NHS modernisation in Scotland combining a broad political consensus, legislated employee participation and cooperative industrial relations. They further conclude that NHS Scotland provides a leading edge example in assessing the contribution of innovative industrial relations arrangements towards improving the

delivery of public services. Mutual gains have resulted, with staff benefitting from the development of staff governance standard that underpins the workforce strategy and sets high standards for health board employers, in particular employment protection during organisational change. The Scottish Government and employers have fostered staff representatives' commitment to health policies and organisational restructuring in order to improve patient care.

However, by studying partnership arrangements at the regional/board level in NHS Scotland, this research has indicated that albeit the macro-context is conducive to management-union partnership relationships at the national level, it does not necessarily lead to mutual gains being delivered at the lower levels. The features of specific workplace context can still support or contain the development of partnership arrangements and the subsequently the delivery of gains. By comparing partnership arrangements in NHS Highland and NHS GG&C to those in NHS Borders, the result reveals that partnership arrangements in the former two boards have generated more substantial benefits than partnership arrangements in the later one, suggesting the importance of strong workplace trade union organisation and power to the delivery of mutual gains (Oxenbridge and Brown, 2004). By comparing partnership arrangements in NHS Highland and in NHS GG&C, this study suggests that partnership agreements born in a cooperative industrial relations tradition are likely to generate more gains for both management and trade unions than those agreements arisen in a history of industrial relations conflict (Oxenbridge and Brown, 2004; Samuel, 2007).

### **8.3.2 Partnership Structures and Agendas**

It has been hypothesised in the partnership literature that partnership structures combining strategic and operational arrangements and addressing agendas of substantive significance of broad scope should lead to positive outcomes for the main

stakeholder groups (Cutcher-Gershenfeld and Verma, 1994; Kochan and Osterman, 1994). Based on data from a survey of managers' perspective on partnership outcomes, O'Dowd and Roche (2009: p34) have tested this hypothesis and concluded that structures that involve management-union cooperation at both operational and strategic levels and that address dense agendas of broad scope are associated with more positive outcomes for stakeholders.

By assessing the operation and outcomes of partnership in three NHS boards using different research methods, the findings in this study support the above point of view. At the national level, Bacon and Samuel (2012) indicate that appropriate partnership structures in NHS Scotland have developed to facilitate joint problem-solving and mutual commitment to an agreed overall strategic direction for the service, and the subsequent joint development of appropriate workforce policies that help deliver improved health services. At the local level, albeit formal partnership structures are well embedded in all the three health boards, the composition of APF, the frequency of partnership meeting and the scope of agendas varied among the three NHS boards. In the APF of NHS Highland and NHS GG&C, managers and trade union representatives explicitly defined the main subject of each partnership meeting and discussed strategic and operational issues as alternative options. In contrast, the NHS Borders APF showed characteristics of management control over the APF and there was an absence of senior managers in the consultation process. As a result, the outcomes of partnership in NHS Highland and NHS GG&C are more substantial than outcomes in NHS Borders. Furthermore, by comparing NHS Highland to NHS GG&C, it confirms the hypothesis that as partnership outcomes in the NHS Highland APF was more robust and associated with some important features including regular and

consistent involvement of senior managers, higher frequency of partnership meeting and a broader range of partnership agenda.

There is another strand of partnership debates arguing that informal partnerships can be more successful than formal partnerships (Oxenbridge and Brown, 2004). Yet some researchers have concluded the opposite, emphasising the importance of formal partnership structures (Heaton et al., 2002; Kochan and Osterman, 1994). The research presented here, suggest that the formality of partnership structure is important to a successful and enduring partnership, but it is not a necessary and sufficient condition to create a robust partnership. In all the three NHS boards, formal partnership structures have been well established and embedded within the organisations. However, the delivery of partnership outcomes differed between the three cases, suggesting the significance of many other partnership practices (Dietz, 2004). As the Employee Director of NHS Highland APF concludes:

*“... the existing structure within NHS Highland is adequate, however there was a need to ensure that this was operating effectively. Aspects related to strategic matter consideration, membership, number of meetings and shared agenda as well as the role and remit”. (Employee Director, NHS Highland)*

### **8.3.3 Voice and Participation**

With regard to the aspects of voice and participation, academics have concluded that senior managers' commitment and active involvement in the consultation meeting and union involvement in problem solving at an early stage, including their involvement at a strategic level, are important features of a 'robust' partnership (Kochan and Osterman, 1994; Oxenbridge and Brown, 2004; Samuel, 2007; Wills, 2004). In contrast, a 'shallow' partnership arrangement is associated with features including managers restricting union involvement at the decision-making process, limited union

involvement in workplace affairs, implementation of ready-made management decisions and managers using communication techniques to keep unions informed, rather than involving them in the decision-making process (Munro, 2002; Oxenbridge and Brown, 2004; Taiby et al., 2004).

In the case of NHS Scotland, Bacon and Samuel (2012: p24) concluded at the national level, 'voice is enhanced by facilitating the wide involvement of a broad range of views to develop a range of solutions from which the best options may be selected or policy refined'. Again, the findings in this study revealed that trade unions are actively involved in a broader range of agendas covering strategic and operational issues at the regional/board level. However, the extent to which trade unions' voice and participation can influence the management decision-making varied between the three health boards. In NHS Highland, where trade union representatives were actively involved in an early stage of management decision-making process and openly discussed issues with managers in a cooperative manner, the outcomes of partnership appeared to be the most substantial among the three cases. While in NHS GG&C, albeit trade unions were also actively involved in partnership meetings, the challenging behaviours of union representatives have reduced managers' willingness to consult the APF. Managers would choose to avoid trade unions when the 'hard' issues were raised where possible. In contrast, features in NHS Borders were more likely to associate with the 'shallow' partnership arrangements. Most of the time, managers only gave information to trade unions in the partnership meeting, rather than involve them in decision making. Furthermore, front-line managers were reluctant to release staff representatives to join the APF, which further limited the involvement of trade unions in management decision making. As one employee director commented:

*“There was a need to ensure that staff representatives were supported by their managers as it was generally felt that there was not always sufficient time to discuss staff issues on particularly full agendas. There was also a need to consider the content of future agendas and ensure full participation and attendance of all the membership. It is only by doing this that the forum will be seen to be effective and relevant.” (Employee Director, NHS Highland)*

### **8.3.4 Behaviours**

The modernisation of employment relationship via partnership is articulated in terms of the need to move away from adversarialism to cooperation, on the basis of a common interest between capital and labour in enterprise performance and competitiveness (Ackers and Payne, 1998; Guest and Peccei, 2001; Kochan and Osterman, 1994). For advocates of partnership, such cooperation is perceived to produce better outcomes than traditional or more adversarial industrial relations (Kochan and Osterman, 1994). Critics argue that partnership can be used by managers as an instrument to exploit trade union cooperation, therefore, rather than cooperating with managers, unions should reserve militant actions in order to preserve their position and protect the interests of members (Kelly, 1996).

Although many researchers have mentioned the importance of observing participants’ behaviours in partnership consultations, few studies have systematically examined the subtle changes in attitudes and behaviours caused by partnership and the mechanism by which bargaining behaviours influence the decision-making process (Johnstone et al., 2009). This research therefore focuses on this issue by examining participants’ behaviours in the three APFs. At the national level, Bacon and Samuel (2012: p25) have indicated that positive partnership behaviours from all the participants can produce a cooperative partnership climate that involves an open, joint

problem-solving approach and a search for optimal solutions. At the regional/board level, however, the behaviour pattern varied between the three health boards according to their particular history and contexts. In NHS Highland which has a good history of union-management cooperation, it was generally felt that the partnership process had reduced the level of conflict and non-cooperation within the organisation through increased involvement of trade union representatives and meaningful improvements in working conditions. Although some conflictual behaviours were observed when discussing some 'hard' issues, the good manner of the key negotiators had helped reach the optimal solutions that resulted in mutual gains for both parties. In addition, there is a need to note the importance of the ability of key negotiators, as the choice of certain conflictual tactics depends on the issues to be dealt with and the party leader's judgement on the overall external and internal conditions (Walton and McKersie, 1965). However, in NHS GG&C where the board was associated with management-union conflicts, the findings suggest that signing a partnership agreement has no impact on changing the behaviour pattern of both parties. The trade unions had challenged management decisions in the APF over the six years observed in this study, and in return managers tried to block trade unions when apprehensions were raised. Such behaviour patterns have resulted in the outcomes of partnership meetings being less fruitful than those in NHS Highland, suggesting that cooperative behaviours and mutual respect from both parties are essential for effective partnership.

### **8.3.5 Does the Balance of Power Really Matter?**

It has been hypothesised in the previous literature review section that the distribution of power between key participants in partnership may influence the scope of substantive issues under discussion and the final decision made. On the one hand, it might be expected that in a partnership relationship shaped by a high degree of

employer dominance, the scope of partnership agenda will be constrained by management to remain at the workplace level or mainly reflect management's interest, behaviours were acted in a unilateral manner by management side, and senior managers were reluctant to put their commitment into partnership working and rarely participated the joint working committee. Under these circumstances, unions have very little influence on management's decision-making. On the other hand, it might be expected that in partnerships where labour-parity exists, unions are likely to have a stable access to express their voice, the partnership agendas are jointly established by both managers and unions and the scope of issues are not only workplace issues but also covers strategic plans and a range of board level employment matters which unions are concerned about. In addition, unions are expected to secure a meaningful role in the decision-making process and hold the power to challenge management under certain occasions. Under these circumstances, unions can influence the management decision-making to some extent (Kelly, 1998; 2004).

Samuel (2007) tested this hypothesis by conducting a comparative study in two employer dominant British life and pensions firms. Samuel indicates that the level of employer dominance is not the sole determinant of the nature of partnership consultation as suggested by partnership critics (Danford et al., 2005; Kelly, 1999; 2004). Instead the motives and industrial relations context can affect the form of consultation committees and the subsequent operation and evolution of consultation in partnership firms (Samuel, 2007: p473). He further argues that a history of mature industrial relations, consultation involved a broader range of participants and strong commitment and involvement of senior managers are more important than then degree of employer dominance (Samuel, 2007: p468), an observation consistent with the findings in comparing partnership arrangements in NHS Highland and in NHS GG&C.

Although the degree of labour-parity in NHS GG&C is attached to a deeper extent than that in NHS Highland, the outcomes appeared to be more robust in NHS Highland. In NHS Highland, there witnessed a cooperative culture of industrial relations where management and the trade unions worked together to deliver local public health services and implement national health policies, trade union representatives were involved in the consultation process over a broader range issues in an early stage, senior managers were actively and consistently involved in the partnership meetings, and managers and trade union representatives openly discussed the 'hard' issues in a cooperative manner and sometimes conceded to each other. In contrast, a history of industrial relations conflict in NHS GG&C had limited the involvement of trade unions in partnership consultation and sometimes slowed down the decision-making process, and senior managers only joined the partnership meetings when strategic issues were discussed and tactics to bypass trade unions were used when conflictual issues arose. Therefore, it can be concluded the above factors are more important than the degree of employer dominance.

## **8.4 Conclusions and Prospects**

The section is divided in three parts. The first part presents the conclusions of this study. The second part highlights some of the limitations of this research. The third part discusses few suggestions and directions for future studies.

### **8.4.1 Conclusions**

This study has assessed the partnership arrangements in a specific political devolution context of NHS Scotland. A key conclusion is that mutual gains can be successfully secured through a partnership approach. However, the extent to which mutual gains can be obtained by both management and trade unions is greatly shaped by the

external and internal contexts surrounding the organisation and the way partnership is implemented.

Partnership in NHS Scotland was developed against the background of a post-devolution consensus on how health services should be organised. The political devolution has increased the strategic choices available and the willingness to develop an innovative partnership approach to industrial relations. Therefore, it has created a particular favourable circumstance for partnership to thrive in NHS Scotland. As expected, mutual gains have been reported for employers, trade unions and employees at the national level (Bacon and Samuel, 2012).

However, through the assessment of partnership arrangements in three health boards in NHS Scotland, the findings of this study suggest that it is over-optimistic to assume that the advantages of partnership arrangements would simply transfer from the national level to the local level. The specific organisational contexts and the way partnership arrangements are implemented can significantly limit or increase mutual gains. First of all, the findings support the view that a precondition for cooperative relationships to thrive and survive is relatively high union membership levels and strong workplace organisation (Kochan and Osterman, 1994; Oxenbridge and Brown, 2004). In addition, features associated with 'robust' partnership arrangements include a tradition of cooperative industrial relations, frequent partnership meetings, early involvement of trade unions in a broad range of issues, strong commitment and regular involvement of senior managers, as well as mutual respect and cooperative behaviours of both managers and union representatives. In contrast, 'shallow' partnership arrangements are more likely to associate with conflicts in industrial relations, the lack of senior managers' commitment to partnership working, infrequent partnership meetings, managers' reluctance to release staff representatives to join

partnership meetings, the use of communication techniques by managers to keep union representatives informed rather than involve them, and conflicts between managers and trade unions. 'Robust' partnership arrangements results in mutual gains, with trade unions benefitting from early involvement in the management decision-making process and exerting greater influence over a broader range of issues. For employees, they can obtain better terms and conditions and most importantly, greater job security. Managers can gain trade unions' support when facilitating the organisational change, implementing the national policy and achieving performance targets.

Overall, it is fairly to conclude that partnership arrangements in NHS Scotland have been successful in the past decade, at least at the national level. The findings in this study has indicated that partnership structure at health boards have been well established but the outcomes were considered unevenly distributed in different health boards associated with different contexts and features. It is suggested that there is a need for the SPF to consider the development needs and support that health board partnership forum will require in the next few years (Bacon and Samuel, 2012). In addition, in order to sustain partnership in NHS Scotland in the future, all parties have to work together to pass both the litmus (process) test of academic pluralists and the acid (outcomes) test of academic radicals (Evans et al., 2012).

#### **8.4.2 Limitations**

Although the research has reached its aims, there were some limitations that could be improved in the future studies. First of all, analysis of minutes of the three cases was not started from the same time point, as it was constraint by the access to the data source. The APF minutes in NHS GG&C were started from 2002, but minutes in the NHS Highland and NHS Borders were started from 2005. Therefore, there was a

period that comparisons can't be done between the three cases. Secondly, the research has relied largely on the documentary analysis and therefore could be criticised as being subjective (Ellem, 1999). A semi-structured interview or large scale of survey can fill this gap. Thirdly, the outcomes of partnership were measured by analysing the decisions made in the APFs. Though this method can reflect the general outcomes of partnership to a decent degree, a survey on employees and trade union representatives could furtherly complement the study by explaining how the decisions made in the APFs affect employees in reality.

### **8.4.3 Suggestions for Future Research**

This research focuses on labour-management partnerships in NHS Scotland at the local level. For future studies on partnership in NHS Scotland, they should also focus on the partnership arrangements at the national and the lower CHP levels that would help to get a more holistic picture of partnership workings in the NHS Scotland. Furthermore, future studies in NHS Scotland should also pay attention to the changing political contexts, financial environment, and strategic directions of the modernisation agendas. The NHS Scotland is currently facing a few challenges. These challenges ahead are primarily considered in three aspects. First of all, it is important to maintain the political interests in partnership working. The ability of public sector employers to contain union influence in partnership arrangements depends on whether the interests of politicians are more closely aligned with employers or labour. The employers' relative bargaining power vis-a-vis unions in public sector partnerships is not fixed and is politically contingent on party politics, electoral outcomes, and the implication for health service policy (Bacon and Samuel, 2009). Secondly, the tightening financial environment may require some difficult negotiations in the years ahead. Employers' support for partnership requires staff-side representatives to cooperate with their

initiatives to change and improve health services within the finance available. Therefore, staff-side representatives are required to have the abilities and management skills to assist managers addressing such challenges. Thirdly, the integrated healthcare model in NHS Scotland may limit local managers' discretion to deal with industrial relations issues comparing to its counterparts in NHS England where decentralisation has given local managers greater autonomy. It is therefore important for senior managers to consider how exemplary partnership working structures and practices can be effectively integrated into the broader industrial relations processes to integrate health and social care (Bacon and Samuel, 2012). These aspects are suggested as important for future studies on NHS Scotland to consider.

For future academic research on partnerships, it stresses the need to conduct more longitudinal and comparative case studies. The longitudinal study can trace the changes of the contexts surrounding partnership arrangements, different participants' experience, attitudes and behaviours over time. And comparative case studies can enable comparison to be made more appropriately between organisations operating between similar external constraints. Furthermore, it also suggests that for future studies to understand more about the linkage between the context, operation, evolution and outcomes of partnership and to develop a benchmark or a common acceptable model to define a positive or negative partnership arrangement.

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