

Organisational Change, Partnership  
Working and Agenda for Change in the  
Scottish NHS: A Phenomenological  
Study

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## **Abstract**

When the Labour Government won the election in 1997, one of the biggest challenges they faced was restructuring the public sector. This forced the new Government to move the public sector away from managerialism to become a more collaborative organisation, with greater employee engagement (Senior, 2008). This was when the work of developing new ways of partnership working was started in the NHS (Munro, 2002; Farnham *et al.*, 2003).

In order to assist the restructuring of the public sector, the Government introduced change in response to human capital needs, this included the implementation of the Agenda for Change Programme which was the biggest alteration to the pay structure of NHS staff in 50 years. Agenda for Change covered over one million NHS employed staff (with the exception of doctors, dentists and some senior management positions), and aimed to offer fairer pay based on new job evaluation, and to move towards harmonised conditions of service for NHS staff, to build links between career and pay progressions (DoH, 2004a). A partnership approach was seen as being a critical success factor in implementing this change.

This thesis focuses on partnership working through the implementation of Agenda for Change in the NHS. It aimed to explore the perceptions of different levels of participants of Agenda for Change Implementation Teams in relation to organisational change and partnership working. Four research questions were considered to address the above aim:

- 1). What were the perceptions of the Organisational Change which occurred within the NHS?
- 2). What key aspects of Partnership Working were employed in the NHS to address Organisational Change prior to the implementation of Agenda for Change?
- 3). What were the key constituents of Partnership Working that facilitated Agenda for Change and how were they developed by its implementation?
- 4). What were the incentives and challenges in implementing Agenda for Change?

As a phenomenological study, this research intended to interpret people's perceptions and experience of partnership working and Agenda for Change. Some 18 individual interviews were conducted with selected members of the implementation teams across three Health Boards in Scotland. Particular attention was given to the organisational change context, Agenda for Change, and partnership working in the Scottish context.

This research confirms the perceived view that there has been a period of continuous planned change within the NHS and these changes have transformed the culture of the organisation to become more business focused. Agenda for Change, was perceived, in the main, through the whole organisation, as a positive one offering an easier and fairer pay system allowing workforce flexibility. However there were indications that partnership working does not go on at all levels and where it is present it places a great strain on staff and resources which in the main, is in decline. The Agenda for Change structure has distinguished characteristics of organisational development. Unions and employees had much influence through the change process since partnership working existed at three levels: strategic, functioning, and workplace. However, findings suggest that despite the well maintain partnership at the strategic and functioning level, a partnership arrangement cannot be fully supported at workplace level. Workplace manager's faced pressure from the Government's targets and deadlines, as well as financial budget cuts; which were some of the challenges of encouraging partnership working at workplace level.

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# **Chapter 1 Introduction**

## **Introduction**

The impetus for this work arose from my student years. During my undergraduate programme I worked within the National Health Service (NHS) in Scotland in a number of roles. These included salaries, Human Resources and as a co-ordinator of smoking cessation services. At the same time I completed my undergraduate and master's level work in marketing. These experiences led me to realise that health care provision and their management was very different to that of my home in mainland China. This provoked an interest in Organisational Change and partnership working. Whilst working within the HR department of the NHS an advert appeared which gave me the opportunity to obtain the PhD studentship to undertake the current work.

## **Context of the Study**

In order to understand the context of the current study it is necessary to provide some background information of the politics and policies of the healthcare sector, which led to the implementation of both partnership working and Agenda for Change within the National Health Service (NHS) in Scotland. This also includes the difference between UK and Scotland where devolution resulted in the Scottish Government having responsibility for the National Health Service.

## **The Political Context of Partnership in Public Sector and NHS**

The external context embracing political economic and social factors can strongly influence the initiation and diffusion of a partnership agreement (Kochan & Osterman, 1994). The impacts of political context on partnership can be seen from three major periods: 1979-1990 when the public sector management was re-defined by Thatcher's government as purchaser-provider relationship; 1990-1997 when public sector was reformed which caused conflicts between individual culture and joint working; and post 1997 when the new government put partnership working in the centre of the public sector management.

In 1979, Thatcher's Government were influential in promoting a culture of independence, organisational efficiency and bureaucracy. The strategy implemented by Thatcher's Government was to "private services and to subject those remaining to the discipline of the market place" (Miller and Ahmad, 2000, p3). This included the creation of the purchaser-provider relationship, where the responsibility for evaluating needs and strategic policy direction for services were separated from delivery services in the public sectors. In addition to the purchaser-provider relationship, the Government also encouraged competition by replacing large organisation with smaller delivery organisations. As the result, these smaller organisations competed with each other with short-term strategies, resulting in the development of service delivery capacity for the public sector. Miller and Ahmad (2000) argues that the changes implemented by Thatcher's Government had to re-define the public sectors from ones where services existed as a matter of "right" to those which targeted those deemed to be "really" in need (Miller and Ahmad, 2000, p3).

Although the Thatcher's government has introduced many changes in the public sector to establish the culture of dependency and competition, the National Health Service truly experienced reforming after 1990, when the National Health Service and Community Care Act 1990 was introduced. This Act splits the role of health authorities and local authorities, which local authorities purchase the necessary service from health providers (Miller and Ahmad, 2000). Since then, the health organisations were divided into NHS Trusts, which had to compete with each other. NHS Trusts were run by Boards of Directors, they were given freedom to develop their own plans and strategies, including terms and conditions of employment of staff which could be modified outside the national system of the Whitley Council (Munro, 2002). So each Trust had their independence and were able to use resources to compete with each other. This is when the idea of the culture of independence vs. collaboration started to be questioned. For example, Miller and Ahmad (2000) cited literature from the 1990s which suggested that the welfare reform had resulted in an individualistic rather than a collaboration culture. The opinion of an individualistic culture as opposed to the 'real' market situation has led to fragmentation of service in terms of resource management and decision making, which undermined staff morale and created a climate of mistrust. As Miller and Ahmad (2000) quoted from Maddock and Morgan (1998, p238), this

culture has “dramatically affected all staff and their capacity to engage with transforming processes in collaborative fashion”.

The National Health Service and Community Care Act 1990 changed the health authorities' internal structure and encouraged a competitive culture. The network between health and social services had also significantly increased significantly. This Act empowers Local Authorities to respond to people on social care and are responsible for ensuring that people get an appropriate service through community care. The formal involvement of the voluntary sector was encouraged in joint planning structures. In addition to this, the Health Authorities and Social Services had to work jointly to draw up a community care plan covering needs analysis, objective setting and the development of strategies.

However, the initial practice of joint working between Health Authorities and Social Services in the competitive environment was criticised. Joint working has always been problematic and uneven in market relations, resulting in greater mistrust and hostility between sectors (Miller and Ahmad, 2000). At local Trust level, although each one had flexibility to pursue a range of human resource management practices, it was difficult to implement any major change or move away from Whitley Scale and the tradition of working with Trade Unions (Munro, 2002). As a result, there were great differences in the human resource management practices between Trusts, the Whitley Council provided the same standard to all trusts, but it was subject to adjustment. In addition to the effect on human resource management practice, the individualisation culture also affected union development. This has been shown statistically by Cully *et al.* (1998) from their research on behalf of Department of Trade and Industry. They suggest that the influence of unions had been declining from 66% in 1984 to 53% in 1990 to the lowest 45% in 1998. Yet, in contrast, the percentage of union members in the workplace had been rising from 36% in 1990 to 47% in 1998. This change on employee relations had impacted on the way in which management and unions had worked together Cully *et al.*, (1998) suggested that joint agreement between managers and unions was no longer the norm even where union representatives were present. In 50% of workplaces with union representatives there were no negotiations taking place over any issues. Bacon and Storey (2000), report that the public policy environment challenged managers to reappraise efforts to

manage employees more directly rather than in partnership with unions. There was little joint regulation or negotiation between the management and employees at the workplace level. This means that traditional industrial relationships had become a 'hollow shell'. The Conservative Government also realised the mismatch between market structure and joint working relationships. They started to de-emphasise the competition culture; instead, they encouraged purchaser and providers to work together.

When the Labour Government won the election in 1997, they were keen to improve public services through local capacity building. The new Government recognised that there was shortage on local leadership and organisational capacity to meet the requirement of delivery service at community level. They had to change and re-match the relationship between citizen and state. The Prime Minister encouraged moving beyond narrow individualist and old style socialism to the solution adopted being "one where the population at large 'pulls together' whilst enmeshed in a balance between obligations and responsibilities, and in the context of a new moral order" (Miller and Ahmed, 2000, p5). Partnership working between organisations had then been encouraged to end competition, and Local Authorities were guided to pull together rather than pull apart. In practice, the language of the 'market' had been shifted from government policies and guidelines. The annual contract between purchaser and provider was changed from three to five years to encourage longer term planning. These new actions allow public sector organisations to work with each other and with the private sector during the Labour Government's time. This relationship was maintained under the most recent coalition Government between the Conservatives and the Liberal Democrats. Prime Minister Mr Cameron had encouraged development of the Big Society from the Office of Civil Society aimed to encourage local communities to increase collective actions with public organisations to solve local problems and implement innovative solutions at local community level. Since then, partnership and public governance, which is new concept of partnership introduced by the Coalition Government, had been brought up to a higher level in public sector policies across the nations (Fenwick *et al.*, 2012). For example, in 2002, the Wanless Report (Wanless, 2002) suggests that focusing on prevention and supporting individual well-being in the community helps the high-cost of hospital treatments. Also, in response to the

government's guideline, Scotland is one of the first Nations to guide community partnership at Local Government level. The Scottish Government established community planning partnership in 2003 as part of the statutory requirements of the Local Government Act 2000. It aims to encourage engagement between people and communities in decision making to provide better public services. In England, the White Paper 'Local Growth: Realising Every Place's Potential' was introduced in 2010 (Department for Business, Innovation & Skills, 2010). It encouraged the public sector to shift power to local communities and business and aimed to allow better business outcomes such as efficient marketing, better investment support, through working together by local communities and businesses. With the similar view, the Welsh Government published "Shared purpose – Shared Delivery" (Welsh Government, 2012) to encourage public sector, private sector and third sector to work together in partnership with the Government.

In terms of the health sector, partnership working became normal practice. Thus, partnership in the Scottish health sector, which is again ahead of other nations, can be traced to the Community Health Partnerships (Scotland) Regulations of 2004 (Scottish Statutory Instruments, 2004). The partnership allows better integration between the NHS Scotland, public sector bodies, such as the local government, local authorities, and voluntary and community organisations. In England, since the introduction of the Health and Social Care Act 2012, there are currently 153 health and well-being boards established to encourage co-governance of health and social care of the NHS, social care, children's service and Health watch representatives. These boards have responsibility to meet the needs of the local population and health issues, and enhance accountability to the local community.

## **The Political and Policies Context of Devolution in the NHS in Scotland**

In the NHS in Scotland political devolution appeared to be a crucial factor in encouraging the adoption of National level partnership agreement, reflecting the ambition of the devolved Governments to include Trade Unions in plans to

improve public services (Bacon and Samuel, 2012). This commitment was frequently mentioned and reflected in key strategy NHS documents. It is important to stress that the partnership arrangements discussed in this study are related to a modernisation agenda with managers seeking union support in achieving performance targets.

The most notable step on devolution in Scotland occurred in 1997 when the Labour Government was in Westminster with a clear aim of holding a public referendum on devolving political power to Scotland (Bacon and Samuel, 2012). The outcome of the Scottish Referendum on Devolution was supportive and the Scotland Act was passed on 19<sup>th</sup> November 1998 which provided Scotland with the legislation to create a parliament (The Scotland Act, 1998). Moreover, The Scotland Act (1998) also delineates the legislative competence of the Scottish Parliament in making primary and secondary legislation (Bacon and Samuel, 2009).

By providing more political autonomy and financial flexibility devolution has created great opportunity for devolved nations to address local needs with determination and more focus than ever before. The establishment of new power and decision making centres in Scotland has enhanced the ability to address specific geographical needs and priorities. Healthcare is one of the most significant areas Scottish Parliament's policies (The Scotland Act, 1998). Under the governance of the Scottish Parliament, the independent political structure was established with the Minister for Health and Community Care being responsible for the running of the NHS. Meanwhile, the parliament Committee can call the Chief Executive of the Executive Health Department, and Chairs of all the NHS boards for information. Devolution provided great opportunities in terms of political autonomy and financial flexibility, as well as the opportunities for addressing local needs with greater determination and focus. For example, the Health Act (1999) established a different internal market structure for Scotland compared with the competitive market forms of the NHS in England. In 2010, the Scottish National Party passed legislation to exclude commercial companies with shareholders from holding primary medical services contracts, as well as banning private contracts for hospital cleaning and catering services. The aim of doing so

was to reduce private sector involvement in Scotland, and encourage collaboration rather than competition.

Alongside the Labour Government's programme for NHS Modernisation, the change of political environment was an important factor leading to divergence in the process of the Modernisation of the Scottish NHS. Unlike its counterpart in England where individual Trust managers were empowered to determine their own terms and conditions in relation to the level of partnership within their organisations, the embedding of partnership structures to local levels was a mandate from the central power in Scotland. This in turn formed a political incentive to facilitate union involvement in the public service process and thus created a unique political environment providing a solid foundation for partnership to emerge (Bacon and Samuel, 2012).

Since devolution Scottish ministers have expressed a high commitment to partnership working (Scottish Executive 2000, 2003, 2005a) and a series of written agreements which seek to define the broad principles, shared priorities in terms of engagement with a range of partners have been introduced. As the biggest employer in the public sector employers the NHS has led in developing and growing partnership initiatives. 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 patients' perspective (DoH, The Scottish Office, 1997). At the same time, it was accepted that this idea could not be achieved without giving staff and their Trade Unions a greater say in how the NHS service was planned and managed. As the result, The Scottish Executive published "NHS MEL(1999) 59" (Scottish Executive, 1999), which suggests the Scottish Health Ministers, NHS employers and trade union leaders have shared a vision of working in partnership is vital to build a world-class health service from the patient's viewpoint. The employee relations model below particularly demonstrates and highlights the need for all stakeholders to be involved at the stage of formulating potential change before moving to the consultation stage. This is a big step forward on partnership working, as it encourage Trade Unions to be involved at the beginning of formulating change needs and resulting decision making.

In relation to NHS the Scottish Health Ministers, NHS employers and Trade Union leaders shared a vision that working in partnership was vital to build a world class health service from the patient's perspective (DoH, 2000). However this could only be achieved by giving staff and Trade Unions a greater say in how the *NHS* service was planned and managed since a workforce that understands the local population and its demographic make-up was better able to develop a responsive, inclusive service which is directly related to the delivery of high quality care and ultimately patient satisfaction (Scottish Government, 1997).

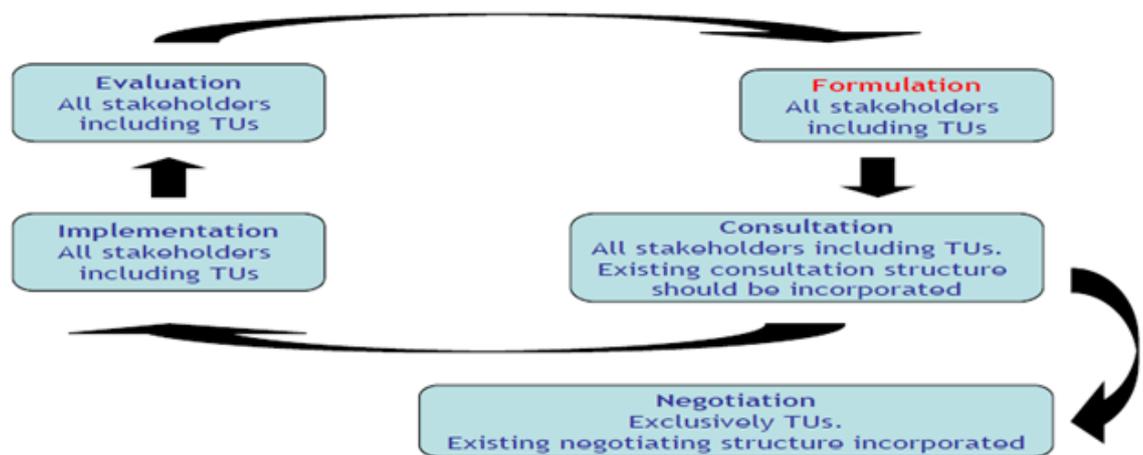


Figure 1 Partnership model MEL (1999) 59 (Scottish Executive, 1999)

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Therefore, the Scottish Executive proposed a strong commitment to build a spirit of partnership and cooperation within the NHS. Such commitments were frequently mentioned in strategic policy documents--Our National Health, a Plan for Action (Scottish Executive, 2000), Partnership for Care (Scottish Executive, 2003), The Community Health Partnerships (Scotland) Regulations 2004 (Scottish Statutory Instruments, 2004), Better Health, Better Care (Scottish Government, 2007), for example:

*“We reaffirm the principle of partnership working, that all NHS staff in Scotland must have the opportunity to be involved and engaged in the decision-making process”--Our National Health, A Plan for Action, (Scottish Executive, 2000, p79).*

*“We reaffirm our commitment to taking forward NHS pay modernisation on a UK basis with our partners in the other UK Health Departments. We will discuss in partnership with the NHS, staff and their representatives how best to implement any changes in Scotland” -Our National Health, A Plan for Action, (Scottish Executive, 2000, p83).*

*“High quality services and good employment practice go hand in hand. So 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 t make sure staff have a voice at the highest level.”--Partnership for Care, (Scottish Executive, 2003, p51).*

*Our staff are the agents of change. We cannot hope to bring about the improvements envisaged by this plan unless the people who will deliver these improvements are protected in their places of work, recognised and rewarded for their contribution to our success and given the opportunities to develop the skills and experiences they require. --Better Health, Better Care: Action Plan, (Scottish Government, 2007 p12).*

*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: action Plan, (Scottish Government, 2007 p12.)*

These policies gave clear political commitment to partnership working with trade unions in the NHS in Scotland. They also show the direction of partnership working approach from national level to local boards. In order to address the guidance from Scottish government's policies, there are several actions taken in the NHS Scotland, for example:

In 2002 a Memorandum of understanding between the Scottish Government and the Scottish Trade Union Congress (STUC) was signed with the aim to establish effective co-operation and develop a framework for developing genuine partnership working in Scotland (Scottish Trades Union Council & Scottish Government, 2007). This was followed in 2007 by a new Memorandum of Agreement between the Scottish National Party Government and STUC to share a commitment to partnership working on strategic issues and areas of common interest based on mutual understanding of the distinct values and roles of each party (Scottish Executive & Scottish Trades Union Council, 2002).

The Partnership Support Unit was set up in 2002, with the role of dedicating resource to support development and implementation of partnership working at both national and local level (Scottish Government, 1997). In the following year, the Human Resource Forum was set up to assist the operation of NHS Scotland as an exemplary employer, which consistency of HR practice and procedures could be maintained (Scottish Government, 1997).

The Staff Governance Standard was revised in 2007, it sets out what each NHS employer should achieve to maintain continuous and fair improvement in the management of staff (Scottish Government, 2007a). This standard is the overreaching policy for partnership working, employment practice and employee relations which proposed to establish local partnership arrangements to promote negotiate and monitor staff side involvement in all aspects of service planning. In order to achieve this, a Staff Governance Committee was established within each

of the NHS Boards to form the full Governance Framework alongside the Clinical Governance and Audit Committee (Scottish Government, 2007a).

One of the explanations for the differences between the adoption of Agenda for Change north and south of the border has already been described under devolution. Importantly, one of the areas which was covered by these powers was the Health Service for Scotland which fitted the needs of the local population. The strategic direction of health policy was threefold and included an integration strategy for health care; the changing role of the private sector and the influence of health communities on strategic decision making. In 2000 the NHS published *Our National Health, A plan for Action* (Scottish Executive, 2000) which was seen as the plan on the way to a healthier population. It led to modernisation of NH Scotland including changes to governance and accountability, increased public and patient involvement in the NHS and service change and modernisation (Scottish Executive, 2000). This responded to the anticipated “*ageing of the population, the growth of long term conditions and the continuing pressure on emergence beds can and must be dealt with an integrated whole system response that moves NHS 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*” (Scottish Executive, 2005b, p64).

## **Context of the Organisational Structure and Management in the NHS Scotland**

Significant organisational structural changes were introduced within the NHS in Scotland with the aim of creating an integrated health system. The governance structure has largely focussed on collaboration and integration prior to 2004, the fifteen NHS Boards in Scotland ensured efficient and effective and accountable governance of the local NHS system. The Scottish White Paper ‘Partnership for Care’ was published in 2003 and proposed a new management structure for *NHS* (Scottish Executive, 2003) which proposed replacing the Acute and Primary Care Trusts with fourteen Boards responsible for delivering community and primary

care services. In addition Community and Health Partnerships (CHP) were established in 2005. Since then, the local NHS Boards are responsible for delivery community and primary care services, while CHPs for engaging with Community Planning partners (Scottish Executive, 2003).

These changes resulted in an organisation with fewer levels thus allowing more communication between Scottish ministers and managers. There was also a strong impetus to seek Union cooperation in facilitating the organisational change. As was suggested by the Scottish Government—“The new duty on NHS Boards to put in place devolved systems of decision-making carries with it responsibility to ensure that local services are provided as efficiently and effectively as possible within the resources available” (Scottish Executive, 2003, pp58), the new NHS structure in Scotland encouraged partnership working at national, and local NHS Board levels, with the potential benefit of cost and resource saving.

Since the establishment of the Regional Health Boards, the interval market was abolished in April 2004, making the policies and structures between NHS Scotland and England (the purchaser-provider split was maintained in the NHS in England) even diverged (Fenwick *et al.*, 2012). In addition to the above NHS with its counterparts south of the border also pursued a different performance management system. The Health, Efficiency, Access and Treatment (HEAT) targets are a core set of Ministerial targets and measurements which in essence set out to improve health life expectancy, efficiency and effectiveness of the NHS, provide quicker and easier use of the NHS services and finally, to ensure that patients receive high quality services to meet their needs (Scottish Executive, 2005a). The HEAT performance management system sets out targets and measures against which NHS Boards are publicly monitored and evaluated. Performance targets has certainly become the goal with procedure and processes developed to achieve targets as opposed to other strategic objectives.

Under the HEAT system significant HR reforms have occurred and the most relevant to this study are pay modernisation and staff governance. The NHS was implemented in 1948 under a Labour Government and adopted the Whitley Industrial relations system which was already in use in the civil service and local

Government. This system arose from work carried out by a committee chaired by JH. Whitley in 1916 and provided a framework for pay and terms and conditions (Ewing, 1998). The NHS Whitley System was essentially unaltered since its inception despite some changes. Nonetheless, it had been criticised over the years because of its complexity over centralisation and lack of flexibility. It is important to note that the Whitley system was set up originally during the First World War in response to the introduction of the shop stewards movement and widespread protest action being taken in industry. The committee proposed a system of regular formal consultative meetings between workers and employers known as Whitley Councils. These were authorised to cover any issue which related to pay and conditions of service and to take matters through to arbitration if required (Scottish Executive, 2003).

Although this system had been in place for many years it continued to be fraught with difficulty and decent coming, at least in part, from the ever increasing numbers of staff and indeed, professional development for many of the different groups involved which led to even more pay scales being developed. In 2004, Agenda for Change was launched with plans for far reaching reforms of pay, conditions and working practices. The plan provided common terms and conditions for all staff and was supported by the NHS Job Evaluation Scheme and the NHS Knowledge and Skills Framework. Designed to deliver a fairer pay system with an underlying principle equal pay for work of equal value, improved links between pay and career progression, harmonised terms and conditions of service (DoH, 2004a). Central to these proposals was the emphasis on partnership working between management, Trade Unions and staff and participation of implementation of Agenda for Change at local level. The context of Agenda for Change is now reviewed in the following section (DoH, 2004a).

## **The Context of Agenda for Change**

### **The Needs and Aims of Agenda for Change Project**

Collective bargaining arrangements and associated pay structures have changed little in the 50 years since the creation of the National Health Service in 1948

(DoH, 2004a). Before Agenda for Change there were 12 separate pay structures covering more than 400,000 different job descriptions under 11 defined staff groups across the NHS. The General Whitley Council and more than 20 individual joint committees and sub-committees for different occupational groups were responsible for their own grading and pay structures, and terms and conditions of employment (DoH, 2004a). For examples, Staff in the NHS were entitled to different amounts of leave and different lengths of working weeks. Staff were also entitled to a multitude of allowances, 59 of which were mentioned in the Agenda for Change handbook such as the Radiation Protection Supervisor's allowance and Authorising Clerk's allowance, different shift patterns and on-call arrangements (House of Commons. Public Account Committee, 2008). In addition, nurses and allied healthcare professionals were covered by a pay review body rather than Whitley Councils. However, the European Working Time Directive (EWTD) was created with the aim of ensuring that workers have safe working patterns and hours, and it has been a key consideration for the NHS since 1996 (The Royal College of Surgeons of England, 2014). The EWTD was then implemented in the UK through the Working Time Regulations (1998) in October 1998. Thus, the NHS has to react on the European legislation, and has to standardise its working hours and conditions (The Royal College of Surgeons of England, 2014).

The variety of job descriptions, working hours, benefits and allowances created barriers to developing new roles and new ways of team working, designed around patient care pathways. The lack of comparable terms and conditions across different staff groups made it difficult to develop non-traditional roles for staff. There were different ways of rewarding staff who were working in the same team. It also caused problems of negotiating staff to do extra works or overtime even when they had the ability to do it, because they were under different pay conditions (National Audit Office, 2009).

Apart from the variety of terms and condition, the old Whitley pay system was also becoming increasingly susceptible of challenges under equal pay legislation. The Gender Equality Duty (amended from the Equal Act 2006) was not in place until 2007 (Equal Opportunities Commission, 2006). So for a very long time, employees in the NHS was using the Equal Pay Act 1970 as legislation for their

work conditions. The Equal Pay Act 1970 had previously outlawed any pay discrepancies between male and female employees doing the same work. From 1984, the Equal Pay Act was amended to allow equal pay claims when the applicant considered that he or she was carrying out work of equal value (when compared under headings such as effort, skill and decision) to a higher paid male colleague (Edwards *et al.*, 2009, DoH, 2004a). Based on this regulation, over one thousand speech and language therapists were successful in their equal pay claims in 1986 and 1987 by comparing their work with that of clinical psychologists and hospital pharmacists (DoH, 2004a). The others had been settled out of court (National Audit Office, 2009). A report from the Department of Health shows that the NHS had paid out approximately £70 million in compensation and out of court settlements in respect of equal pay claims in 2007-2008 financial year. Under the consideration of equal pay for work of equal value, there is a need of a new system to put in place that would greatly reduce this kind of vulnerability.

In December 1997, a strategy of employing more staff to help achieve its aim of improving access and the quality of care in the NHS was outlined by the Department of Health (National Audit Office, 2009). To meet these ambitions the Department wanted a modern and fit-for-all-purpose reward system to transform the NHS into a modern and attractive employer (DoH, 2004a). In 1999, a proposal named "Agenda for Change: Modernising the NHS Pay System" for a new pay framework was published by the Department of Health (DoH, 1999b). This proposal aimed to enable staff to give the best service to the patients by working in the new ways and breaking down professional barriers. It also aimed to give fair pay to the employee based on responsibility, competency and satisfactory performance. At the result, the department wanted to use this new system to simplify and modernise conditions of service with national core conditions and considerable local flexibility (DoH, 2001, National Audit Office, 2009).

In addition to this soft benefit, The Department of Health also estimated the hard benefits for the new pay system. The department estimated that there would be £1.4 billion added to the annual pay bill over the two years from 2004 to 2006 to move staff to the Agenda for Change system (National Audit Office, 2009). This is what the NHS employee would directly be benefited from the new system. The

saving of Agenda for Change would exceed the implementation cost, so that over the first five years of the contract there would be a net saving of over £1.3 billion for the NHS (National Audit Office, 2009). These saving would come from reduced pay drift, a reduction in the equal pay claims and increased productivity.

Based on these reasons, the Department of Health had been working with the NHS Staff Council to create the Agenda for Change project. The Negotiations for Agenda for Change were lengthy because there were a large number of stakeholder groups involved in the process (National Audit Office, 2009). There were 17 Trade Unions recognised in the negotiation process. These Trade Unions ranged from small professional bodies such as the British Dietetic Association to UNISON with 400,000 memberships working in healthcare. The involvement of these numbers of Trade Unions caused some delay in the negotiation and reviewing process. As the result, over 90% of midwives, 81% of UNISON member, 86% of physiotherapist, and 88% of Royal College of Nursing members voted to accept the Agenda for Change proposal (Edwards *et al.*, 2009). Radiography was unique amongst the major health professions as The Society of Radiography members rejected Agenda for Change. However, following a lengthy period of negotiation, the Society of Radiography believed that Agenda for Change would be applied to radiographers regardless of the membership vote, as they determined to remain with the collective bargaining process to ensure representation for radiographers (Edwards *et al.*, 2009). By December 2002, the final agreement was agreed between the Department of Health, the NHS Confederation and Trade Unions.

Overall, the Agenda for Change project is based on the needs of equal pay and national operation system purpose. It was brought up by the Department of Health, and was negotiated with a large number of stakeholders. Once the proposal and final agreement was agreed and published, these stakeholders then working closely to determine the core elements of the new pay system.

## **Definition of Agenda for Change**

Agenda for Change is the name of the new pay system for the NHS. It applies to

all directly employ 1.1 million NHS staff except doctors, dentists and the most senior managers at or just below Board level (DoH, 2004a). Doctors and dentists are in a different system known as Modernising Medical Careers (Tooke, 2008). In addition, the Review Body on Doctors' and Dentists' Remuneration (DDRBR) advises government on rates of pay for doctors and dentists. DDRBR is an advisory non-departmental public body, sponsored by the Department of Health. In June 2003, the Agenda for Change system began to be implemented in twelve NHS sites in England. In the meantime, four pilot studies of parts of the Agenda for Change system were undertaken in four Scottish Boards. A report named "Review of Experience in the Early Implementer Sites" was published with the purpose of reviewing and analysing the results from early implementer sites and learning from the results (DoH, 2004b).

In December 2004, Agenda for Change the biggest change on the NHS pay system for over 50 years, started to be implemented after the Trade Union's second ballot had been held. The main sub-group of staff covered by Agenda for Change are qualified nurses which are one third of the total staff (National Audit Office, 2009). Other healthcare professionals such as occupational therapists and radiographers (one third) and infrastructure support such as maintenance, catering, laundry and managers (one fifth) were the other majority of the sub-groups. In 2009, the National Audit Office carried out a research on the Agenda for Change project in England, and their report shows that the total pay bill for staff employed on Agenda for Change contracts in 2007-2008 was £28,182 million (National Audit Office, 2009).

## **Core Elements of Agenda for Change**

Agenda for Change was designed to deliver a variety of benefits for staff and patients with the explicit expectation that it would act as a catalyst and enabler of service improvement in the NHS (DoH, 1999b, 2004a). In order to achieve this aim, the Agenda for Change system provides three core elements that can be used to support change and improvement (DoH, 2004a, DoH, 2005, National Audit Office, 2009):

- Harmonised terms and conditions
- NHS Job Evaluation Scheme
- NHS Knowledge and Skills Framework (KSF)

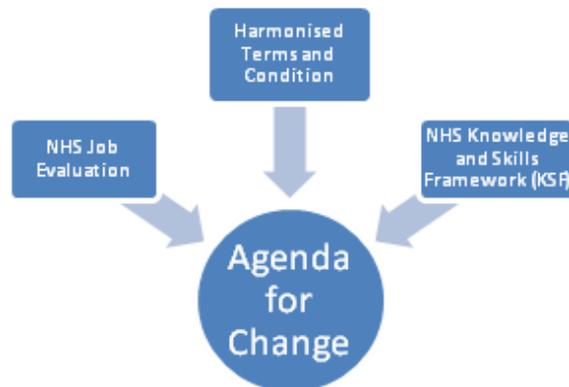


Figure 2: Three Core Elements of Agenda for Change

## Terms and Conditions

A key feature of satisfaction with working for the NHS is the terms and conditions offered to staff (Ipsos MORI, 2006). The terms and conditions have always been in place since the establishment of the NHS (DoH, 2004a). These include the key pay methods such as standard hours of working, overtime rates and annual leave. Based on the proposal of Agenda for Change, a new terms and conditions were designed to ensure comparability and fairness for all staff (DoH, 2004a).

## Job Evaluation

The first Job Evaluation Working Party was set up in the mid-1990s to review the job evaluations schemes introduced in the health service. In 1999, the Agenda for Change proposal published by the Department of Health suggests that a

single job evaluation scheme to cover all jobs in the health service to support a review of pay and all the other terms and conditions for health service employee will be designed as a core element of the new pay system (DoH, 2004a).

## The Knowledge and Skills Framework

The NHS Knowledge and Skills Framework (KSF) includes the knowledge and skills that the NHS staff need to apply in their work in order to deliver quality service. The KSF lies at the centre of the career and pay progression strand of Agenda for Change. It applies to the whole NHS staff that come under the Agenda for Change Agreement (DoH, 2004a).

The main focus of KSF is about the application of knowledge and skills rather than the specific knowledge and skills which individual employees need to process (DoH, 2004a). Department of Health suggests that the KSF does not describe the attributes people have. It will focus on how people need to apply their knowledge and skills to meet the demands of work in the NHS (DoH, 2004a).

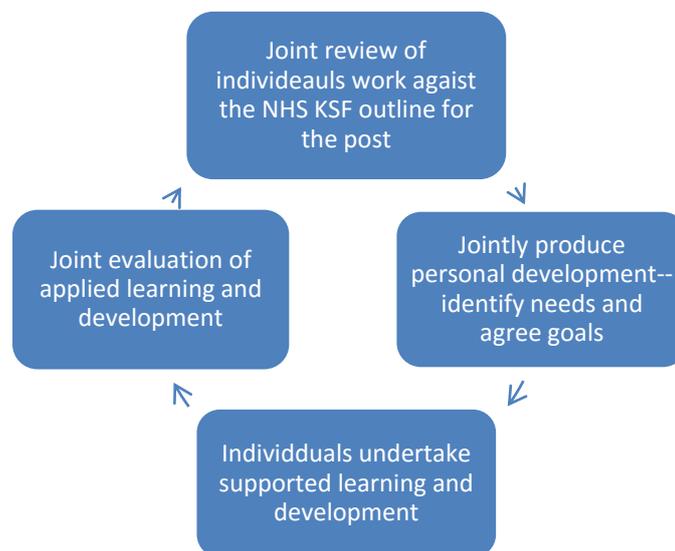


Figure 3: KSF Development Review Process

Overall, the Agenda for Change system was proposed by the Department of Health in order to solve the two main problems in the NHS pay system:

1. Staff were under different terms and conditions, which caused barriers to the human resource management and development.
2. The old pay system has many weaknesses in terms of equal pay. The NHS had to pay a large amount of money on the staff's equal pay claim (DoH, 2004a).

## The Implementation of the New System

The new pay system was experienced long negotiating period before officially signed off by all parties. The open talk and three joint statements were all done between the Department of Health, Unions and Professional Associations, aiming to develop the new change and its targets. A study by Buchan and Evans (2007) listed the timetable of key milestones of Agenda for Change the summary of timetable from generating idea to rolling-out the Agenda for Change is shown as following:

May 1997	Labour government elected
September 1997	Exploratory talks on new NHS pay system begin
December 1997	White Paper on modernising the NHS is published
February 1999	<i>Agenda for Change-Modernising the NHS Pay System</i> is published
October 1999	First joint statement of progress
November 2000	Second joint statement of progress
November 2001	Third joint statement of progress
December 2002	Framework agreement agreed and published

January 2003	Proposed agreement and three-year pay deal announced
June 2003	'Early implementer' sites begin to implement Agenda for Change
December 2004	National roll-out of Agenda for Change starts

Figure 4: Timetable of Key Milestones of Agenda for Change (Buchan and Evans, 2007, p 3)

Under the guideline of the third joint agreement, there were three new bodies and procedures agreed to be established for the implementation. These three bodies were national-wide organisations which were responsible for making recommendations on pay and conditions of service in the NHS pay modernised system.

- The NHS Staff Council was established to replace the relevant functions of the old General Whitley Council and have overall responsibility for the pay system set out in the Agenda for Change Agreement (DoH, 2004a). It is an independent monitoring organisation of the new pay system. The decisions of the Council have to be agreed by both by employer and staff representatives. These decisions then required the formal Government's decision from the Secretary of State for Health and the Minister of Health in Scotland.
- NHS Pay Review Bodies was an existing organisation which was responsible for making recommendations to the NHS staff pay rates (DoH, 2004a). It was made to be a reviewing and appealing body for the new system. This organisation is open to the Government, employer, and employee to make a case for awarding differential pay increases to staff and for adjusting the differential between pay bands.
- The Pay Modernisation Team was responsible for the Human Resource Management and Human Resource Development roles. The main remit of the National Pay Modernisation Team was to support the NHS Boards in the successful implementation of the Agenda for Change pay system.

Overall, the Agenda for Change Implementation and Monitoring Teams were a combination of both NHS employers and Trade Unions. The whole change designing and implementation process was done by partnership working between the NHS employers and Trade Unions.

## **Outline of the Thesis**

This chapter has described the context of this study, it presented the background of partnership working in the public sectors, especially in the special context of Scottish devolution. The context of Agenda for Change has also been described in this chapter. Chapter 2 gives a detailed view of the literature concerning organisational change, partnership working, and Agenda for Change. It starts from reviewing literature concerning how organisational change is influenced by the development of partnership working the NHS in Scotland. The chapter then reviews the literature related to partnership working, starting from the key aspects of this concept in general, and moves to the specific labour-management partnership working. It discusses the definition of this concept, the approaches of working in partnership, key factors and challenges of partnership working. The literature review then moves to the study of Agenda for Change in relations to the expectations, implementations and outcomes of Agenda for Change. Chapter 3 presents the research design and methods. The overall aim and research questions are defined as is the process of conducting the study from the consideration of the ethical implications of the study through to the analysis of the data. Sampling techniques are described and because of the size of Scotland the sites are anonymised and referred to as sites 1, 2 and 3. The data analysis strategy is discussed at the end. Examples of how data is analysed are shown step by step. Chapter 4 presents the outcomes of the data analysis under four key headings namely Organisational Change in the NHS prior to Agenda for Change, Reasons for introducing Agenda for Change, partnership working prior to the implementation of Agenda for Change, and Describing how partnership working affects Agenda for Change. This is followed by Chapter 5 which discusses the key findings in light of the literature currently available. This chapter

also acknowledges the limitations of the study. Chapter 6 draws the conclusions of the study and makes recommendations for future research, education and policy.

## Chapter 2 Literature Review

### Introduction

The overall aim of the study was to explore the perceptions of different levels of Agenda for Change Implementation Teams in relation to organisational change and partnership working in three NHS Health Boards in Scotland. In order to develop the specific research questions, this chapter discusses current literature, which will be presented in three sections:

1. *Change models in the NHS Context.* This section reviews literature in relations to the organisational change happening in the NHS. It pays particular attention on how partnership working affect the change, and the debate from current literature on change models used in the NHS.
2. *Partnership working.* This section starts from reviewing literature on partnership working in the public service, it draws a generic picture on the approach of working in partnership. Reviews then moves its focus to the partnership working between management and unions. This gives a closer view on partnership working, in terms of its nature, approaches, key factors, and barriers.
3. *Agenda for Change.* This section reviews current research interests in the Agenda for Change. It helps to identify current research gap and develop research questions.

### Change Models in the NHS Context

As the example of the NHS structure has been continuously changed from 1970s to the 21<sup>st</sup> Century. It experienced the relative calm administration from 1970s to general management in the 1980s (Griffiths, 1983). After being influenced by the Private Sector and being operated with a purchaser and buyer approach by the Conservative party for many years, it was then transformed to a new partnership working approach with an onerous performance measurement regime by the new Labour government after 1997 (DoH, 2001, Greener, 2004). A study carried out by Lamb and Cox (1999) suggests the Health Sector has experienced major changes since the late 1980s, and is still under continuous structural changes.

The organisation has learned about the transition from administration to management in the 1980s and 1990s, while now the emphasis focuses less on doing and more on being. But beyond the continuous structural changes, there is the fact that the behaviour of the organisation has not changed with it. Plamping (1998) spots this fact and argues that while there has been much advice offered regarding NHS reforms and structural change, their behaviour does not change. Government admits this fact at their report of “Making Informed Decisions on Change: Key Points for Health Care Managers and Professionals” an influential article which shows that the NHS changes all the time but stays the same” (Cameron *et al.*, 2001). Because of this, it is important to review change management literature in the Health Care Sector context to understand what approaches are being used.

## **Implementing Changes through Partnership Working**

As the introduction of emergent change and the new Labour Government’s partnership working happened many Health Care organisations began to re-think the way in which they manage change. The new management style of empowering professionals, staff and stakeholders was more and more welcomed by both senior managers and line members (Wilkin *et al.*, 2001, Massey and Williams, 2006, McWilliam and Ward-Griffin, 2006, Wallace and Schneller, 2008).

Wilkin *et al.*, (2001) review the case for the establishment of Primary Care Groups under the new Labour Government’s partnership working approach and argue that successful Government has grappled with the problem of devolving decision making to frontline health professionals while remaining in control over NHS policy and management performance. To make their argument more clearly, they recognise the need to empower frontline staff required to be reflected in proposals for further structural reform (Wilkin *et al.*, 2001).

Wallace and Schneller (2008) identify the important role of stakeholders in the Health Sector, and argue that certain stakeholders are well positioned in each General Practice setting to instigate local change. They also call for a distribution of power to local level. They saw three dimensions of power which included

decision making where perceived interests may be seen to cause conflict, agenda setting which consequently limits the possible decision alternatives, and an ideological dimension that shapes perceptions and values, subliminally through power in legitimated arenas to determine future action. Wallace and Schneller (2008) suggest that the third dimension is the most covert expression of power, so that members of an organisation may be persuaded voluntarily to change their behaviour (Wallace and Schneller, 2008).

Davies *et al.* (2000) agree the importance of involving frontline members in the change process, although their research does not mention the direction of the change in terms of organisational learning. They do state that Health Authorities are structured in a way in which people within the organisation think about their organisation, and the relationship between them and the organisation, colleagues and themselves. They argue that empowering and enabling individual members within organisations has to be counterbalanced by providing clear direction and articulating a coherent set of values that guide member's action (Davies *et al.*, 2000).

The requirement of empowering and involving frontline members in the change process within the Health Care context can be seen as result of the establishment of Transformational and Emergent Change as well as the political encouragement of partnership working. Much evidence has shown that the Health Care Organisations were advised by the Government to operate under a rapid turbulent business context and empower members within their organisations. One example is the fact of the establishment of The Modernisation Agency in April 2001 by the Department of Health (DOH, 2000). This action was to ensure that the managers and clinicians across the NHS in the UK to make change happen because rapid service improvement was required by targeting professionals to practice better and stimulate change locally (DoH, 2000, Whittle and Hewison, 2007). This shows two key themes from the Government's opinion: firstly, that the business environment had become rapid and turbulent, so previous small scaled pre-planned change needs to be shifted to large scaled emergent change. Secondly, previous top-down model would not be successful under the new change approach. DOH suggested making change happen locally (DoH, 2000, p138). This needed to involve members at all levels within the

organisation by empowering them and partnering with them. Along with the need to empower staff, health care organisations was literature starting to shift their focus from a top-down management style to transformational and emergent change approaches.

## **Planned Change**

The NHS Service Delivery and Organisation and National Research and Development Programme was launched in March 2000 (Iles and Sutherland, 2001), and an area of common concern was the implementation and management of change. Their paper looks over different change models from previous academic literature and summarises the whole change process. In terms of the approach of change, Iles and Sutherland (2001) examine four approaches: organisational development, organisational learning and the learning organisation, action research, and project management. These approaches are mostly based on the planned change theory. Iles and Sutherland (2001) simply present the use of these approaches, but each receives little coverage. This article seems to ignore previous argument that the well-established importation of inappropriate industrial models to the NHS may not work (Hunter, 1988, Curie, 1998, Greener, 2004), and failed to explore detailed processes of change models in the Health Sector environment. Even the authors themselves admit that practicing managers may rarely be seeking to find out about a change model just because it falls within a particular school of thought (Iles and Sutherland, 2001, Greener, 2004).

The review of Iles and Sutherland's (2001) planned change models for Health Care Sector is supported by Hurley and Hult (1998) who look at the changes within the Health Care which are pre-planned and have a top-down approach. Meantime, they have to admit that this well accepted model has flaws when the Health Care industry develops. They concur with Southon (1996) who point out that changes within Public Sector are more difficult than in the Private Sectors in many ways but predominantly the complex political context, but also the fact that change has to involve a range of stakeholder's not just shareholders. On the other hand they admit that a large number of change events in Western Health

Organisations were top-down and executed pre-planned change by change agents telling people how to act (Ferlie *et al.*, 1996, Hurley and Hult 1998, Allen and Stevens, 2007). In line with the above argument, Organisational Development, which is defined as a top-down model of planned change by Beckhard (1969), has been considered for the above purpose. Furthermore, Beckhard (1969) suggests that organisational development often include behavioural-scientist consultants to play roles of change agents to lead changes.

Garside (1998) also supported using organisational development. But her argument is the start of looking at the entire organisation participating during the change process. She expands Hurley and Hult.'s (1992) theory on dividing people in the organisation into three broad change categories, and argues that change strategists are senior managers and professional leadership, change implementers are the project coordinators, and the recipients are the most of staffs in Health Organisations (Garside, 1998). Garside (1998) also suggests that change will only be successful if Health Organisations can include the entire three categories in the effort. In addition, Burnes (2004) Senior and Fleming (2006) and French and Bell (1999) suggest that organisational development allows change agents plays important role of implementing changes, while individuals within the organisation are involved in decision making and change planning. Moreover, organisational change can benefit organisation's long term strategic changes rather than short term target changes.

## **The Debates**

The above section points out that changes in the NHS is shifting from planned change to emergent change in the need of the new organisational context. Literature believes that emergent change, especially transformational change allows participation from workplace level. It meets the needs of the new public management. As what McWilliam and Ward-Griffin criticise (2006), Organisational Development processes often involves telling learners to do what the change agents tell them to do, which may end up with a stance that is widely renounced as being doomed to failure.

Although transformational change supporters successfully identified the strengths of emergent change, as reviewed above, they failed to prove how this approach can be used on large scaled organisational change, which has to be well pre-planned. Moreover, emergent change is designed upon individual's involvement and motivation on changing, current studies failed to consider the impact of employee resistance on change. In order to manage the resistance, the management has to carefully plan the change implementation (Lamb and Cox, 1999). Thus, debate exists between planned change and emergent change. In order to combine change resistance and involving employees in the change process, a highly democratic change model as Organisational Development seems to be suitable.

Esain *et al.* (2008) argue that because Structural and Operational change has become a common strategy for continuous improvement in the NHS, managers need to overcome the functional boundaries and bring together employees (Davies *et al.*, 2000, Wilkin *et al.*, 2001, Massey and Williams, 2006, McWilliam and Ward-Griffin, 2006, Wallace and Schneller, 2008, Esain *et al.*, 2008).

## **A Shift from Planned Change to Emergent Change in the Health Care Sector**

In response to the new public management introduced by the Labour government, changes in the NHS are seen to include more involvement from workplace level. It can be shown that much research argues planned change for health care organisation (Ferlie *et al.*, 1996, Hurley and Hult, 1998, Allen and Stevens, 2007) and starts to shift to transformational change under an emergent change approach (McWilliam and Ward-Griffin, 2006, Massey and Williams, 2006, Whittle and Hewison, 2007, Esain *et al.*, 2008, Gillies and Maliapen, 2008, Wallace and Schneller, 2008). The notional of shifting from planned change to emergent change is caused by the professional work in Health Care Sector with individualised decision making which causes organised anarchy (Greer, 1995, McWilliam and Ward-Griffin, 2006), which reframes professional esteem in terms of impeding change toward an empowering partnering approach (Spreitzer and Quinn, 1996, Fisher, 2001, McWilliam and Ward-Griffin, 2006). Thus, a

professional may use satisfaction with the status quo and contextual barriers as rationalizations for not accepting change (Spreitzer and Quinn, 1996, McWilliam and Ward-Griffin, 2006).

McWilliam and Ward-Griffin (2006) takes up information about the impact of Organisational Development on the NHS which includes emergent change as the second option of change approach for the Health Care Sector. They argue that the aim of using these typical Organisational Development strategies and principles is to describe behaviours, skills and actions that people have in order to influence them to the change from the outside in (Ackerman-Anderson and Anderson, 2001, McWilliam and Ward-Griffin, 2006). The Health Sector needs to change the organisation first, followed by changing members within the organisation.

McWilliam and Ward-Griffin (2006) believe transformative change fits with the affective and relational dimensions of the Health Care Sector, especially the new partnership working. Transformative change needs people to change consciously from the inside out (Ackerman-Anderson and Anderson, 2001, McWilliam and Ward-Griffin, 2006). It is a flexible client-driven approach as it involves the process of creating empowering care partnerships, readiness, commitment and conscious attention being given to action aimed toward attaining the approach (McWilliam and Ward-Griffin, 2006).

In terms of the principles of transformational change, Hurley and Hult (1998) draw chiefly upon the work of Kotter (1995, 1996) on the requirements of Transformational Change. They recognise that agreement among staff and managers make and a powerful coalition of leaders to drive the change are needed to achieve successful change. But the approach and method of how to involve people in the change process is not clearly stated in their research. Hurley and Hult's (1998) argument on the transformational change principles is supported by Allen and Stevens (2007) who summarise four difficulties that Health Care change agents are facing including vision, leadership and structure, resources and culture.

Hurley and Hult's (1998) use the work by Dunphy and Stace (1990) on Transformational change which refers to tackling all structures including making

changes to power and status of individuals within the organisation. However, Hurley and Hult (1998) focus on a modular type rather than corporate type. Thus, although in principle Hurley and Hult. (1998) admits the need to build a coalition of leaders to drive the change, they lack the arguments on how to involve people in the transformational change process as a coalition. In recent years literature related to telling members to change starts to be replaced by a plea that the voice of members who are willing to change be heard (McWilliam and Ward-Griffin, 2006, Massey and Williams, 2006, Whittle and Hewison, 2007, Esain *et al.*, 2008, Gillies and Maliapen, 2008, Wallace and Schneller, 2008).

## **Partnership Working in the Public Sector**

### **The Definition of Partnership**

Since 1997, partnership working has been placed at the centre of New Labour's approach to a range of key policy areas including health, education, employment, crime and disorder and social inclusion (Charlesworth, 2001). This has resulted different definitions and terminologies on partnership working, including the newly introduced 'co-production', 'co-governance' by the coalition government (Lloyd, 2014). Lloyd (2014) and Barnes *et al.* (2007) suggest that the concept of participatory governance was translated into a number of different practices, as part of labour's policy renewal agenda. Literature (Lloyd, 2014, Barnes *et al.*, 2007, Fenwick *et al.*, 2012, Skelcher, 2003, 2005, Skelcher and Torfing, 2010) on public policies agree this. Thus, partnership and its related terminology is defined from the perspective of how it is operated and worked, rather than arguing for a standard definition. For example, Brandsen and Pestoff (2006) and Pestoff and Brandsen (2008) define partnership working from the perspective of co-governance, which is to include public, private and civil society organisations in the planning and/or delivery of services, their collaborative activities contribute to the provision of public services. Bovaird (2007) studies participation between public service users and communities, and defines "user and community coproduction as the provision of services through regular, long-term relationships between professionalized service providers (in any sector) and service users or

other members of the community, where all parties make substantial resource contributions” (Bovaird, 2007, pp847). Sørensen and Torfing (2011) suggest that implementation of the new solutions in the public services needs partnership working in the form of resource exchange, coordination and the formation of joint ownership. Kernaghan (2008, 2009) study partnership as a network of public governance, and suggest public governance is networks of actors, integrating services and engaging the community at this micro-level, with joined up policies services, structures, processes and systems in arrangements that extend across organisations or departments. Overall, the definition of partnership lies on three main arguments: 1) sharing and exchange resources, 2) the structure of working in partnership, and 3) the debate of hierarchy or democracy.

### **Sharing and Exchanging Resources**

The first aspect is collaborative relationship by exchanging resources. It is developed by Labour government to pull together different organisations from community level, encourage them to change resource and work jointly. Stoker (2004) studies how local governance transformed from Thatcherism to New Labour, and suggest partnership allows independency from partners; however, they need to exchange resource to maintain the relationship.

Similar, Kernaghan’s (1993) research looks at partnership in Canada, and uses the concept of power to classify the meaning of Partnership which also provides details on the practical activities that partners need to engage in, and how the power is allocated between each parties. Casey (2008) summarised bellowing five types of partnership:

Type of Partnership	Characteristics
1. Collaborative Partnerships	Pooling of resources such as money and information. Each partner exercises power in decision making. Partnerships can be mutually dependent, share goals and build a consensus. Partners bring equal amounts of resources to the decision-making process and there is a sense of balance of power.
2. Operational Partnerships	Typified by work sharing rather than decision-making power. Sharing of resources, power, is retained by one partner. This type of Partnership is not as empowering but can lead to efficient and more responsive operations.
3. Contributory Partnerships	Do not require active participation of all the partners in decision making. The organisation agrees to provide funding with little operational involvement.
4. Consultative Partnerships	Take the form of advisory committees or councils whose main task is to advise on particular policy issues.
5. Phoney Partnerships	Usually established by a public organisation for co-opting various stakeholders. The likely result is disempowerment

Figure 5 Types of Partnership (Kernaghan, 1993, quoting from Casey, 2007, p74)

Gaster and Deakin (1998) and Casey (2008) did similar research on the concept of partnership. They classifies partnership working into five approaches from low level of stakeholders' involvement to higher level of collaboration.

Type of Partnership	Characteristics
Information exchange	Involves cross boundary working
Action planning	Involves mutual learning, joint problem solving and identifying the need for new partners
coordination	Involves active co-ordination process where a coordinator knows what is going on and draws on each partner as appropriate to develop and involve new partners
Collaboration and full Partnership	Involves shared value, pooled resources, blurred boundaries, constant change and providing support

Figure 6 Types of Partnerships (Gaster and Deakin, 1998, quoting from Casey, 2008, p74)

Comparing with Kernaghan's (1993) framework, this one brings thoughts of the practical activities involved in the Partnership activity. However, Casey (2008) questions the application of these two models. She points out that these do not specify the role relationship between the individuals involved, and the activities within the Partnership's context.

In contrast, these two classifications are based on a social Partnership approach, which is the other name for the hybrid approach. Thus, the role of representative is essential when considering the related activities. These two classifications do not show the involvement of representatives, or the outcome of business performance, which make partnership working lose its fundamental nature.

However, on agree partnership involving resources exchange and negotiated shared purpose from partners, Fenwick *et al.* (2012) point that there is limitation on resource exchange. Partnership can only come with pooled budgets, joint and even unified management and organisation structures. Social services such as addiction and child safety are funded ring-fenced by central government, but it would not be accurate to say that mainline budge are integrated and resource shared. The continuous of further partnership is limited as a function of financial and performance incentives.

Partnership working can also be cost effective. Lloyd (2014) studies the early childhood policies and agreed that the results of co-produced services at local level is claimed to be more effective for the public and more cost-effective for policy-makers. With the similar view, Lowndes and Skelcher's (1998) study on partnership's impacts to competitive market presents more in-depth view on the cost-effective aspect. They suggest that partnerships enable the levering-in of new resources either by enabling access to grant regimes requiring financial and in-kind contributions from the private and community sectors or using private sector partners to overcome public sector constraints on access to capital market.

### **Partnership Working Structure**

The second aspect is around the idea of bringing local government to a key site in co-governance and co-production. The idea of Labour government's 'pull together' is to invite public to the service planning and decision making. Lloyd (2014) suggest partnership requires the concept of citizens as stakeholders, as opposed to citizens as voters previously. Skelcher (2005) also study partnership working as democratic governance, he suggests that current partnership offers a democratic system, which citizens are enable to give consent to and pass judgment on exercise of authority by that governmental entity. Barnes *et al.*'s (2007) case study on public participation also suggest that under New Labour's 'pull together', a raft policies of involving active citizens in local policy making was developed. Sørensen and Torfing (2012) agree this by arguing that citizens give critical and constructive feedback on policies and services in and through their participation using their voice opinion in user boards, public hearings and so on.

Similarly, the coalition government speaks of a 'Big Society' which include citizens, civil society and government in co-governance arrangements solving policy problems and delivery public services at local level. Skelcher and Torfine (2010) who study the democratic governance in Europe provide helpful discussion on partnership as a model of 'participatory governance' to provide policy consultation, development and implementation. They suggest that partnership is institutional forms of participation which involves citizens as stakeholder and will contribute to a responsible production of relevant policy outputs and outcomes through active engagement and democratic deliberation.

With the similar view, Voorberg *et al.* (2013) studies partnership in relation to social innovation. They suggest that the process of generating new services requires the willingness of relevant partners to cooperate and share ideas, as well as to exchange vital resources, such as staff. In addition, partnership and open innovation is an embedded process, which takes place in organisational context (Bekkers *et al.*, 2011). Thus, the innovation process should be studied from an ecological perspective as innovation milieus (Bekkers and Homburg, 2007)

Above literature has recognised there are different levels of operating partnership, where 1) policies are made by central government (state), 2) local authorities (actors) are required to work in partnership, and 3) service users (citizens) act as stakeholder to decide service planning and delivery. However, current research pay great interests on the relationship between policy maker and local authorities, rather than overseeing the relationship between all three levels. For example, Fenwick *et al.* (2012), Bovaird (2007), Johnson and Osborne (2003), and Sullivan and Skelcher (2002) argue that local authorities are sharing greater extend decision making responsibilities than before with other agencies, through legislative and cultural changes. Stoker (1997) suggests that the overall effect of partnership is a shift from a system of local government to a system of local governance. Sullivan and Skelcher (2002) take a comprehensive research of local partnerships in 2002 and find that local authorities are the main bodies of getting funding for partnership. Their statistic result suggests that £5 billion were spending on 5,500 local partnerships with 75000 partnership board members.

Similarly, Fenwick *et al.* (2012) compared partnership working in England and Scotland, all state actors in their case study are accountable through a hierarchy to political leadership from local to central government level. Partnership is at the level of service delivery planning. To extend this argument, Osborne *et al.* (2002) use policy and document review and three case studies in England, Scotland, and Northern Ireland to study impacts of geographic issue on rural community partnership. Their study suggest that the Scottish devolution has important impacts on partnership structure and natures. On one hand, devolution establish closer links between local authorities and Scottish Executive and Parliament. On the other hand, the new national bodies have challenged the broader hegemony of Scottish local government in local governance, however the hegemony of government has remained unchallenged.

In addition, Fenwick *et al.* (2012, p405) summarised a large amount literature on public sector governance, they identify that current theoretical underpinned UK public sector partnership are ranging from considering of the following out of the state and the growing influence of self-organising networks, the exploration of the proliferation of non-state actors; the interdependency and resource exchange between these actors; debates around the multiple centred or polycentric nature of the state; interaction between various network actors; the extent to which governments are restricted to steering and monitoring with financial inducements rather than more direct forms of control and delivery; and if power of the state may have declined or within a complex network of multiple modes of governance.

However, all above studies have focused on the working approach between the central government (state) and local authorities (actors). Although service users (citizens) have been identified as the end level of government's partnership policies, literature on how to involve the role of public play in partnership is very limited. Skelcher and Torfing (2010) and Bovaird (2007) contribute very valuable work among limited studies on service users level. Skelcher and Torfing (2010), their study on 'participatory governance' distinguishes between four broad institutional forms of citizen participation: 1) opinion-seeking through public consultation; 2) data-gathering though public surveys; 3) policy-exploration through deliberative forums; and 4) interactive dialogue through governance networks. Their study contributes partnership working studies by identify public

opinions should be consulted and gathered through surveys. More importantly, the last two process identify the existence of partnership forum. They suggest that representatives from citizens are sometimes invited to partnership forums along with relevant experts and policymakers on policy issues, including negotiating and identifying policy problems, formulating policies, implementing joint solutions, and monitoring outcomes. However, Skelcher and Torfing's (2010) research is too generic on how service users cooperate with communities.

Osborne *et al.* (2002) suggest that rural geographic and local context of rural regeneration partnership is an essential mediating factor to involving local communities in these partnership, as what partnership forum needs. Transport and accessibility is important across urban and rural area. Meanwhile, rural areas have difficulties to establish partnership relationship and forms as large geographic scale, distinctiveness, and low in the paucity of human capital. Osborne *et al.*'s (2002) research contributes partnership studies by listing and explaining how the above factors impact partnership relationship and forums. However, as the same as other literature, it does not across the link between local authorities and service users.

Bovaird (2007) compares previous literature on user and community coproduction of public service, and produces a table to identify range of professional-user relationship depending on if service user and professionals have role of service planner or deliverer. This clarification opens up the range of ways which professionals, service users and communities may interact.

### **Hierarchy vs. Democracy**

The third aspect of partnership working sits on the debate of whether local government is in the centre of decision making, or if it still sits at the bottom of governance hierarchy. Miller and Ahmad (2000) reviewed the concept of collaborative partnership by using illustrative case study materials drawn from their research and consultancy experiencing in public sectors, such as inner city community based mental health, urban regeneration, policing, and child and adolescent mental health. They suggest that working in partnership, as with inter-

agency work and inter-professional collaborative, is the current emphasis for effective governance. More importantly, Miller and Ahmad (2000) and Hughes and Carmichael (1998) take a strategic view and suggest partnership is a more inclusive multi-agency approach which is premised on the bottom-up notion of community consultation, involvement and ultimately ownership.

However, researchers such as Jessop (1999, 2003, 2004), Stoker (2004), Whitehead (2007), Pestoff (2009) and Fenwick *et al.* (2012) have different view on who is in the centre of decision making. For example, Jessop (2004) study partnership as the term of meta-governance. His research suggest that governments play a role in meta-governance by being involved in the redesigning of markets, in constitutional change ad juridical regulation of organisational objectives. Hierarchies still exist between government and local level, but they operate in a way of negotiated decision making. Central government acts as a participant among pluralistic guidance system rather than sovereign authority. Stoker (2004) agrees this opinion, and argues that the state retains the power to coerce and control, although it encourage partnership. Whitehead (2007)'s study on partnership identifies the persistence of hierarchy and control through analysis of 'architecture' behind partnership. Pestoff (2009) examines what kind of different levels of participation of parents in childcare services can be distinguished in different EU countries. His study suggests that partnership is operated as top-down direction. With the similar opinion, Fenwick *et al.* (2012) also agree that the hierarchy and control from central government on the public services. They use case study to compare public sector partnership working in both England and Scotland and argue that hierarchy and bureaucracy are the key mechanisms for resource allocation and management in local government conventionally. Although local government is encouraged to play a main role of partnership, contemporary aspects of local government underpin this view and remain distinctly 'traditional' and top down in both England and Scotland, as the majority of local spending comes from central government. This can be proved by many government reports such as Department of Communities and Local Government (DCLG) (1999) and Audit Scotland (2010), which suggest local government establish accountability to the centre through performance and financial audits.

In summary, the concept of partnership working in the public sector is meant to pull together different stakeholders to work together by sharing information, exchange resources and jointly work on the shared goal. It is implemented as a three level hierarchy approach, where local authorities play important role of working in partnership. By working in partnership, public sectors are meant to delivery better service, it can also be cost effective for policy makers, and help to implement changes.

Miller and Ahmad (2000, p12) summarised “effective partnerships can be expected to generate information sharing, improved communication, a better understanding of what each stakeholder can offer, the avoidance of duplication, inefficiencies and the identification of opportunities for the effective sharing of resources”. Partnership can exist either in formal arrangement or informal relationships. However, it needs regular maintenance. The key characters of effective partnership include trust, respect reciprocity, mutuality, and openness in sharing of information, resources, decision making, responsibility and accountability (Miller and Ahmad, 2000, Pugh, 1993). Fenwick *et al.* (2012) suggest that trust is important to governance interactions in terms of partnership accountability. It is built upon game-like interactions through internal accountability though a hierarchy towards the centre.

Huxham and Vangen (1996) did four steps research over few years, including workshops, work with participants in practice, in-depth interviews, and run post experience sessions. They suggest that stakeholders need to have agreed aims and goals of collaboration, and have the wiliness to compromise on different agendas to make progress in collaboration. Communication is essential to partnership. Although keeping up the communication between organisations and sub groups can be time consuming, it is essential in terms of gain trust commitment, support and resources from organisation, as well as diagnose early signs of disagreements. In addition, equality and trust also make essential contribution to partnership.

It is clear that partnership working makes contribution to planning and delivery public service. However, in the special context of reforming and modernising public sector, partnership is pointed to the direction of making changes. For

example, Department for Education and Employment publication (DFEE, 1998) suggests that partnership is a mechanism for change, with the capability to build a way of working for future, by using the maximising of influence. Lowndes and Skelcher (1998) suggest that multi-agency partnership forums are to open up local decision-making process. Nonetheless, literature on partnership working in the particular context of decision-making and organisational change remains blank.

Above literature presents an overview of partnership working in the public sector to delivery public services. Meanwhile, partnership working is also used as a type of intra-organisational relationship for the aim of delivering better service to the public, where labour and management jointly work together. In order to understand partnership working within organisations and to generate research questions, literature review will now focus on labour-management partnership working.

## **Labour-Management Partnership Working**

### **Partnership Working Definitions**

The early studies on partnership working (Ackers and Payne, 1998, Bacon and Storey, 2000, Guest and Peccei, 2001, Ackers *et al.*, 2004, Dietz, 2004, Stuart and Martinez-Lucio, 2005) have showed great debate on the definition of Partnership. Again, with the similar view in the earlier section, it is hard to find a standard definition which helps with classification. There is an inherent ambiguity in defining partnership working, especially in the Health Sector (Bacon and Storey, 2000, Johnstone *et al.*, 2009). As Guest and Peccei (2001) pointed out, partnership working is clearly agreed by researchers, but no one can clarify what they agree with.

However, Johnston *et al.* (2009) suggest the useful definition that partnership working should be able to “describe a set of organisational characteristics and practices that, first, do justice to the idea of management employee relations in a Partnership manner and second, are readily observable in order to verify a genuine example in practice (Johnston *et al.* 2009, p261). The work on

partnership definitions including organisational characteristics and practices is drawn from Dietz's (2004) study between the Involvement and Participation Association (IPA) and the Trades Union Congress (TUC). The key Partnership element is shown in the Figure 7 below

Partnership element	IPA	TUC	Classification
A joint declaration of commitment to organisational success	Y	Y	Values (Marchington, 1998) Commitment (IPA, 1997)
Mutual recognition of the legitimate role and interests of management, employees and trade unions where present	Y	Y	Values (Marchington, 1998) Commitment (IPA, 1997)
Commitment and effort to develop and sustain trust between the organisation's constituencies	Y	Implicit	Values (Marchington, 1998) Commitment (IPA, 1997)
Means for sharing information [IPA]/ Transparency [TUC]	Y	Y	Process
Consultation and employee involvement, with representative arrangements for an 'independent employee voice' [IPA]/Transparency [TUC]	Y	Y	Process
Policies to balance flexibility with employment security [IPA/TUC]	Y	Y	Outcome
Sharing organisational success [IPA]	Y	-	Outcome
Adding value [TUC]	Implicit	Y	Outcome
Improving the quality of working life [TUC]	Implicit	Y	Outcome

Sources: Adapted from Dietz (2004: 8), IPA (1997), TUC, (1999).

Figure 7 The key partnership elements (Dietz, 2004)

According to the above summary, it is understood that both TUC and IPA accept partnership definition to be transparent on information sharing (IPA defines as sharing information, while TUC defines as transparency), with the needs to balance the flexibility with employment security, and positive employee outcomes (IPA defines as sharing organisational success, while TUC defines as improving quality of working life). However, IPA and TUC's definitions are different in terms of the employee's involvement context of working in partnership. IPA accept partnership to exist in the non-union context, while TUC believe that unions are essential for representing members in the partnership relations.

Although this work fits with context of a generic business environment looking at the Partnership element, Johnstone *et al.* (2009) were able to draw the key characteristics common to definition in the Health Sector. Guest and Peccei (2001)

suggest a genuine Partnership Agreement is a key principle of working in Partnership; while trust and mutuality are the key components of a Partnership Agreement. Martinez-Lucio and Stuart (2002) reviewed the aim of working in Partnership from the perspective of Organisational Change, and commented that Partnership was a bureaucratic centrally driven approach to Organisational change in the NHS. Stuart and Martinez-Lucio (2005) took this view on a long-term strategic level, they further suggested that management would gain economically, effectively, ethically and responsibly by co-operating with Unions and employees on issues of strategic Organisational Change. With the similar view, Tailby *et al.* (2004) stated that partnership working and employee involvement became central themes of the Labour Government's policy for the particular purpose of reforming the NHS. What they wanted to achieve through union and management partnership working was to improve targeted performance while cutting endemic recruitment and retention difficulties.

In association with Government's policy to transform the NHS into a modern employer, partnership working was decentralised to local NHS Board and workplace level for the purposes of management. The Health Service Report (Industrial Relations Service, 1998) defined partnership as being an approach to involve employees in the drawing up and executing policies while managers retained their rights to manage. Farnham *et al.* (2003) support this view by arguing that the aim was to increase employee involvement and commitment to the purpose of Organisational Change, improved performance, and also produce better employee relations. Bach (2004) suggests that current partnership working policy was drawn from the attention of Human Resources practices in assisting the new NHS reform. However Tailby *et al.* (2004) points out that Human Resource managers consider partnership as an approach to restrict employees, meanwhile use the partnership institutions instrumentally to achieve formal policy and procedural change.

However, the mainstream of partnership working literature paid great attention on how the union and management relationship needs to be approached. Studies (Guest and Peccei, 2001, Martinez-Lucio and Stuart, 2002, Tailby *et al.*, 2004, Johnstone *et al.*, 2009), suggest that the centre of partnership working should be around the idea of co-operation for mutual gain, where management and Unions

both benefit through joint working. Meanwhile, literature on the NHS partnership working has paid great interests on how partnership working is driven by human capital (Munro, 2002, Mason *et al.*, 2004, Young *et al.*, 2011) and a mutual gains approach at all levels (Farnham *et al.*, 2003, Bach, 2004, Tailby *et al.*, 2004, Bacon and Samuel, 2012, Bennett, 2013).

### **A devolution approach driven by human capital needs**

Partnership working is affected by Governmental policies in different ways. Guidelines from the Department of Health in recent years aims to encourage local Trusts to enhance the quality of this Public Service. This is to be done though providing greater workforce flexibility and co-operation through creating a highly committed employment relationship. One of national strategies designed by the Labour Government is decentralisation, this means that the strategy of policy reforms was implemented at local level (Mason *et al.*, 2004). Collective bargaining still remained in place at national level, while local Trusts were also encouraged to implement best practice human resources and performance management (Mason *et al.*, 2004). At this time, partnership working still existed strongly at national level, while local Trusts were encouraged to be engaged. The Department of Health (DoH, 1999a) believes that frontline staff are best placed to make decisions about patient care, and in fact employee involvement has already existed in some ways. On the other hand, the UK NHS must achieve continuous improvement in service delivery while making annual efficiency savings to deliver the best value. At local NHS Board level, management was proved to be benefiting by allowing Unions to influence the pace of change and agree common objectives with management (Mason *et al.*, 2004). These benefits are shown by three positive impacts: employment relations and performance, ability to embrace change, and improved access to management (Guest and Peccei, 2001, Reilly and Denvir, 2008, Oxenbridge and Brown, 2002, Young *et al.*, 2011).

Farnham *et al.* (2003) studied the DoH's (2000) Partnership Strategy, and summarise the action plans at two levels:

- At national level, Partnership plays a strategic role in terms of developing leadership, training package for Unionists and managers, joint problem-solving, as well as establish a framework of employee involvement and responsibility.
- At local level, NHS Boards are required to establish action plans in connection with Human Resources policies on time off, facilities, local Partnership Forums, as well as improved communication, and training and development.

In addition, Stuart and Martine-Lucio (2000) study partnership working in terms of mutual gains from three levels:

1) Strategic level:

- Supportive business strategies;
- Top management commitment; and
- Effective voice for human resource in strategy making and governance

2) Functional (human resource policy) level:

- Staffing based on employment stabilisation;
- Investment in training and development; and
- Contingent compensation and reinforced co-operation, participation and contribution

3) Workplace level:

- Higher standards of employee selection;
- Broad task design and teamwork;
- Employee involvement in problem solving; and
- Climate of co-operation and trust

(Stuart and Martinez-Lucio, 2000, p312, quoting from Kochan and Osterman, 1994, p46)

Stuart and Martinez -Lucio's (2000) study manage to reflect the mutual gains at all levels of the UK NHS organisation. However they do not examine the partnership working approach or at any of the three levels.

Overall, partnership devolution was to reform the NHS with the purpose of improving service, performance, and industrial relationships. Partnership was devolved from national level to the NHS Board and the workplace, where they had opportunities and responsibilities to implement their own Partnership policies. However, partnership working at workplace level did have tensions. Mason *et al.* (2004) argues that the NHS faced challenges of restructuring, which results in a turbulent industrial environment, where local NHS Trusts face Human Resource and financial pressures (Guest and Peccei, 1994, Kelly, 1998, Mason *et al.*, 2004). In order to meet performance targets, management attempted to exploit Partnership at workplace level (Kelly, 1998). The Labour Research Department (1998) produced similar findings that there is little evidence to show that partnership agreements were fully supported by managers at workplace level. In addition, evidence also suggest that, if there is a history of cooperative relationships between senior management and union representatives, partnership working may be more positive under informal arrangements rather than formal arrangements (Dietz, 2004; Oxenbridge and Brown, 2004; Samuel, 2007).

In order to gain an understanding of the actual approach of partnership and the union and management relationship, the review has been expanded from a vertical top-down direction to a horizontal one with studies of theoretical approach, mutual gains, and unionism.

### **Theoretical Approach of Partnership Working**

Different researchers tend to emphasize potentially different elements and dimensions of Partnership (Woodworth and Meek, 1995, Marchington, 1998, Taylor and Ramsey, 1998, Guest and Peccei, 2001). Guest and Peccei (2001)

having reviewed the existing literature either explicitly and implicitly have drawn attention to the approaches to Partnership. They summarise three broad intellectual traditions and theoretical perspectives which they have labelled as being a pluralist, unitarist and hybrid approach.

The Conservative Government used to adopt the unitarist approach by supporting an individualist and market-based ideology until the European Union required them to make accommodation to the European model from the pluralist perspective by introducing partnership working. The new approach reveals how the pluralist concept can be presented within a unitarist context by sharing goals, culture, learning, effort and information (DFEE, 1998). Although the involvement of Trade Unions is recognised, it is in a secondary role (Guest and Peccei, 2001). This situation changed when the Labour Government was elected and reinvigorated the debate with the concept of Partnership and fairness. Their approach on partnership working is similar to the hybrid perspective in many respects (Guest and Peccei, 2001). Then the new Government worked closely with Trade Unions using a hybrid approach with the aim of involving employees at work and increasing their ownership. The role of Trade Unions has then been placed in a primary role and has regularly appeared in many policies and regulations from the Government (McMurray, 2007).

When looking at the industrial relations context, Guest and Peccei (2001) suggest that the hybrid approach is very similar to the American mutual gain theory where employee works with management either directly or through representatives to provide shared benefits (Kochan and Osterman, 1994). This leads to an approach of union-management collaboration where Unions have larger voice in the investment in training and development and fairness at workplace.

### **Mutual Gains Approach**

Partnership practices in the NHS have been suggested as being a cooperation between Unions and management (Tailby *et al.*, 2004). Earlier a discussion of three theoretical Union and management models were presented. They were pluralist, unitarist, and hybrid. Of these, the hybrid model was seen as a modern solution to sustain the long-term employee involvement through providing shared benefits for both parties. Mason *et al.* (2004) examined partnership working

approaches which were used on two different NHS Trusts; their findings suggest that the first implementation change with fewer industrial conflicts was achieved by adopting the hybrid partnership model. In this Trust, the management and Unions were able to agree common objectives on change, as well as respecting the mutual risks taken in implementing change. The partnership approach of change implemented with a top-down direction, where the new service was introduced and partnership arranged. However, their research also argues that although the hybrid approach involves Unions to participate with management, in parallel with the partnership approach, management can and did push change unilaterally.

With similar characteristics the model of “mutual gains” have been influenced by hybrid and high commitment, and are now used in many partnership working theories in the NHS (Kochan and Osterman, 1994, Kochan, 2008). For example, Bach (2004) recognised that partnership working in the NHS has shifted from a managerial emphasis toward forms of union and management working with direct communication and participation (Bach, 2004, Millward *et al.*, 2000). This has been proved by a number of studies on such arrangements (Munro, 2002, Farnham *et al.*, 2003, Bach, 2004, Mason *et al.*, 2004, Tailby *et al.*, 2004, Bacon and Samuel, 2012, Bennett, 2013). With the similar opinion, Stuart and Martinez-Lucio (2000) argue that the NHS has been driven from a management driven by a human resource management ethos to a perspective which relies on the assistance of Unions to work with the management on changes. As the result, when the management offers guaranteed benefits such as employment security or better training and development, Unions are likely to be involved in joint-working. Kinge (2014) argues that a mutual gains approach allows the management to invite Unions into a joint-working relationship. By doing so, Unions have raised their profile in the NHS, with extended involvement, a legitimate and expanded role; while management has benefited in terms of having support to manage changes and from a Human Resource Management perspective.

Similarly Bach (2004) suggests that Human Resource managers attach more importance to the relationship with Unions than their managerial colleagues, when they expressed an interest in developing partnership working. Tailby *et al.*

(2004) also took an inside view of partnership working at Trust and workplace level. They suggest that mid-line managers have less positive reaction to partnership working than the managers at Trust level. This is because line-managers have concerns regarding daily tasks and performance, and how this may conflict with the patient's requirements. More importantly, their study suggests that employees at work-place level are more concerned about their pay than any policy of change. If the change is large scaled organisational wide, it can be driven better according to Government's objectives than by involving staff.

Mason *et al.* (2004) also compared partnership working in two NHS Trusts, and suggest that Partnership can be used as a top-down change model, but there have to be project teams made up of top level people to manage change and control quality issues. By supporting to the importance of having a partnership structure, Bacon and Samuel (2012, p24) also argue that with an appropriate partnership structure it can "facilitate joint problem solving and mutual commitment to an agreed overall strategic direction for the service". In addition to the above, the Health Service Report (Industrial Relations Services, 1998) suggests that, partnership allows employees to be involved in the drawing up and executing policies while managers retained their rights to manage.

Among these studies on partnership working, McMurray (2006) is one of very few that argues that the NHS is experiencing a transformational process in which partnership does fit into this particular change uncertainty. However, this research failed to examine how partnership working assists organisational transformation, either to identify the common characteristics of partnership working and organisational change.

However, despite the different views on partnership working approach, it is clear that the role of union plays in partnership has changed, and has become more important. In order to have better understanding on the approach and process of partnership working, literature review will now draw attention on the relations between unions and partnership.

## Unionism

Chapter one has presented the political context of partnership working in the public sector. It is understood that the public sector's privatisation has declined union membership, as well as unions' involvement in the management decision making. Union recognition has been declined from 66 percent in 1984 to 53% in 1990 to the lowest 45% in 1998. In contrast, the percentage of lacks of union members at workplace has been risen from 36% in 1990 to 47% in 1998 (Cully *et al.*, 1998). Along with the public sector modernization and partnership working encouragement since 1997, union's involvement was brought back to the centre of governance. Employee representatives, especially Union representatives are the key factors of both pluralist and hybrid approaches. This brings positive impacts on union's recognition.

In the literature, there are two views of the impact of the Partnership with the Unions. Some researchers suggest that the new partnership working approach gives a positive impact towards the development of Unions. For example, Ackers and Payne (1998) argue that partnership working offers Unions a new role as joint architects in contrast to earlier attempts by the Conservative Government to ignore and erode the Unions. With a similar view, Boxall and Haynes (1997) suggest that involving Unions in the partnership working approach could be a potential survival strategy in a neo-liberal environment, because this approach combines their servicing and organising aspects, as well as blending their traditional roles with more modern approaches. Meanwhile, Kochan and Osterman (1994), Knell (1999), TUC (1999) and Guest and Peccei (2001) have commented on the benefits of involving Unions as employee representatives and how this links the Human Resource Management impact to the hybrid approach. They and argue that employees will be benefited in terms of greater job security, training, quality jobs, good communication and a more effective voice.

The other view on the relationships between partnership working and Trade Unions is the belief that the Unions have made a positive impact on successful partnership working and an improvement in organisational performance. This view is naturally supported by the Trade Unions and employee representative organisations such as the Trade Union Congress (TUC), National Centre for

Partnership and Performance (NCP), but also perhaps unexpectedly by the Department of Trade and Industry (DTI). The TUC (2002) claim that Unions play an important role in adding value to the organisation, contributing to improving organisational performance, facilitating changes, improving decision making, and creating a more committed workforce. More importantly, the report from the TUC (2002) shows that by using partnership working, organisations are one-third more likely to have the above average performance, lower labour turnover and absenteeism, and higher sales and profits. Guest and Peccei (2001) agree that Unions can make a positive impact on organisational performance and productivity. Similarly, the UK Government also note the efforts that Unions make in terms of workplace consultation and organisational performance and competitiveness (DTI, 2002).

However, critics questioned the negative impacts on unions being working in partnership with the management. Tailby *et al.* (2004) rose the concern that unions of being too close to the management on partnership working may cause problems on unions' development of membership-led and resistance strategies. It can also lead to a long-term weakening of union structures by undermining of workplace activism. Taylor and Ramsay (1998) argue that partnership allows unions to be involved in the management strategy, which enhance surveillance and work intensification. Presenting more sharply, Oxenbridge and Brown (2002) criticise that unions cannot really meet their original aim of protecting jobs and increase employee benefits from working in partnership with the management. In fact, the management uses partnership as a change legitimising strategy or a short term method to achieve long term de-collectivisation.

Contracting both sides, partnership working enables benefits for both Unions and management, but also brings limitations to unions. However, partnership working allows both management and unions to gain shared benefits by working together. This is discussed by Kochan and Osterman (1994) using the term Mutual Gains Theory in the American literature and by McMurray (2006) using balanced reciprocity in the UK.

## **Key factors of Partnership Working**

Most of the recent studies pursue an interest on the need for partnership working (Guest and Peccei, 1994, Kelly, 1998, Farnham *et al.*, 2003, Bach, 2004, Mason *et al.*, 2004, Young *et al.*, 2011) and partnership working approaches (Munro, 2002, Mason *et al.*, 2004, Tailby *et al.*, 2004, Bacon and Samuel, 2012; Bennett, 2013).

Of those who have investigated the key factors of partnership working Stepney and Callwood (2006) suggest that in order to build a sustainable partnership, parties need to replace tribalism and self-interest with mutual trust, honesty, openness, and common understanding. In supporting this, Young *et al.* (2011) emphasises the importance of trust to develop partnership working. Moreover, they suggest that “there is something of a chicken and egg dilemma in this relationship” (Young *et al.*, 2011, p504), which means that the impact of trust and partnership working are two way. Partnership can enhance interpersonal trust inside the organisation, while trust is also a “necessary precondition of partnership working and the process through which Partnership is realised” (Young *et al.*, 2011, p504). All levels of management need to engage with the workforce to overcome change management decision-making, and to demonstrate that Partnership is part of the culture and not the transient initiative (Young *et al.*, 2011).

Young *et al.* (2011) look at partnership working key factors from a behavioural perspective. However, Bacon and Samuel (2012) examine the key factors from much more practical view. Their findings suggest that Scotland is ahead of the other nations in the UK in partnership practices. In Scotland, managers are engaged with Unions in terms of consultation at an early stage when developing policies and negotiating changes; while managers from the rest of nations only inform employee representatives of the key developments rather than engaging them in change decision making. They go on to identify the five enablers: developing a shared aim, Partnership structure, and frequency of attending Partnership Forums, the scope of Partnership meetings, and voice from all parties. Their study suggests that their common aim of change is normally merged at national level, along with others to assist policies which provide support. However,

local NHS needs to develop appropriate workforce policies to support the nationally shared aim. In addition, appropriate Partnership structures are needed to allow joint working and joint problem-solving. It needs to be in association with frequent Partnership meetings where broad scope of issues can be discussed jointly by the management and Unions.

Kinge (2014) argues that setting up Partnership institutions can help to formalise arrangements and guidelines to sustain partnership working in the long-term. Partnership working is not new to the NHS, and the current pattern is a continuation and the further development of relationships which already existed at local level. However, the institution is a strong driver and instigator of developing and sustaining partnership working.

### **Negative impact on Partnership Working**

The critical debate on partnership working is not solely concerned with the positive impact of Partnership on Unions, or the impact of unions on partnership (Hyman and Mason, 1995, Marchington, 1998, Taylor and Ramsey, 1998, Guest and Peccei, 2001, Kelly, 2005, Martinez-Lucio and Stuart, 2002). This critical debate is divided into two three arguments:

Kelly (2005) questions the actual improvements for employees or the Unions that have emerged from partnership working in terms of Union membership, wages and conditions for employees or indeed the degree of Union influence. By evaluating the current data, he argues that there is no evidence to show that membership has increased by adopting a partnership working approach, nor is there any supporting evidence from the Union organisations or Government to show that those organisation who have adopted partnership working have gained higher wages than non-Partnership companies. The studies by Cully *et al.* (1998) and Guest and Peccei (2001) also have not shown that better job security is more widely available in organisations using partnership working than others or as it was suggests to be. However it must be accepted that the general downturn in the financial situation may well have had an unexpectedly huge effect on pay levels or job security. Also because of the lack of evidence, partnership working

and Unionism are facing the barriers that managers would have had to deal with alone and directly with employees rather than through Unions (Cully *et al.*, 1998). Because managers have the concern that partnership working can be time consuming to come to a decision the whole decision making process comes with extra costs. But Deakin *et al.* (2004) and Heery (2002) point out that the reason that makes managers feel uncomfortable with involving Unions is that the UK business environment and its structure of organisation governance are too focussed on short-term performance. While if one looks at the long-term organisational strategy, unionism can be seen to make positive efforts on engaging with partnership working (Heery, 2002, Deakin *et al.*, 2004).

Martinez-Lucio and Stuart (2002) apart from also noting a lack of evidence on how Unions make efforts on partnership working in terms of employee benefits. They go on to make comment about exploring the reasons of the lack of evidence. They believe this disadvantage is caused by methodological measurement challenge. They suggest that this comes from difficulty of conducting a controlled experiment. However they do pleas for the topic to be investigated in a more detailed and methodologically rigorous way (Martinez-Lucio and Stuart, 2002).

The second main argument on the critical debate is based on the relationship between Unions and management (Hyman and Mason, 1995, Ackers and Payne, 1998, Marchington, 1998, Taylor and Ramsey, 1998, Ackers *et al.*, 2004, Johnstone *et al.*, 2004). Marchington (1998) and Johnstone *et al.*, (2004) note that the Unions are becoming too close to management and being party to unpopular decisions, while having only limited influence over management's decision making. As a result, it may lead to an inability of union members to resist management, and create new difficulties of recruiting new members. This then would seem to give the Unions an imbalanced situation with negligible benefits (Johnstone *et al.*, 2004).

The third criticism of partnership working lies with the impact of the Government's policies. Regulations and governmental policies play an important role in the interest of regulation of the market, self-interest, and the actual working approach of partnership working. However, McMurray (2006) question the policies' negative impact on partnership working. They argue that the set of Government

policies and guidance such as the Health Act (1999) lead commissioning, pooled budgets and access to national performance and Partnership funds. It creates a visible commitment that government fosters collaboration. Organisations lose the flexibility of adopting the Partnership approach which can be suitable for their own situation. When the spirit of flexible partnership working is moved away from, the approach of collaboration becomes wasting time (McMurray, 2006).

## **Agenda for Change**

Current studies have showed interest in the Agenda for Change implementation (May *et al.*, 2006; MORI, 2006; ), employees' views and experiences (Pollard, 2003, Walmsley, 2003, National Audit Office , 2009; Chartered Society of Physiotherapy, 2009) and the outcomes and impacts of Agenda for change (Buchan and Ball, 2011, McMahon, 2005, DoH, 2004b, McClimens *et al.*, 2010;). The Literature on this change programme will be reviewed from these three perspectives.

## **Views and Expectations on Agenda for Change**

There were positive expectations from both employers, employees, and academic researchers before Agenda for Change implementation. Before implementation, Agenda for Change was expected to be a beneficial development which would include new roles, changing roles, extended roles, improved team working, new ways of working, improved recruitment and retentions (Edwards *et al.*, 2009), a possibility for rewarding staff for the work they actually do (Walmsley, 2003), it was fair and transparent (Pollard, 2003). Since the implementation started, these benefits are also expected by the NHS Employers. They said out a schedule and timeline for benefits realisation (see below).

<b>Implementation benefits</b>	<b>Intermediate benefits</b>	<b>Long-terms benefits</b>
--------------------------------	------------------------------	----------------------------

Fair pay	More teamwork	More patients treated more quickly
Better pay	Greater innovation in staff deployment	Higher-quality care
Partnership working	Better career development	
Equal opportunities and diversity	Better recruitment and retention	
Human resources systems	Better moral	
Simplified administration		

Figure 8 Agenda for Change benefits (NHS Employers, 2005, quoted from Buchan and Evans, 2007)

National Audit Office (2009) suggest statistically that more than 80% of employees agreed that the old pay arrangement were overly complex, 59% that they were insufficiently flexible, around two-thirds employees thinks the old pay system was lack of harmonised terms and conditions, which provided barriers to team working. Moreover, 90% of employees agreed that a new contract is needed. Chartered Society of Physiotherapy (2009) thought although Agenda for Change was not perfect, it was much improved and considerable than the Whitley system, it was also a good deal for physiotherapy, physiotherapist ad physiotherapy assistants.

Although the general expectation on Agenda for Change was positive, concerns were also raised from literature. Parish (2004) expected Agenda for Change to be time-consuming. Edwards *et al.* (2009) suggest many radiographers were unhappy about the increase in working hours, and senior II radiographers could be disappointed since they were assimilated into band 5, despite having several years of post-qualification experience.

## **Implementation and Partnership**

Agenda for Change was developed and implemented in partnership between unions and the NHS employers. There have been two ways benefits between Agenda for Change and partnership working. On one hand, Agenda for Change was implemented through partnership working, which assist the success of implementation and contribute to the low level of challenge to the system. On the other hand, Agenda for change also give employees and management opportunities to work together and develop good constructive relationship (House of Commons. Public Account Committee, 2008).

A report from House of Commons Public Accounts Committee (House of Commons. Public Account Committee, 2008) suggests that Agenda for Change was developed and implemented in Partnership between the Department, employers and Trade Unions. This collaboration led to the development of constructive relationships between Union Representatives and management in the NHS, it also contributed to the low level challenges to implementing the new pay system (House of Commons. Public Account Committee, 2008).

Unions have also play an important role of communicating members on Agenda for Change. Ipsos MORI's (2006) interview research suggest that employees felt that Agenda for Change had been discussed in many professional and trade publications. The volume of information and available communication allowed them to access information with ease. McMahon (2005) take a snapshot analysis on the impact of Agenda for Change to nurses working in research role. Her research is carried out on behalf of RCN, and suggest that the RCN plays positive role on Agenda for Change implementation in the way of supporting nurses through regional RCN workshops and events, and establishing Agenda for Change website for research nurses with sample job descriptions, information on career pathways and access to a discussion zone for RCN members. However, this research is limited by low research response rate, which only 60 out from 4000 employees responded the on-line survey. Moreover, this research does not present the employees' view and experiences on Agenda for Change.

Meanwhile, partnership relationship has been developed by implementing this change. This sign has been shown from the early implementation sites even

before the national roll out. As the example of East Anglian Ambulance Service, Agenda for Change has improved relationship between staff side and management side so much. Representatives from both sides work well in the job matching panels, “it is sometimes difficult to tell who is staff side and who is management side” (DoH, 2004b). This relationship has been achieved through working together on Agenda for change and being guided by the mantra that both parties would only consider solutions that are best for patients and for staff. As what the report on early implementation sites suggests, “the process of implementing Agenda for Change has meant that new behaviours on both sides have been developed and the trust is beginning to see this reflected in better day-to-day working relationships” (DOH, 2004b). This positive outcome on partnership working is also shown statistically after the national implementation. NAO census suggests that 63% employees think that agreed that partnership working had increased as a result of Agenda for Change (National Audit Office, 2009).

However, there has been problems with Agenda for Change implementation. National Audit Office (2009) result suggests that Agenda for Change is time- and cost-consumer. The Knowledge and Skill Framework encourages employees to have opportunities for training and development, but this is not always met due to time-consuming. Buchan and Evans (2007) argues that although the national negotiations were slow, local implementation was rushed. Timescale for implementation is optimistic to trust managers, they had to rush the process to accompany pressure from their strategic health authority and the Department of Health. Edwards *et al.* (2009) argue that although the management can alleviate free up staff for training, employees still find their continuing professional development (CPD) time restricted by work pressure.

## **Outcomes of Agenda for Change**

There have been positive outcomes of Agenda for Change. Gould *et al.* (2007) study the impact of Knowledge and Skills Framework, they suggest that this framework has the potential to increase the human resources management aspect of the clinical nurse manager’s role, in terms of training and learning. It

also has implications for providers of continuing professional development in the universities and is likely to demand closer liaison between education providers and health professionals who commission education and training. Buchan and Evans (2007) argue that most of the managers they interviewed are in favour of Agenda for change, they believe that Agenda for Change will provide fairness, flexibility, and teamwork to the workforce. It will also assist in delivery the improvements in patient care and staff experience. The benefits of Agenda for Change is also presented statistically by National Audit Office. Their census (National Audit Office, 2009) shows 56% employees agree that the Agenda for Change contract enables staff to work flexibly for the benefits of patients. 68% agree that it has helped with role specification, over half of trusts in England agree that they had used Agenda for Change to improve clinical pathways by creating new roles for nurses

However, there are also a few studies (May *et al.*, 2006, Buchan and Evans, 2007, Edwards *et al.*, 2009, McClimens *et al.*, 2010, Williamson and Williams, 2011) suggest that Agenda for Change does not have the positive outcomes as expected. The King's Fund's research carried out by Buchan and Evans (2007) suggests that there are few signs proving that Agenda for Change has delivered increasing productivity despite the extra cost. Managers also complained that the KSF is cumbersome and costly to implement (Buchan and Evans, 2007). Edwards *et al.* (2009) argue some employees may not be promoted after obtaining extra qualification due to lack of available on-site posts at higher band, which contradicts the aim of Agenda for Change. In addition, funding shortage also limits the opportunities of moving up to higher bands. Lack of opportunities for training is also a barrier to career progression amongst allied health professionals. Edwards *et al.* (2009) use interviews to stakeholders and survey employees on a large radiographic workforce samples to study the effect of Agenda for change on career progression, they suggest that the majority of the radiographic workforce is dissatisfied with Agenda for Change in relation to their career progression. A large proportion of Radiographers feel that there has no effect of Agenda for Change. Moreover they are against being defined by their salary band, and feel that their professional identity has been lost with the removal of the Whitley Council grades (Edwards *et al.*, 2009). McCliments *et al.* (2010) argues Agenda for Change is seen to reward specialization rather than

skill sharing, and it has difficulty differentiating between and rewarding staff with broad generalist roles

There are some literature (May *et al.*, 2006, Buchan and Evans, 2007, Edwards *et al.*, 2009) identify that there are winner and loser under Agenda for Change. Buchan and Evans (2007) suggest there are winner and loser under Agenda for Change in terms of employees' financial impact (term and conditions). They point that band 4 and 5 administrative and clerical staff are the main "losers" under Agenda for Change, while senior clinical nursing and senior allied health professional staff are the big "winners". This is agreed by Edwards *et al.* (2009), they further add that ancillary grades appear to have done relatively well by moving across to this new system with a lengthened pay scale and improved career progression, and band 2 healthcare assistant also have new career opportunities to progress to bands 3 and 4 by completing NVQ awards and foundation degrees. May *et al.* (2006) did focus group research to look at the experiences and opinions of estates and facilities staff surrounding Agenda for Change during the implementation period. They suggest that the framework does not adequately cater for the needs of estates and facilities staff, as their trade qualifications are not recognised in comparison to academic qualifications. Nurses are more likely to make progress through the bands than estates and facilities staff. Williamson and Williams' (2011) phenomenology research on radiographers suggest that there is a perceived lack of justice in relation to the implementation of Agenda for Change, which result in a lowering of staff moral and organisational commitment. The House of Commons Public Accounts Committee (House of Commons. Public Account Committee, 2008) also agree that Agenda for Change does not meet its financial expectation. Their report shows that, in England, the NHS pay bill for the staff employed on Agenda for Change terms and conditions of service has risen by 5.2% a year on average since 2004-05, while productivity fell by 2.5% a year on average between 2001 and 2005.

## **Limitations of Current Literature on Agenda for Change**

Despite the fact that Agenda for Change is one of the biggest changes in the NHS history, literature on this subject is limited. The limitation of literature is shown from two reasons. Firstly, studies, especially evaluation and measuring studies on this project is limited. This is because the Department of Health and NHS did not establish ways of measuring the effects of Agenda for Change (House of Commons. Public Account Committee, 2008, Buchan and Evans, 2007). Secondly, current studies show much interests on employees' experience on Agenda for change, very little studies paid attentions on Agenda for Change implementation teams. Thus, the research methodology is designed to use samples from employees, such as radiographers (Williamson and Williams, 2010); nurses (Buchan and Ball, 2011); care nurses (Stewart and Rae, 2013); Estates and facilities staff (May *et al.*, 2006), mix of clinical professions (McClimens *et al.*, 2010); and union members (Ipsos MORI, 2006, Ball and Pike, 2006, McMahon, 2005). Although Edwards *et al.* (2009) has applied interviews with stakeholders as one of their research methods, they are more interested in the effect of Agenda for Change rather than the partnership working relationship and change implementation.

## **Conclusion**

Since the importance of Partnership Working on organisational transformation was identified in section 1, debate of if planned change or emergent change being more suitable to the NHS exists. However, there is to doubt that either change models should consider how employees are involved in the change process. But the question lies on which direction should changes been made—top down or bottom up?

The review was then narrowed down to the specific concept of Partnership Working in section 2. As the result of inherent ambiguity (Bacon and Storey, 2004), the researcher identified key principles and characteristics of Partnership Working, as well as approaches of working in Partnership. In order to gain an understanding on this broad subject, a summarization of the key principles of

Partnership Working, as well as Partnership Working approaches from both a theoretical and practical perspective was given.

Finally, reviews on Agenda for Change literature suggested that current understanding on how Agenda for Change implemented and people's view on Agenda for Change was very limited. Partnership working was essential to Agenda for Change implementation. Thus research on this interests is valuable.

## **Chapter 3 Methodology**

### **Introduction**

This chapter stipulates the theoretical underpinning for the research design and methods used. The aim is to provide a clear account of the research process for this study along with justification for the approaches adopted. The chapter is presented in a number of sections, first the research aim and research questions are posited. These are followed by a brief discussion on the two main research paradigms and the reason for adopting a qualitative approach in this instance. Three different research designs within the qualitative research paradigm namely ethnography, grounded theory and Phenomenology are then reviewed. The principal schools of Phenomenology are considered in relation to the research aim followed by a rationale for embracing Phenomenology as the guiding framework for this study.

Details of the sampling and recruitment strategy and the various components of data collection and analysis. A detailed account of the methods used in the study along with the recruitment strategy and ethical considerations is also provided. This includes sampling (purposive) data collection methods used (interviews) and methods of data analysis and the processes followed. The quality and trustworthiness of the study is considered including the fundamental issues of the ethical underpinning and approval.

It should be noted to begin with that, in places, in this Chapter it was decided to write in the first person rather than use a more conventional, impersonal form of writing since it was important for me to make it clear that I was responsible for the interpretation of the data. This point of style implies that interpretation other than the one I am putting forward might be possible and plausible.

## **Overall aim and research questions**

The overall aim of the study is to explore the perceptions of different levels of Agenda for Change Implementation Teams in relation to organisational change and partnership working in three NHS Health Boards in Scotland

### Research questions

1. What were the perceptions of the organisational change which occurred within the NHS?
2. What key aspects of partnership working were employed in the NHS to address organisational change prior to the implementation of Agenda for Change?
3. What were the key constituents of partnership working that facilitated Agenda for Change and how were they developed by its implantation?
4. What were the incentives and challenges in implementing Agenda for Change?

## **Quantitative and Qualitative Research Paradigms**

Marshall and Rossman (2006) define a paradigm as being an interpretive framework, a basic set of beliefs that guide action. For a researcher a paradigm is the perspective taken toward data leading to an analytical stance which facilitates the gathering and ordering of data in such a way that the processes of data collection and the structure in which the data is presented are integrated. Saks and Allsop (2007) offer a definition of the paradigm specific to the area of health care research suggesting that the researchers paradigmatic positioning relates to his or her understanding of reality and the nature of knowledge in this field of enquiry.

Denzin and Lincoln (2003) offer a functional account of the paradigm, highlighting specific issues the researcher must consider in formulating an approach to data collection and analysis. They identify the three principles of a paradigm as ontology (knowing what the nature of reality is), epistemology (knowing what the

nature of knowledge is) and method (knowing how to gain knowledge of the world). In terms of this definition the researcher approaches the world with a set of ideas, or framework (theory, ontology), that specifies a set of questions (epistemology) which the researcher examines in specific ways (methodology) in the course of which the process in which data can be collected (Denzin & Lincoln, 2003).

Defining a specific paradigm involves asking what the researcher conceives of as the nature and essence of things in the social world, or in other words, what the researcher's ontological position or perspective is (Mason, 2002). As mentioned, in this study the researcher's aim was to investigate the role of partnership working in developing and implementing the Agenda for Change Framework within the NHS. Central to this aim was to enquire into the perspectives of the managers themselves. The researcher considered that this objective was best approached by asking such managers about their perceptions and understanding in relation to partnership and Agenda for Change. The outcome of such an enquiry should be an understanding of reality from the managers perspective; in other words the participants ontological position with regard to a very specific circumstance contributing to a broader ontological position – that of the researcher – regarding the general focus of the study.

The second element in a general definition of a paradigm is epistemology (Denzin and Lincoln (2003). The epistemology of a paradigm pertains to a researcher's theory of knowledge, and should concern the principles and rules by which the researcher decides whether social phenomena can be known, how they can be known, and how such knowledge can be demonstrated (Mason, 2002). This involves posing complex questions about the nature of evidence and knowledge from allegedly simplistic questions about how such evidence can be collected. The researcher may use deductive methods, (for instance by testing hypothesis), as a way of generating knowledge. Knowledge developed by such an approach takes the form of a theory. In the current study this approach was considered unsuitable, since it was not the researcher's aim to produce a theory. This is an instructive example of the way in which consideration of epistemological issues facilitates the choice of an appropriate data collection approach - illuminating the relationship between epistemology and method.

## Rational for Choosing a Specific Research Approach

Wainwright (1997) emphasises the importance of distinguishing methodology from method. Methodology involves the philosophical analysis of research strategies, whereas method refers to the techniques used to gather and analyse data. In addition, in terms of overall philosophy of research Wainwright (1997) stresses ontology (that which exists or the study of being) and epistemology (how we come to know what we know) as being fundamental to the construction of knowledge. Crotty (1998) suggests that the starting point of all research is that researchers should always ask what methodologies and methods will be employing, and how to justify this choice. She summarises the four elements of the research process starting from the broad epistemological consideration and narrowing to methods as shown below:

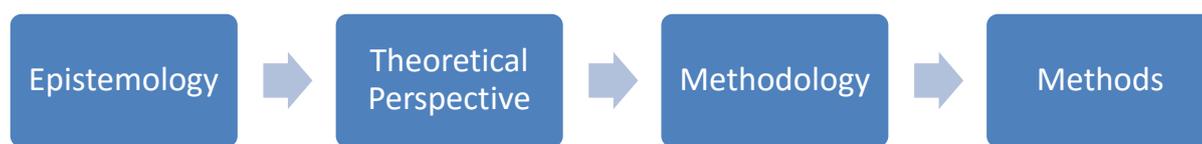


Figure 9: Journey from Epistemology to Methods (Crotty 1998)

The above framework demonstrates how philosophy influences the underpinning of the research approach. This four-element framework has been used as a guide for the design and data collection strategy employed in this study.

## Quantitative Research Approaches

Perspectives on the nature of knowledge are a key area of consideration for the researcher; they fall into two subsidiary paradigms positivistic and naturalistic. The positivist approach involves the use of measurement designed to test assumptions about the nature of phenomena being studied and is commonly carried out by quantitative design. Bryman (2008) provides three aspects which

define quantitative research which are; a deductive approach to the relationship between theory and research in which the accent is placed on the testing of theories; incorporates the practices and norms of the natural scientific model of positivism in particular; and embodies a view of social reality as an external objective reality. Quantitative research within the social sciences or business can employ a variety of methods to evaluate phenomenon including epidemiological or analytical design strategies (for example Randomised Controlled Trials, Before and After studies, Cohort or Incident studies and Cross Sectional studies), Survey research, Secondary Document Analysis, Structured Interviewing and Systematic Reviews (meta-analysis) (Bryman, 2008, Sacks & Allsop, 2007). The main aim of the quantitative approach is that in attempting to ascertain knowledge about a particular phenomenon, the researcher should remain objective (detached and separated from the participants) by employing scientific techniques to produce reliable findings (through inferential statistics) which may be generalised to the larger population. In contrast, the naturalistic approach is when knowledge is maximised when the distance between the researcher and the participants is minimised.

Bryman (2008) further summarises qualitative research into the following points; predominately emphasises an inductive approach to the relationship between theory and research in which the emphasis is placed on the generation of theories; has rejected the practices and norms of the natural scientific model in particular with preference for an emphasis on the ways in which individuals' interpret their social world; and embodies a view of social reality as a constantly shifting emergent property of individuals' creation. In research conducted with this emphasis the voice and individual perceptions of those under study become crucial to understanding of the phenomenon of interest; subjective interactions are the primary means of gaining access to that phenomenon. Research design influenced by the naturalistic paradigm commonly feature Ethnography Grounded Theory or Phenomenology (Morse and Field, 1996, Silverman, 2010).

Despite their differences all of these designs are concerned with ensuring that the original voices of the participants are heard but, as these methods incorporate greater explanatory content, the voice of the researcher is added to that of the participants. Variations arise in relation to the object of their inquiry, the aim and

the purposes to which the research will be applied, the nature of the data and finally, the role of the researcher. In addition each design is based on its own philosophical underpinning, which in turn influences the purpose, sampling, data collection and analysis (Brink, 1989). Rubin and Rubin (2005) recommend that these methods are in keeping with the interpretivist paradigm in that they attempt to record types of data (for example peoples' words) which enable reflection on subjective meanings and interpretations, the nature of peoples' experiences and the relationship between the researcher and the researched. Before moving on to discuss the design chosen it is important to rehearse the options within the different designs of qualitative research and give an explanation as to why two were rejected and one chosen.

## **Research Design**

The research design should demonstrate to the reader that the research project is well planned that the researcher is competent to undertake the research, capable of applying the approaches identified and sufficiently interested to sustain the effort necessary for successful completion (Marshall and Rossman, 2006). Silverman (2010) suggests that before committing to a specific research design it is essential to have an understanding of how previous work has been conducted. A review of the literature in the current work highlighted that the majority of previous research was conducted using quantitative methods. Having determined that the meaning of partnership working could be constructed from people's perceptions and experience, rather than be discovered as an absolute truth, the choice was made to adopt a qualitative approach and method.

Qualitative research designs range from pure description (Phenomenology), to description and interpretation (Hermeneutic) or description, interpretation, explanation and action as evident in Action Research (Marton and Booth, 1997). Interpretivism asserts that natural reality and social reality are different and therefore require different kinds of method (Crotty, 1998). Bryman and Bell (2011) stress that Interpretivism shares a view that the subject matter of the social sciences which is fundamentally different from that of the natural science. In order to identify a method with the flexibility advocated by Lincoln and Guba (1985),

and so ensure the practicability of the project's aims three different qualitative designs were considered.

## **Ethnography**

Early on in my reading I concluded that an Ethnographic design would not suit the purpose of this research, because in Ethnography the aim is to understand people, their ways of living, and the ways in which people use cultural meanings to organise and interpret their experiences. An Ethnographic researcher may observe, describe, document, analyse and interpret the general customs and beliefs of a particular group of people at a particular time (Leininger, 1985). The focus of culture is the essence of Ethnographic research and distinguishes it from other qualitative designs. The researcher takes on the role of a participant or non-participant observer who enters the culture or sub-culture to study the rules and the changes that occur over time (Laugharne, 1995). This was considered unsuitable for two reasons. Firstly it was not possible to take on an insider research role as the Agenda for Change process was implemented before the study began and secondly, my primary interest was not culture *per se* but had more to do with Organisational Change and emphasis on partnership working brought about by Agenda for Change.

## **Grounded Theory**

Developed by Glaser and Strauss (1967) in 1967 this design uses similar data collection and analysis processes as Phenomenology. However, in this approach the researcher does not approach research with the intention of validating or modifying a preconceived theoretical standpoint. It is more common that the researcher will be prompted to focus on a situation in which he or she perceives some theoretical inadequacy or lack. Also while Grounded Theory shares with Phenomenology a focus on extracting the underlying meanings of what has been said, Grounded Theory is often conducted from a perspective which searches for the unconscious intent of the interviewee, rather than the integrated, situational

and personal focus which is the trademark of Phenomenology. As it was the phenomenon of partnership working which was being investigated it was this rather than a theoretical explanation which was to be investigated and so this design was rejected.

## **Phenomenology**

Edmund Husserl (1859-1938) the founding father of Phenomenology, believed that the world of inner experience could be scientifically and systematically explored and devoted his life to the development of Phenomenology as a science of consciousness (Langridge 2007). The Phenomenologist is concerned with getting to the truth or essence of an issue, to describe phenomena as they appear to the person who experiences it consciously (Moran, 2000). There are multiple ways of conducting Phenomenological research but these converge in the desire to gain knowledge and insight about a particular phenomenon. There are three different approaches which stem from three major philosophical phases: The preparatory phase and descriptive Phenomenology (Husserl, 1859-1938); The German phase Heideggerian Hermeneutics (Heidegger, 1889- 1976), (Gadamer, 1900-2002); and The French phase and Existentialism (Merlau-Ponty, 1908-1961, Sartre, 1905-1980) (Holloway & Wheeler, 2010). However, debate continues about the distinctions and overlaps between these different strands.

Martin Heidegger then developed his thought of *being* in the form of Hermeneutic theory. Hermeneutics comes from the Greek word of hermeneuein, which means “to interpret or translate” (Liamputtong, 2009, p8). As the word suggests, Hermeneutics offers a theoretical framework for interpretive understanding with special attention to context and original purpose. This requires researchers to search the meaning of the lived experience by developing the power to immerse themselves in that world rather than reformulating another’s experience in analysable form (Johnson, 2000). It means in order to understand the human world as it impinges upon the actions and consciousness of participants, the researcher must not only investigate the relationships and events in which participants are involved, but also to establish and deepen that understanding by relating the experiences of participants to her own. For example, if this research

is to understand the experience of implementing Agenda for Change through partnership working, the researcher has to go to organisations and teams to explore the experience of people who work on this. He also asserted that all beings are inseparable from the world in which they live and so it is not feasible to bracket off one's pre-suppositions and directly identify the true essence of a phenomenon (Moran, 2000). He believed that human action must be studied within its historical and cultural context and stressed the importance of acknowledging investigator pre-knowledge and understanding that are present as a result of the shared background meanings given through culture and language (Leonard, 1994).

Heidegger made an important distinction between ontology and what he termed the ontic. The former refers to the nature of being which he reasoned could not be researched empirically but can only be made known through conjecture whilst the latter refers to observable facts about people in existence or their mode of being in the world. These, in contrast to ontological enquiry are open to empirical investigation and it is this ontic concept that forms the basis for much of contemporary Phenomenological research in the fields of health and psychology (Langdrige, 2007).

The research context comes from both theoretical knowledge and real-life experience. It also comes from critical evaluation of the literature in relation to partnership working in an organisational change context in particular within the public sector; reviewing different change models from the perspective of people involvement; and then narrowing down from a general context to the specific NHS context. As the result, good theoretical understanding on the context of partnership working in the NHS was gained.

The practical understanding on this context was gained from real-life experience. I worked for NHS Lothian in many departments through these years. I experienced the Whitley Council system, and also the implementation of Agenda for Change although I was not involved directly in its implantation, I was affected by this new system and have a good understanding of partnership working in the NHS, as well as Agenda for Change. So when I tried to understand how partnership working was adopted to implement Agenda for Change, I was able to

combine my experience of everyday phenomena to appreciate participants' experiences with genuine empathy and understanding, along with more theoretical interests.

## **The Phenomenological Attitude to Bracketing**

It is in the pursuit of the purity of apprehension referred to by Koch (1999) of the essential meaning that Husserl's concept of bracketing (i.e. of laying aside all but the fundamental invariants of any phenomenon) is the most pertinent and most useful to the researcher. In the act of bracketing the researcher must be alert both to the danger of pre-supposition and also to the potential presence of essential Phenomenological significance in the evidence gathered and in the interpretation of it. Bracketing is also important in underlining the researcher's attitude to theory, helping to examine how preconceived intellectual interpretation may gloss or obscure the experiential reality upon which it must ultimately be based.

There are divergent views amongst Phenomenologists about bracketing and the degree to which this can be achieved but overall agreement exists that the investigator maintains an empathic and open attitude towards both the research participant and the topic area (Finlay and Evans, 2009). In practice this technique demands considerable researcher skill and the extent to which this can be realised represents one of the principal differences between descriptive and Hermeneutic Phenomenology (Moran 2000). In light of this I have chosen to ignore the concept of bracketing and adopt a more hermeneutic approach.

## **Access to Study Sites**

One of the important and difficult steps in qualitative research is to gain access. Bryman and Bell (2011) suggested gaining access to organisations can be a very formal process involving a lengthy sequence of letter and meetings. The process of gaining access, so called negotiation is a continual process. However, Hennink *et al.* (2011) suggest contacting a gatekeeper as the first point of access. Gatekeepers are people who have a prominent and recognized role in the local community. They have knowledge about the characteristics of community

members and are sufficiently influential to encourage community members to participate in a study.

The Agenda for Change project was implemented in a hierarchical structure. The change agreements are made at UK level, while each nation has their own flexibility of modifying details, without moving away from the national agreement. This research only studied the partnership working of Agenda for Change in the NHS. The implementation structure and process has been discussed in the introduction chapter. The national Agenda for Change Implementation Team in Scotland is STACC (formerly SPRIG). This team comprised the Agenda for Change Project Lead, NHS employer and Union representatives who administered the Agenda for Change implementation and monitoring of all NHS Boards. The Agenda for Change Lead (also called the National Agenda for Change Lead in this thesis) worked full time on the Agenda for Change project only, she was also the key person who had expertise, contacts, and leadership skills to all Agenda for Change Teams in local NHS Boards. In this case, the National Agenda for Change Lead acted as gatekeeper, and became the first contact and access for this research.

Bryan and Bell (2011) pointed out that the negotiation process is time consuming, and maintaining access is a continual process. When making the first contact to the gatekeeper, I sent an email to her to seek an appointment with a clear message to introduce myself and this research. The aim of sending this email was not to gain access for the study, but to seek an appointment with her face-to-face to discuss the possibility of gaining access. A copy of this email is attached in Appendix 1.

Once the appointment was made, I prepared an agenda for this meeting. I aimed to achieve two objectives through this valuable opportunity. First, I wanted to present this research in more detail, and to make her aware of the context of research and the potential use of the findings. Secondly, I wanted to discuss my sampling method with her, to seek her advice and help to choose sampling sites among all the NHS Boards, and also to seek assistance in accessing these sites.

The outcome of this meeting was that I was able to make initial contact to the local Agenda for Change Leads in four NHS Boards. A copy of the information

sheet with an introduction to my study and the participant consent forms are provided in Appendices 2.

## **Sampling**

In qualitative research samples are smaller than in quantitative research because the items of data collected by qualitative methods, such as interviews or group discussions, are proportionally larger, richer and yield more information than those collected by quantitative methods. Samples are chosen for their representativeness of the phenomenon under study, here the stakeholders were key individuals within the Agenda for Change setting in the NHS. Such samples are called theoretical or purposive (Clifford, 1997) because they are selected by the need to choose participants who also have existing knowledge regarding the phenomena under study.

## **Sampling Process**

Qualitative research is concerned with rich information and in-depth understanding of the issue to be studied. The understanding relies on individual participants who provide the researcher with rich accounts of their experience. Thus, sampling becomes a key methodological decision for qualitative researchers. Liamputtong (2009) suggested that the nature of qualitative research is to interpret and construct the meaning of subjects rather than measure or test subjects, so qualitative researchers sample for meaning rather than frequency. Furthermore, Hesse-Biber and Leavy (2005) support the difference between qualitative research sampling and quantitative research sampling, but they added that qualitative research sampling is to sample participants with the aim of examining a process or meaning by collecting participants' own perspectives, understandings or experiences. Qualitative research requires a generalisation of the findings as in positivistic science. Thus, the overall sampling strategy for this research should be able to demonstrate a range of views from participants who were selected for the interviews.

Before describing the sampling strategy, it is important to clarify that this research was focused on strategic views; this decision was based on the nature of the research context (managing organisational change) and the research questions. It is clearly recognised that there are different layers of partnership working: strategic, functional and workplace level (Stuart and Martinez-Lucio, 2000). It was clear that Partnership existed at all three levels, but operated differently from the top to bottom represents the organisational structure and the decision making hierarchy. The senior management work at the strategic level overseeing how partnership is operated strategically. The functional level is involved in designing policies and working out approaches to meet the partnership strategy's needs.

However, at the workplace level, employees and managers implemented the change by completing day-to-day tasks. The people who completed the job matching parts of the process made decisions about the point that a particular job description matched to a point on the pay scale and this did not require the level of discussion initially expected of partnership working. Mason *et al.* (2004) suggested that partnership working has to exist at senior management levels. The aim when designing partnership should not only be short-term problem solving, but also be a long-term organisational operating strategy. Hence partnership working at the strategic level and functional level plays an important role in the change process.

It is also necessary in this context of change to consider the importance of participants from both a strategic and functional level. Scotland has flexibility to make some changes to the Agenda for Change terms and conditions and implementation. These decisions are made at the national strategic level. Each local NHS Board (functional level) then worked on the approaches of implementing changes. However, there was little partnership working involved in the job matching panel (workplace level) in terms of making joint decisions and working with other partners as the guidance and procedures have already been decided. Therefore, I decided to sample participants at strategic and functional level to a great extent and participants at workplace level to a lesser extent.

In order to include all three levels of the change implementation teams in this research, samples of each were included. Because of the context, each Agenda

for Change Implementation Team have three key partners: the Agenda for Change Lead, Management Representative, and Employee Representative. At each NHS Board, the Management Representative role was taken on by the Human Resources Director of the NHS Board; and the Employee Representative was filled by the Employee Director of the NHS Board. The job matching panel also included Management, union and Employee Representatives. Although there were many panels in each NHS Board, only one Management Representative and one Employee Representative from each NHS Board was recruited. This was based on two considerations: 1) the sampling strategy for this research was designed with the aim of collecting qualitative data, the purpose was to explore the in-depth meaning of data; and 2) The Agenda for Change agreement was discussed and designed at national level. The role of the job matching panel was to complete day-to-day tasks, rather than decision making or negotiation. Compared to the strategic level and function level, partnership working activities are relatively low at the workplace level Mason *et al.* (2004). Based on the above, small samples from the workplace level (job matching panels) were essential, thus, one each from both sides were considered, to represent the views from this level. Overall, the sampling strategy included:

- National level Agenda for Change team (Management Representative, Employee Representative, and Project Lead)
- Local Board level Agenda for Change Team (Management Representative, Employee Representative, and Project Lead)
- Workplace level job matching panel (Management Representative, Employee Representative).

The Literature review suggested that partnership working was impacted by financial resources, staff availability and geographical issues (Guest and Peccei, 1994, Kelly, 1998, Mason *et al.*, 2004; Osborne *et al.*, 2004). NHS Boards recruited for this research contained a mix of above levels. Firstly, there was an NHS Board with more resources and another with less; secondly, it was important to represent both large sized (employee) and small organisations; and thirdly, it was important to include both urban and rural areas. Finally, since Agenda for

Change has been piloted before the national roll out, the sample also included participants from the NHS Board which took part of the early implementation.

After considering the above four criteria and having the initial meeting with the Gatekeeper, there were four NHS Boards considered and approached. However, one of those approached did not respond so only three NHS Boards were included. The description of the sample can be shown as the figure 10.

<b>Scottish National Level (Strategic Level) Scottish Term and Conditions Committee (STACC)</b>		
Agenda for change Project Lead ( <i>Project Lead 1</i> )		
Management Representative ( <i>Manager 1</i> )		
Employee Representative ( <i>Employee Director 1</i> )		
<b>Regional NHS Board Level (Functional Level) Agenda for Change Implementation Team</b>		
<b>Site 1</b>	<b>Site 2</b>	<b>Site 3</b>
Agenda for Change Project Lead ( <i>Project Lead 2</i> )	Agenda for Change Project Lead ( <i>Project Lead 3</i> )	Agenda for Change Project Lead ( <i>Project Lead 4</i> )
Management Representative ( <i>Manager 2</i> )	Management Representative ( <i>Manager 3</i> )	Management Representative ( <i>Manager 4</i> )
Employee Representative ( <i>Employee Director 2</i> )	Employee Representative ( <i>Employee Director 3</i> )	Employee Representative ( <i>Employee Director 4</i> )
<b>Regional NHS Board Level (Workplace Level) Agenda for Change Job Matching Panels</b>		
<b>Site 1</b>	<b>Site 2</b>	<b>Site 3</b>
Management Representative ( <i>Management Rep 2</i> )	Management Representative ( <i>Management Rep 3</i> )	Management Representative ( <i>Management Rep 4</i> )
Employee Representative ( <i>Employee Rep 2</i> )	Employee Representative ( <i>Employee Rep 3</i> )	Employee Representative ( <i>Employee Rep 4</i> )

Figure 10: The Participants who were Involved from the 3 NHS Boards and at Three Levels.

### **A Brief Description of Each Research Site**

In order to gain an understanding of the three sample sites, the Agenda for Change and partnership working context were reviewed up to 2009 before data

analysis. Below are brief descriptions of each research site, from the aspects of organisational size, Agenda for Change implementation progress by 2009, resources available, and partnership working background.

### **Site 1**

This Site was one of the biggest NHS services in Scotland, it provided services to a population of approximately 800,000 people, who were mainly residents from city and towns. It employed approximately 24,000 staff members. It was one of the first sites in the UK to pilot Agenda for Change and had conducted a number of evaluations on this process. By 2009, Site 1 has spent £24.7 million for the implementation of Agenda for Change. Even with the significant amount of financial input, the Board was struggling to achieve the original National Agenda for Change target for assimilating staff and paying outstanding back pay by the end of December 2006. An additional 3 years was given to conclude the Agenda for Change review exercises. Another challenge the Board faced was to expedite the agreed personal development plans (PDP), since only 84.9% of staff covered by Agenda for Change had had a PDP by 2009 (Audit Scotland, 2009a).

Partnership working had been developed for a long time in this site. It appointed one of the first Employee Directors in the NHS Scotland. Since then, the relationship between unions and management had been cordial. The Staff Governance Committee comprising both unions and management met four times during 2008/2009 to discuss topics including Agenda for Change, KSF, and policy development. Site 1 Partnership Forum took an external role of overlooking partnership working between the NHS the public and community services. The challenges of partnership in site 1 were securing financial stability, maintaining strong partnership working activities and workforce capacity (Audit Scotland, 2009a).

### **Site 2**

This site served a population of 500,000 people spread across city, town, village and rural communities. It employed 17,000 people and was overseen by one single NHS Board which was located in a major Scottish city. Site 2 started Agenda for Change in December 2004 along with the national roll-out. By 2009, it had spent £13.5 million in implementing Agenda for Change. Like the other sites in Scotland, Site 2 failed to achieve the National Agenda for Change target by the end of December 2006. However, the majority of employees had been moved to Agenda for Change by 2009, and all employees covered by it had an agreed Personal Development Plan (PDP). Moreover, there was some development towards equal pay claims, and the success rate of appeals for Agenda for Change was reasonably high compared with other NHS sites in Scotland. These successes were already proving to be more costly than previously anticipated. Monitoring and managing the Agenda for Change actual increased the cost, therefore site 2 faced significant challenges in achieving the Board's Financial Plan in the following year and going forward thereafter (Audit Scotland, 2009b). Site 2 had an established partnership structure which allowed them to work with another two Scottish NHS Boards, such partnership activities were supported by specific recurring findings from the Scottish Government. Meanwhile, site 2 was also cognisant of the local recruitment challenges and expressed support for the Board's proactive approach to dealing with this challenge.

### **Site 3**

This site employed over 9,000 staff, and provided services for 320,000 people. Although this is the lowest population among all three sites in this study, the services spread over a large rural area with only a few small villages making it one of the largest and most sparsely populated Health Boards in the UK. Site 3 started Agenda for Change implementation in December 2004, and spent £6.791 in respect of Agenda for Change payments. Like the other sites in Scotland, Site 2 failed to achieve the National Agenda for Change target by the end of December 2006. However, the majority of employees have been moved to Agenda for Change by 2009, with 93% of the staff with agreed Personal Development Plans (PDP). Site 3's main focus was to ensure that all staff were assimilated on

the new Agenda for Change pay scale and that any grading reviews were concluded (Audit Scotland, 2009c).

In site 3 both Partnership working and the Staff Governance Committee had been established prior to the implementation of Agenda for Change. The Partnership Forum comprising both unions and management met bi-monthly to discuss staff issues. The effect of the removal of ring-fenced funding was fully realised, but site 3 did not suffer any significant detrimental impact due to changes in funding streams for areas of partnership working. However, large geographic area and traveling did impact on the attendance at the Forum and Committees (Audit Scotland, 2009c).

## **Preparation for the Study**

### **Ethical Considerations**

There are commonly agreed ethical principles for researchers to follow and these are embodied in general codes for conducting research (Burns and Grove, 2005, Sim and Wright, 2000). These include respect for autonomy, beneficence, and non-maleficence. A brief discussion on each follows.

### **Respect for Autonomy**

This may be defined as respecting the decision making capacity of an autonomous person (Beauchamp and Childress, 2001). In the context of research this is respecting the participant's right to self-determination; that is the right to take part or to withdraw from the study at any time. It was stressed to all participants that their participation was voluntary and that they may choose not to participate or to stop participating at any point. I was also aware that the data collection and analysis should strictly follow the consideration which was provided to the NHS Ethical Committee (South East Scotland Research Ethics Service). It was considered that tape-recording interviews could cause some anxiety. In order to minimize this and follow published ethical guidelines (Holloway and Wheeler,

2010), all participants were provided with an information sheet which outlined the rationale for the study and explained what would be involved in the interview, as shown in Appendix 2. At the beginning of the interview, this issue was once again addressed. When agreement was reached, participants were asked to sign the informed consent form (Appendix 3). During interviews participants were offered to choose either to be tape-recorded or not, but in the event all participants allowed it to take place.

All participants were fully informed about the study before they agreed to participate. This involved verbal information giving and the distribution of an information sheet and time to consider whether they wished to be involved (Appendix 2).

## **Beneficence**

This principle concerns the benefit, actual or potential that the research could have for the participants and the wider population in general (Beauchamp & Childress, 2001) to determine this, the researcher must examine the balance of benefits and risks in the study. The projected benefits of the study were to identify the principles of partnership which were claimed to be an inherent part of the Agenda for Change Programme. It was acknowledged that there might be no immediate benefit to the participants involved however, it was felt that the ultimate intention was justifiable, as it was hoped that the results would improve further changes within the workings of management and Unions within the NHS.

## **Non-maleficence**

This principle upholds any participant's right not to be harmed either physically or psychologically by being involved in the study. Therefore to minimize the risk of any potential; discomfort or distress, participants were informed that their participation was voluntary and that they could withdraw at any time without any repercussion; in addition participants were given the name of an independent advisor connected to the study whom they could contact if they felt they had any

concerns at all about the study which they did not wish to discuss with me. Participants who took part were assured that any information they gave would remain confidential. Participants were assured of confidentiality, and the tapes (digital audio files) were kept secure in my network drive (H: drive) throughout the study. The list of names was kept separate from transcripts and any notes. Only my supervisors and I had access to these digital audio files. All details and files were destroyed at the end of the study. In the final report, participants were not individually identified by name, only the generic titles of their identity are used (Beauchamp & Childress, 2001).

## **Ethical Approval Process**

When this study was being planned, an application was made to the NHS Ethics Committee (South East Scotland Research Ethics Service) for approval to conduct the study. In order to prepare for the ethical approval application, I attended a training course organized by the Wellcome Trust Clinical Research Facility (WTCRF) in October 2009. In this training, I gained a good knowledge on how to prepare and complete the Ethical Approval Application Form for the NHS Ethical Committee.

In this training, the differences between a research project and review project from the Ethical Committee's view were explained. Information was passed to me during the training that the NHS Ethical Committee may exclude research projects which need no contact with patients, or real body tissues from the approval requirement. This was further confirmed at another ethical training session at Edinburgh Napier University Business School, by the Scientific Officer of South East Scotland Research Ethics Service. After having a brief discussion with him, completing the training and submitting a research proposal to him, it was confirmed by email that although this is a piece of academic research, it did not need ethical approval from them. A copy of the decision letter can be seen in the Appendix 4.

Further to this decision letter, the Scientific Officer informed the Clinical Governance Support Team (CGST) in Site 1 that this research was going to be

undertaken and registered it on their database. Followed by the successful ethical approval process, the Scientific Advisor & Manager of the remaining two sites agreed and accepted the decision from Site 1. Therefore approval was granted by all the Boards. I also applied for research approval from Edinburgh Napier University which was granted in March 2010,

## **The Use of Qualitative Methods: Interview Techniques**

The essence of qualitative research implies an emphasis on processes and meaning. The process of understanding the meaning needs an array of interpretative techniques, which seeks to describe, translate and interpret the phenomenon in the social world. Kvale (2007) suggests conversation is a fundamental means of interaction among individuals in society. By having conversations with individuals, researchers have an opportunity to get to know others, learn about their feelings, experiences and the world in which they live.

Research interviews serve to collect information from respondents and, depending on the focus of the information required, they can be more or less structured. Structured interviews ask closed questions, the simple answers to which are scored numerically. At the opposite end of the spectrum, unstructured interviews, also called in depth interviews or intensive interviews allow the researcher to be led by the respondents' agenda. Lofland and Lofland, (1995 p18) define them as being "a guided conversation whose goal is to elicit from the interview rich detailed materials". These are often referred to as unstructured interviews. The term unstructured is to an extent misleading since no interview is completely devoid of framework or direction (Kvale, 2007).

Among qualitative research methods, in-depth interviews are the most commonly known and widely used by qualitative researchers (Liamputtong, 2009). Holstein and Gubrium (2003) suggested that interviews are a method for collecting empirical data about the social world of individuals, the method of doing an interview is to invite individuals to talk about their lives in great depth. Kvale (2007, p1) described the process of interviews as "an inter-view where knowledge is constructed in the inter-action between the interviewer and the interviewee".

The aim of doing an interview is then to understand the meanings interviewees attach to issues and situations in a particular context, which are not structured by the researcher's assumptions. This definition highlights the interaction and personal nature of the interview, by which researchers can gain insights.

For this research, semi-structured, in-depth interviews were utilised to gain rich information from the perspective of individuals. This method also sought deep information and understanding by a greater depth of self-expression by the participants (Liamputtong, 2009). In order to achieve this, researchers need to be sensitive and skilled enough to understand the interviewee's view, and also to assist the interviewee in exploring their own beliefs. Semi-structured interviews are generally organised around a set of predetermined but open-ended questions (Mason, 2002) with other questions emerging from the dialogue between the interviewer and the interviewee. The interviewer generally works from an interview guide which includes suggestions for probing and non-probing questions and contains prompts to allow for a degree of flexibility. In order to capture the full richness and breadth of participant responses, each interview was tape recorded.

There are several issues which were considered when designing interviews, these issues include: a suitable context of interview questions, abilities of clarifying issues to interviewees, social interaction, and interview recording methods. These issues will be discussed in the following sections.

## **Developing Interview Questions from the Literature**

Interview questions are developed from literature review. It lies on the subjects of organizational change management, Agenda for Change and partnership working. A table of how interview questions are developed from literature review is shown in appendix 5.

## Content of Interviews

The design of the interview schedule involved considerable thought and preparation. It was discussed in several of the supervisory sessions and subjected to a pilot study prior to the main study. I referred to my research aim and questions to guide the development of questions that potentially might provide an answer. There were several key subjects I wanted to be included in the interview, these key subjects were:

- The context of general changes in the NHS
- The context of Agenda for Change
- The meaning of partnership working (key principles)
- The approaches of partnership working
- The outcomes of partnership working in relation to Agenda for Change (to be described rather than evaluated)
- Key characteristics of partnership working
- Any issues raised from partnership working

The above list formed the basis of the interview guide for this research. When interviewees were asked to talk about these subjects, questions were asked openly. For example, typical questions included “Can you please tell me something about Agenda for Change?”; “What does partnership working mean to you?” and “How do you work with other partners?” These open questions give the interviewee more flexibility to give me free comments around these subjects.

Semi-structured interview questions may not follow exactly in the way outlined in the schedule. Questions that are not included in the guide may be asked as interviewer picks up on things said by interviewees (Bryman and Bell, 2011). During the interview, questions were kept as open-ended as possible in order to gain spontaneous information from the participants. In the early stages of the interview the participants were asked general questions about the NHS and partnership working. As the interview progressed more detailed descriptions were sought. Questions aimed at encouraging respondents to describe their experiences, but also explored underlying attitudes, beliefs and values (Fielding, 1994). A limited amount of control was essential to ensure continuity of the

interview, however, I was also aware of the dangers of constraining expression through excessive control.

I started to ask participants to talk about themselves, by asking the questions of “What is your job role?”, “How long have you been working in the NHS?”; “What is your role in the Agenda for Change?” These questions were easy to answer and gave the participants time to settle into the interview. However, I was also aware that the participants were busy individuals and I did not want to ask interviewees for personal information which was not directly related to the topic. What information I gained helped me to understand the background of the individuals, which benefited my understanding of their perspectives. At the end of the interviews I asked one final question “Is there anything you want to add?” This was an open question, to check if I missed any perspectives on the subject of partnership working. In all cases, interviewees did not add any new comments. However, they used this opportunity to conclude their comments by giving their brief thoughts on partnership working, rather than raising specific subjects. This was very important for my understanding the context of partnership working.

## **Pilot Study**

Prior to commencing the main study, data collection techniques were piloted. One previous part-time PhD student from Edinburgh Napier University Business School was approached. She has been working in the NHS during the period of Agenda for Change implementation. Her job role at that time was the Lead for Clinical Education in site 1. Having just completed her PhD, she had a good understanding on the subject of partnership working and Agenda for Change, as well research within the NHS. The pilot interview was recoded and transcribed. Some of the original areas in the interview schedules were slightly amended following feedback from her. However, in the main, the interview schedule remained the same.

## **Process of Conducting the Individual Interviews**

The semi-structured interviews aimed to encourage participants to freely comment on specific aspects of their experience of research and provide rich information on the context of subjects. When deciding the location of doing interviews, I chose to arrange the location to be at their offices, where interviewees would be comfortable. This encouraged interviewees to feel relaxed, and interact more openly with me. At the beginning of each interview, I gave the participant a brief overview of both the content of the interviews and the manner in which it would be conducted.

During the interviews, I used a background information sheet to keep a record of interview process. The aim of using the background sheet is for two reasons. When they mentioned any key points or interesting subjects, I would write these down to keep note of issues which would help me to contextualize the data. It also allowed me to record the overall quality of each interview. Tape-recording only can record their words. However by seeing their body language and other interactions, I could record other factors in the general interview environment, such as an interviewee being nervous or upset.

The final issue which was considered was the use of audio tape recording in the interviews. By tape-recording interviews, I could re-listen to the interview, and also could transcribe the data for analysis. When analysing findings, direct quotes from interviews were utilised. However, I also understood that tape-recording interviews could adversely affect the relationship between interviewee and interviewer where the tape recorder becomes the focus. Interviewees may also feel anxiety for being recorded Easterby-Smith *et al.* (2002). This issue was solved by the honest and open seeking of permission to tape the interview and ensuring that the participants both understood and signed the participant consent form. In addition, the interviewee was assured that the tape-reorder would be switched off at their request at any point in the interview if required. This action was taken by one Manager Representative who wished to talk about issues which were particularly sensitive to the organisation. In this case, I took notes instead. This meant that the relationship of trust was upheld and that this Manager continued to talk freely.

## **Transcription and Analysis of the Data**

Close listening and re-listening to individual sections of talk had the advantage of allowing me to become familiar with the individual respondent at an early stage in the analysis which in turn enabled me to understand more clearly the meaning of comments made. The transcripts were typed in a form that produced a text, which provided reminders of the ways in which the interviews were a product of an interaction. All the questions and responses were recorded and noted in a straightforward way. Having such a detailed transcription of the interview proved of great value to me during the subsequent analysis.

Producing a verbatim transcription is extremely time-consuming. A one hour interview can take 4-5 hours to transcribe (Hennink *et al.*, 2011, Bryman and Bell, 2011). English is not my native language; it takes me even longer to transcribe interviews than other researchers. Moreover, transcribing interviews needs professional training and experience. Bryman and Bell (2011) showed some examples of errors made when transcribing. They suggested that small mistakes such as misspelling, mishearing, or mistyping can cause major mistakes on data analysis. After considering these two issues, I decided to employ a professional transcribing company. An Edinburgh based secretarial company - 1st Class Secretarial Services was recommended by researchers at Edinburgh Napier University. They are a digital audio typing specialist company, and had done many transcription projects for Edinburgh Napier University. After a consultation meeting, I decided to choose this company for the transcribing.

In the transcription contract, it is clearly stated that digital audio documents would be named under the digital code only, rather than the interviewees' name or job title. So interviewees would not be recognised in any way. Once my client account was created, all digital audio documents were uploaded to the Company's website. These audio documents were transcribed as Microsoft Word documents within 3-5 days once uploaded. All transcriptions were also saved in my network account, and then were downloaded to my work computer at University's office under secure maintenance.

## **Data Analysis**

Understanding how the data were to be analysed was one of the most important aspects of qualitative research. Within Phenomenology there are a number of different analysis strategies. For the purposes of this study three approaches (Van Kaam, 1966, Colaizzi, 1978 and Giorgi, 1985) to Phenomenological analysis were considered and are outlined below.

### **Giorgi's Style of Analysis**

The method developed by Giorgi (1985) focuses on phenomena as a real object in time and space but the fundamental interest is in how such objects are perceived. Giorgi (2008) suggests that doing qualitative data analysis should follow the steps.

1. Read the entire transcription to get a whole picture and focus initially on the "Gestalt".
2. Break the entire transcription into parts with meaning units which are the language of everyday life.
3. Transform the original data, express the insight from transcription, highlight common themes, and illustrate quotes.
4. Integrate the transformed meaning units into a consistent statement about participants' experience, and use concrete a situation as an example to demonstrate.

### **Van Kaam's Style of Analysis**

Van Kaam's style of analysis is based on content analysis. He advocates the classification of data into categories. These categories should be the result of what the participants themselves understand (Valle 1998). The following steps involve

1. Listening and preliminary grouping, classifying the data into categories.

2. Reducing the concrete, vague and overlapping expressions of the subjects.
3. Checking and eliminating elements that are not relevant to the phenomenon under study
4. Writing a hypothetical identification and description of the phenomenon being studied.
5. Applying the hypothetical description to a randomly selected sample. If necessary the hypothetical description can be revised. The revised description must be re-tested.
6. Reviewing and revisiting previous steps until the final hypothetical description is identified.

### **Colaizzi's Style of Analysis**

The basic tenet of Colaizzi's (1978) approach is that experience is always out in the world. He developed a form of analysis which addressed the objection that traditional science and experiment cannot answer questions. His intention was to embrace human experiences as they are lived. He was concerned to remind himself of the empirical object and of the fact that the phenomenon – the hidden meaning or essence, whose identification is the goal of analysis - derives from the empirical, lived object or experience. It involves the following steps:

1. Reading carefully in order to get a full picture of the phenomenon.
2. Coding and extracting significant statements.
3. Formulating meanings from the significant statements.
4. Summarizing the formulated meanings into clusters of themes.
5. Describing the investigated phenomenon.
6. Sharing the results with the participants.

Patton's (2002) argument on Phenomenological analysis is based on the study of Douglass and Moustakas (1985) which also divides the analysis process into four stages. However, their framework is more related to the philosophy foundation of Phenomenology, which is to understand people's behaviour and phenomena:

1. They use the Greek word of “Epoche” to start the analysis process. At this stage, researchers need to build awareness of personal bias and to eliminate personal involvement with the subject material (Patton, 2002). Epoche needs to look at the data to identify what is real until all the evidence is in. thus, Patton (2002) suggest that Epoche should be an ongoing process.
2. This step is Phenomenological reduction. Researchers need to bracket out the world and presuppositions to identify the data uncontaminated by extraneous intrusions. Again, this stage is heavily related to Husserl’s philosophy of bracketing by using participants’ own words to explain their behaviour.
3. At this stage, researchers need to organise meaningful clusters by identifying themes within the data. Patton (2002) uses the example of finding the bones to describe identifying themes and structural description.
4. The final stage is to provide a synthesis of meanings and essences of experience. Researchers need to composite textual and structural descriptions by providing quotes and themes to show the understanding.

Douglass and Moustakas’ (1985) framework is more theoretical than the other approaches presented previously. It is based on the understanding of Phenomenological research which is to see things through the participants’ eyes, and to explain their behaviour by using their own words. Comparing with this framework with those of Giorgi (2008) and Colaizzi (1978)’s this is more practical and contains more tools and methods of how to analyse the data from transcribed materials. Moustakas (1994) further modified this framework and presents a seven step analysis style which also examines how to analyse Phenomenological research from participants’ interview transcriptions if essentially a process of identifying themes and using quotes (Holloway and Wheeler, 2010).

However, common to them all, the central to all of these Phenomenological analysis frameworks is to identify themes. For example, Giorgi (2008) suggests that researchers should find the themes generated by individuals, but the main focus should be on the overall structure of experiences rather than individuals’ interests (Holloway and Wheeler, 2010). Colaizzi (1978) suggests that clusters of themes should be organised from formulated meanings which are spelt out from

the meaning of each significant statement (Holloway and Wheeler, 2010). Ritchie and Lewis (2003) argue that the process of qualitative data analysis is a route to generating themes. Furthermore, Patton (2002) argues that the core meaning of dealing with qualitative data is to find themes and patterns. He also defines the process of searching themes as thematic analysis. Identifying the process of Phenomenological analysis is a starting point for data analysis. The heart of Phenomenological analysis is to identify themes and getting the bones (Patton, 2002) out from the participants' interview transcriptions.

## **Thematic Analysis**

The actual process of qualitative data analysis is to cluster data which are similar; this is referred to as themes of structural meaning units of data by Streubert and Carpenter (1995) The process of identifying themes from a participant's interview transcription has appeared in many qualitative and Phenomenological analysis methods (Colaizzi, 1978, Patton, 2002, Ritchie and Lewis, 2003, Giorgi, 2008, Holloway and Wheeler, 2010). However, even thematic analysis has been defined as the approach of identifying themes from transcriptions, there is limited research looking at the thematic analysis approach and methods. Most of the Phenomenological analysis frameworks agree that the heart of analysis is to identify the themes, but most of them talk about the how to find the meaning units and what to do with them rather than defining clearly thematic analysis and the process of thematic analysis. However, Liamputton and Ezzy (2005) and Holloway and Wheeler (2010) cross this concept with their own understanding.

Holloway and Wheeler's views on thematic analysis are related to narrative analysis which requires data transcription and reduction (Holloway and Wheeler, 2010). They argue that thematic analysis can also be called holistic analysis which requires the researcher's to analyse as a narrative of the whole (Holloway and Wheeler, 2010). The main aim of thematic analysis is thus to identify the main statement from the transcription, which is also called core experiences by Holloway and Wheeler. Researchers need to reduce the units of text in the transcription to a series of core sentences or ideas.

Liamputtong and Ezzy (2005) argue that thematic analysis is somehow similar to Grounded Theory. The main difference between these two concepts is the Grounded Theory includes theoretical sampling whereas thematic analysis does not. They suggest that the centre of thematic theory is the process of coding. They then divide the thematic analysis coding process into three steps:

1. Open coding. Open coding is the first run of coding process. It aims to compare data by differences and similarity by breaking down events, statements, or sentences, and to apply conceptual labels to them (Liamputtong and Ezzy, 2005). The reason for open coding is to look at the data in the new way and see new relationships between events or interactions. Miles and Huberman (1994) agree that open coding is also a method of noting themes.
2. Axial coding. Once the researcher breaks down sentences and develop initial themes at the open coding stage, they should then put these data back together in new ways by making connections between themes. Axial coding is the putting back together process. This doesn't mean that researchers at this stage should build links between codes. Instead, they should scrutinise codes to ensure that all codes are elaborated and delineated (Miles and Huberman, 1994; Liamputtong and Ezzy, 2005). Miles and Huberman (1994) further argue that axial coding should include partitioning variables and subsuming the particular into the general.
3. Selective coding. Selective coding is a higher level of generality of axial coding in which codes are compared and the core code is identified that provides a theoretical point of integration for the study (Liamputtong and Ezzy, 2005). However, Liamputtong and Ezzy (2005) admit that some researchers disagree that there should be core codes for data analysis, and instead the codes can be complex.

Avoiding the criticism of whether core codes should be established when doing thematic analysis, Liamputtong and Ezzy's work (2005) on thematic analysis process gives clear guidance for researchers who adopt Phenomenological research. However, the main understanding of their guidance is based on seeing thematic analysis as being similar to Ground Theory which requires data to be broken down with labels. This is the opposite of Holloway and Wheeler's (2010)

argument which sees thematic analysis as a way of narrative analysis. They suggest that researchers should interpret stories as a whole, rather than breaking them down into categories. The core statement should be reduced from the whole transcriptions when analysing, but should not be broken down.

There is not a standard definition to clarify if thematic analysis should be seen as a narrative analysis or Ground Theory. However looking back at the Phenomenological analysis framework as references, Giorgi (2008) suggests Phenomenology is holistic and the initial analysing should focus on Gestalt. Colaizzi (1978) does not recommend breaking down sentences, instead he suggests extract significant statements, spelling out the statements into formulated meanings, and aggregate formulated meanings into themes. Patton (2002) also agrees that the bracketing is a step of Phenomenological reduction which identifies the data uncontaminated by extraneous intrusions. The identified statements are then organised as meaningful clusters which make the invariant themes (Patton, 2002).

In order to choose the most suitable method of identifying themes for this research, it is necessary to look back at the previous analysis strategy and Phenomenological analysis framework. This research is to adopt Phenomenology as the theoretical foundation. It leads to the researcher being able to understand the lived persons' behaviour and phenomena. In order to understand what they do and why they do such things, researchers must study the events as whole. The number of labelled phase appearance is not important. What they said and what it means should be the researcher's focus.

Based on this consideration, this research used Phenomenological reduction as the method to identify themes. Transcriptions were first read to gain a general understanding of the participants' background and beliefs. Then the important statements were highlighted for the next level of study. Unnecessary statements were reduced. After highlighting the important statements, the researcher did another round of reading to extract the patterns, which were used for identifying the main themes.

Overall, Phenomenological research needs Phenomenology reduction to identify themes from participants' statements. Phenomenological analysis requires

researchers to follow steps to understand the whole picture of transcription and extract key themes from the meaningful statements. Instead of arguing about whether the themes should be identified by breaking down statements or keeping them as a whole, it is more important to look back at the Phenomenological analysis where the thematic analysis concept comes from. Based on this consideration, the interview data analysis used thematic analysis as method and followed the steps of generic.

This argument is supported by a number of researchers' work on the Phenomenological analysis approach, such as Giorgi's four steps framework, Colaizzi's seven steps framework (Holloway and Wheeler, 2010), Ritchie and Lewis's (2003) analytic hierarchy in qualitative analysis, and Moustakas' four stage framework (Patton, 2002), which all describe the approach of the analysis process. Although all these models focus on the approach of analysis process, Giorgi and Colaizzi's frameworks are more practical than Moustakas' framework. They provide a method for data analysis from the transcribed tapes of interviews.

Colaizzi's seven steps framework is a similar analysis process as Giorgi's (Holloway and Wheeler, 2010). However, Colaizzi breaks the transforming process into more stages of clusters of themes, exhaustive description, and identification of its fundamental structure (Colaizzi, 1978). Colaizzi also suggests that researchers return to participants or interview sessions to ask the subjects about the findings so far (Colaizzi, 1978, Holloway and Wheeler, 2010).

Ritchie and Lewis's (2003) analytic hierarchy in qualitative analysis is a similar framework to analyse qualitative data. But their framework is to describe the analysis process of generic qualitative research, rather than purely on Phenomenological research. However, the 10 step hierarchy describes the analysis process from refining concept to generating themes.

These analysis frameworks set good guidance for this research data analysis. After interviewing the participants on their knowledge and experiences on partnership working, the interview materials were transcribed to analyse the phenomenon from their point of view. So the overall analysis strategy for this research was to use interview transcriptions as data and transform them into an understanding and knowledge which sees the partnership working approach

through the participant's eyes. What they are saying is text. However, this text can be transferred as a key statement, which will then be identified as themes. The themes will then be applied to the original context, and are used to create meaningful understanding.

## Process of Data Analysis

Based on above consideration of Phenomenological research analysis and thematic analysis, the process of this research data analysis is shown in the diagram below.

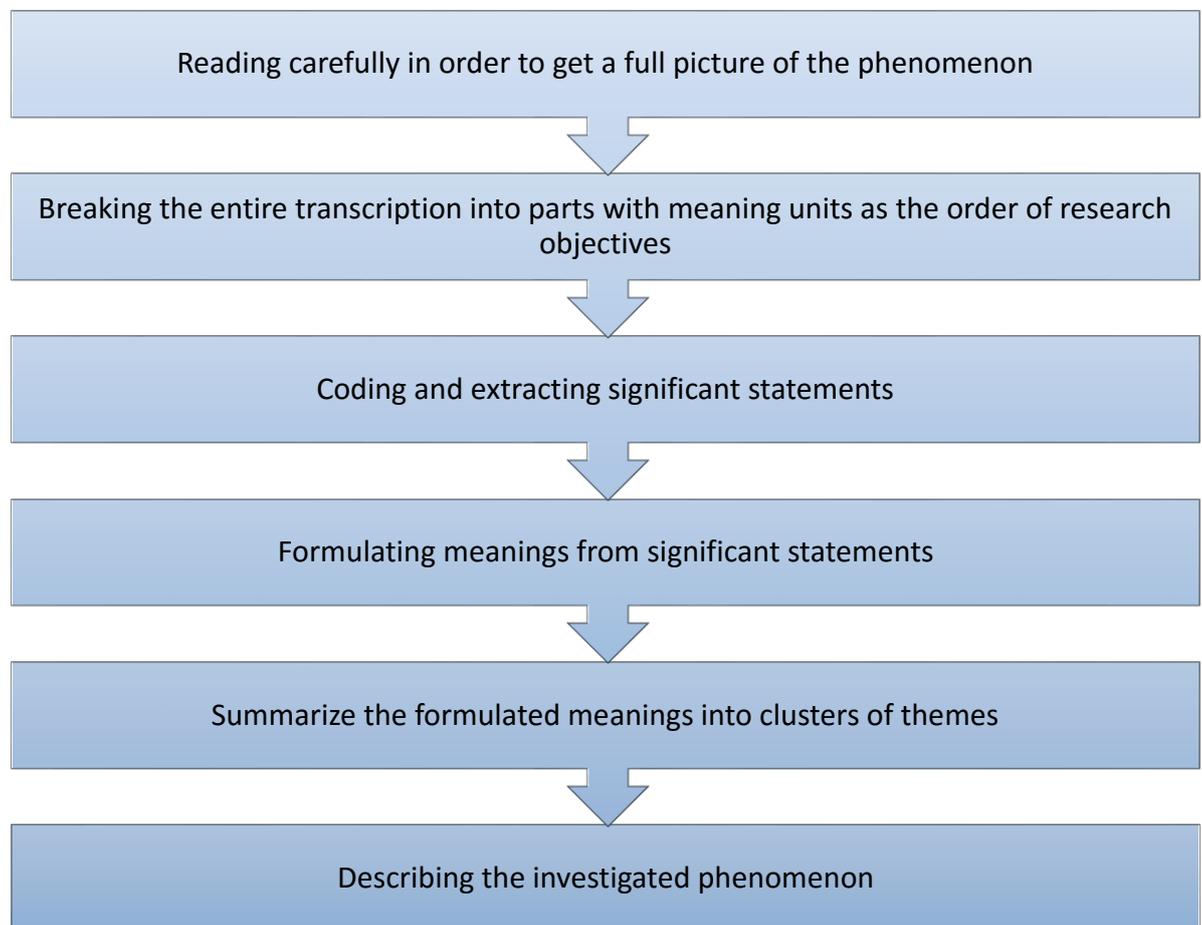


Figure 11: Process of data analysis in this study.

### ***Step 1 Reading carefully in order to get a full picture of the phenomenon***

Once I received the transcriptions back from the transcribing Company, I then read all transcriptions at least 6 times. It helped me to understand the overall picture of participants' opinions on Partnership, with the feel and taste of their perspectives. During this time, all thoughts, feelings and ideas were written in my research diary to assist with the reflection process.

### ***Step 2 breaking the entire transcription into parts with meaning units as the order of research objectives***

Once I had good read of all transcriptions and gained an understanding of the whole picture of their thoughts, feelings and ideas, I then broke each transcription into nine parts in the order of the research subjects. These subjects were also used as interview guide. The list from the transcriptions is shown below.

- Interviewee's job and role (to start interview).
- The context of general changes in the NHS.
- The context of Agenda for Change.
- The meaning of partnership working (key principles).
- The approaches of partnership working.
- The outcomes of partnership working to Agenda for Change (to be described rather than evaluated).
- Key factors of partnership working.
- Any issues arising from partnership working.
- Any issues to be added (to end interview).

All eighteen transcriptions were then broken into parts of the above subjects. I understood that to be able to draw the whole picture of partnership working during the Agenda for Change process, each part of the transcription cannot be studied

as a sole individual subject. Transcriptions in which one subject appeared can also relate to one or several other subjects. For example, an interviewee talked about the context and the process of Agenda for Change. He said it was done in Partnership, and then he explained how it was decided and implemented. This part of transcription is the context of Agenda for Change. However, the designing and implementation of Agenda for Change was done in Partnership. So this part of the transcription also relates to subjects of partnership working principles and approaches.

In order to construct a clear picture and understanding of all research objectives, I used different colours of highlighters for the following coding step. Each colour represents one subject, and it was used to highlight statements, coding, and my thoughts. If statements were related to two or more subjects, all the related colours were highlight in the spare space beside the main colour.

### **Step 3 Coding and extracting significant statements**

At this step, I attempted to identify and highlight the interviewee's experience and knowledge of partnership working and the Agenda for Change implementation. As Colaizzi's (1978) framework suggested, I used coding and extracting each transcription with significant sentences or phrases in order to draw more sense from the data. It was very important to me to identify the relationship between each sentence and the interviewee's story. In order to achieve this, I felt simply coding the sentence or phrase was not enough to identify the relationships. So beside each highlighted sentence or phrase, I wrote down what the sentences meant. The example of analysis at this step is shown as Figure 12.

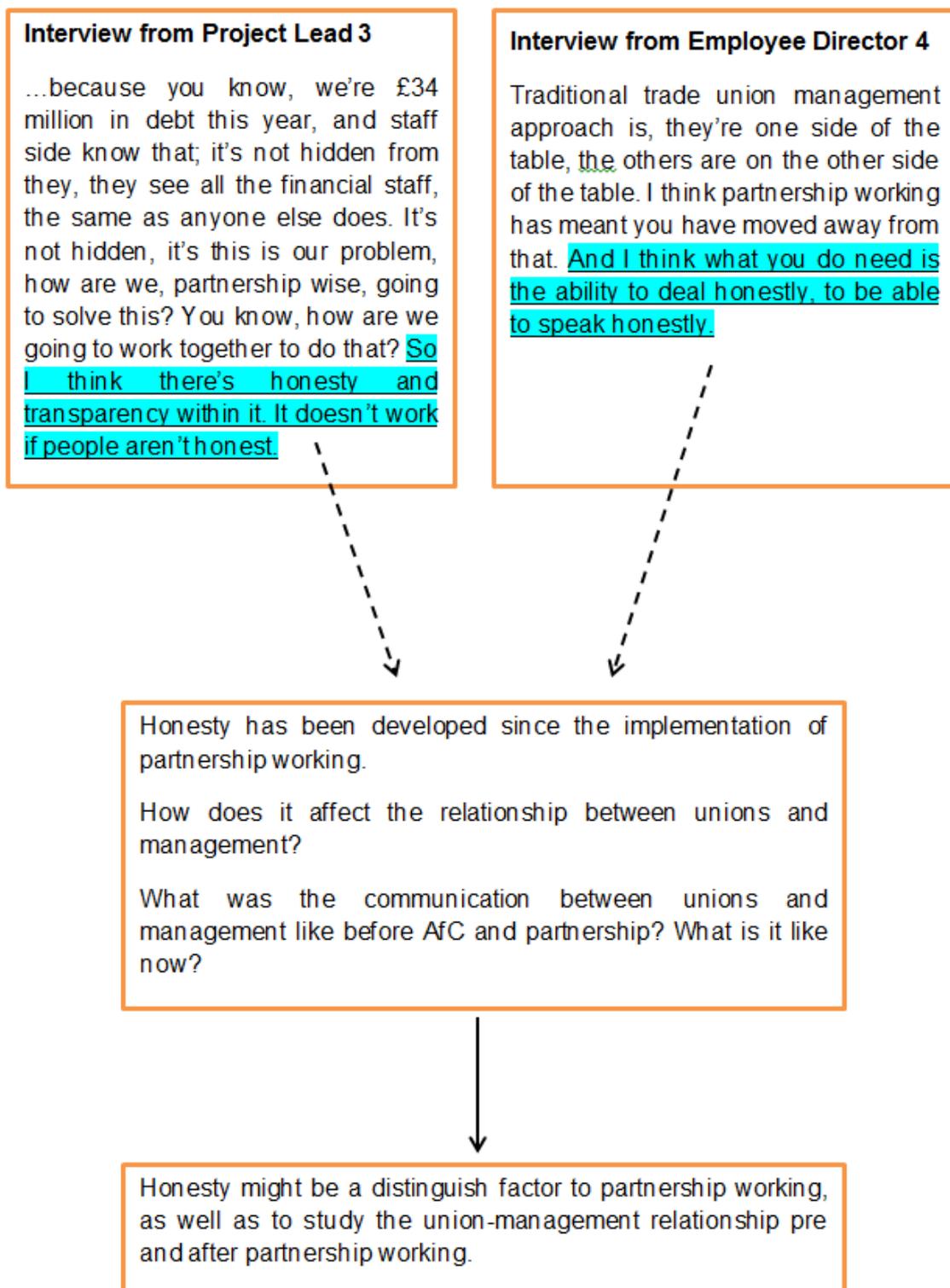


Figure 12: Example of step 3 Coding and extracting significant statements

#### Step 4 Formulating Meanings from Significant Statements

In this step, I sought to understand the hidden and underlying meanings from those evidential statements and phrases. This presents a shift of emphasis in my response and interpretation, from what the interviewees said to what they meant. I intended to understand what participants wanted to express.

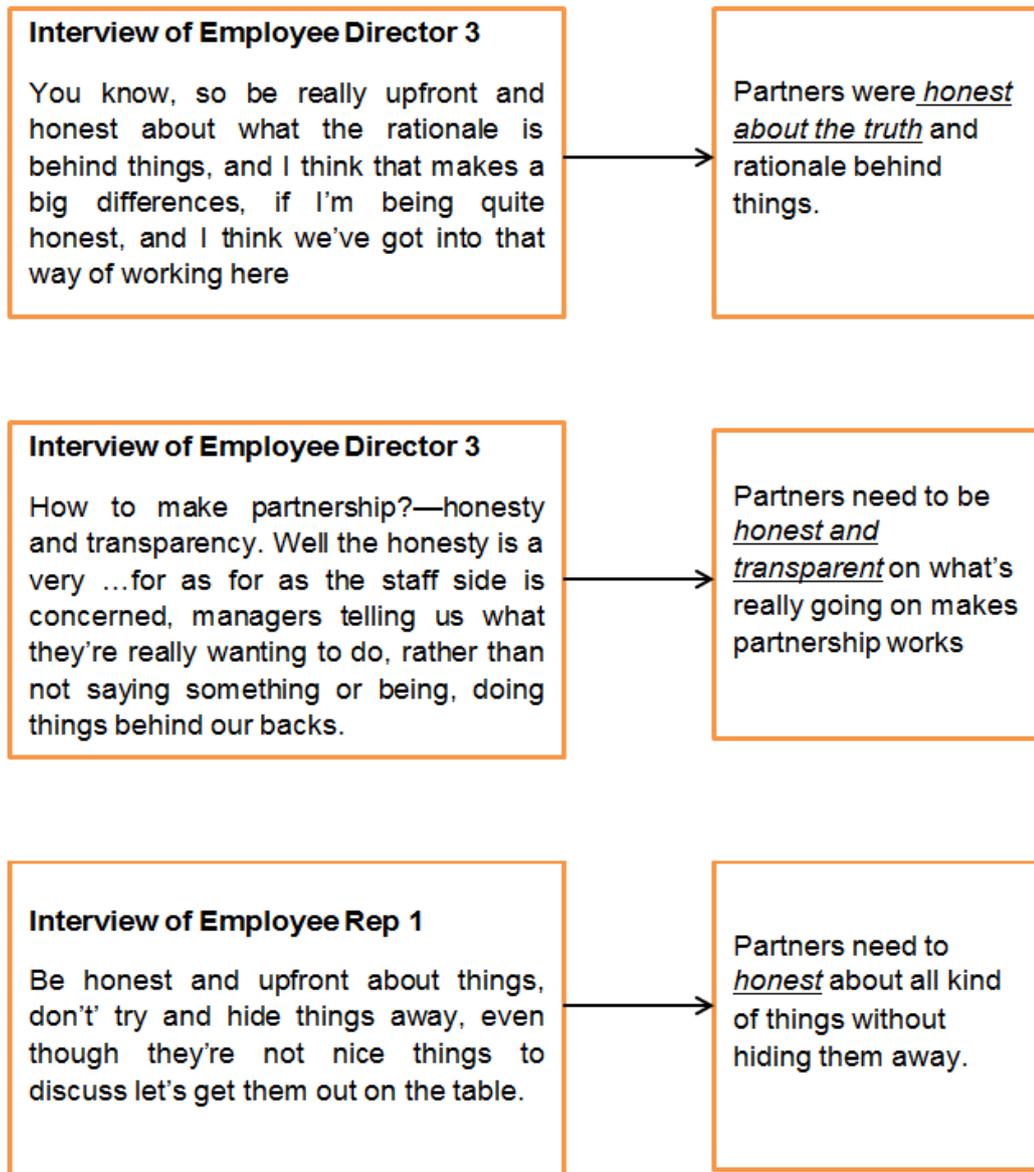


Figure 13: Example of step 4 Formulating meanings from significant statements

### Step 5 Summarize the Formulated Meanings into Clusters of Themes

Once meanings were formulated from statements, I was then in a position to arrange these meanings into clusters of themes. I referred these themes back to the data contained in the interview transcription. This enabled me to verify the accuracy of the extracted meanings and subsequent themes against the original data. It also guarded against the danger of overt improvisation of meanings and themes in the process of analysis.

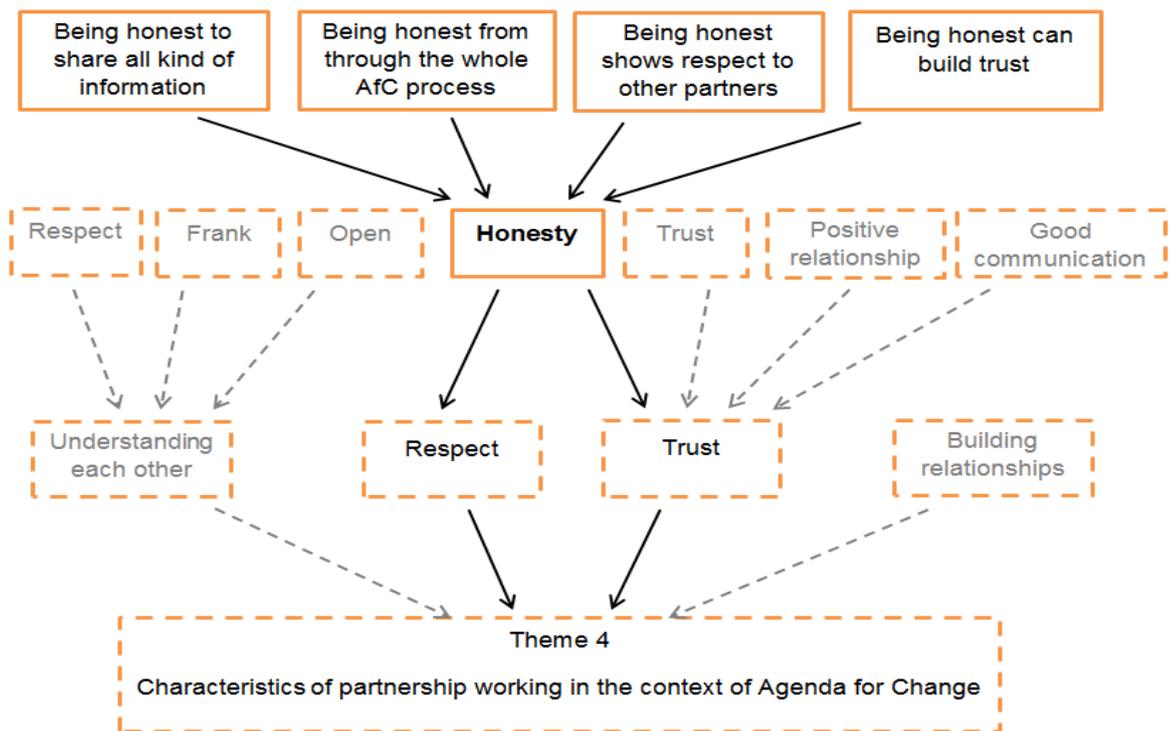


Figure 14: Example of step 5 Summarize the formulated meanings into clusters of themes

### Step 6 Describing the Investigated Phenomenon

Holloway and Wheeler (2010) suggested at this stage research should integrate the results of the analysis into an exhaustive description of the investigated phenomenon. This should include describing the processes which comprised previous steps of analysis and the meanings derived from them. Bryman and Bell (2011) further added that describing phenomenon is different from discussing the

research findings. It is a step prior to discussion, and it outlines the findings rather than presenting the results. The results of this research are presented in chapter 4. In order to present findings of this Phenomenological research, I used a rich amount of quotes from the transcriptions to draw the picture of the interviewees' experiences.

## **Strengths and Limitations of the Research**

The strength of this study was that it provided an in-depth account of the perceptions of specific members of the staff who had been involved in the implementation of Agenda for Change. The qualitative nature of the design implied that the report was a subjective view of a purposive sample of the participants. The depth of explanation would not have been forthcoming if the design employed a quantitative approach. In qualitative research the sampling size is relatively small compared with quantitative research. However, a large amount of data were collected providing an in-depth and detailed account which would not have been forthcoming if the study had used quantitative design. Either approach would only have provided a snapshot of Agenda for Change. However, the qualitative nature of this study ensued that as broad view as possible was collected.

In addition to these, there were cultural challenges which have to be overcome in terms of language and accent of the individuals to be interviewed. This required the researcher to check the agenda several times to ensure that all questions had been addressed in the interviews. The cultural and language differences also challenged interview technique. A well planned and flexible interview should enable the interviewer to obtain descriptions of the interviewee's world and interpret the meaning (Kvale and Brinkmann, 2009). Much of the success of the interview process relates to the interviewer's ability to react spontaneously and intuitively to naturalistic expression embracing a range of cultural inflexions and usages, as well as culturally specific non-verbal semiotics. Particular difficulties identified in the pilot were the participant's use of dialect words such as 'ken' or 'dinnae'. The solution to this problem was for me to make a specific request that the participants use as little slang as possible. Another tactic was to use a

clarifying question such as 'what do you mean by that?' 'Can you explain this further?' both of which proved a sufficient strategy to facilitate clearer communication.

Once the data were collected, and through the process of analysis, checks had to be made at the regular points to ensure clear understanding on the part of the researcher. This was carried out by the supervisory team listening to tapes to make sure that what participants had said had been accurately understood. For clarity, the supervisory team also conducted member checking on two of the interviews and compared the outcomes with the researchers' own analysis. As the analysis proceeded, where there were still ambiguity, the researcher asked either colleagues or supervisory team members that accuracy has been achieved.

## **Conclusion**

In this chapter the choice of research design with its underpinnings was identified and the rationale for the choice made was explained. This was followed by the sampling and recruitment strategy, the ethical considerations and processes and the principles on these were based are described. Finally, the choice of the analysis techniques were outlined and a more detailed description of the process chosen was provided.

## Chapter 4 Findings

### Introduction

In this chapter the findings will be presented under the following sections. In section 1 Organizational Change in the NHS before Agenda for Change. Section 2 will elucidate why Agenda for Change was introduced in the NHS. Section 3 will provide information concerning partnership working and its relevance to Agenda for Change. This is followed by section 4 which reports of the challenges and incentives for the implementation of partnership working in the Context of Agenda for Change.

### Section 1 Organisational Change in the NHS Prior to Agenda for Change

#### Constant Change

In the NHS there have been a large number of changes throughout its history. Organisations were constantly experiencing changes as the following two quotes report.

*“Yes it is about constant change and there’s always something different happening, and something new happening, and the Health Service....this thing is like you never stand still for a minute at the moment,” (Manager 2).*

*“Yes, there was a lot of organisational structure, restructuring and structuring, and there was lots of guidance came out from the Scottish Office that we had to put in stream.” (Management Representative 3).*

Many of these changes were driven by politicians realising that the Health Service was not meeting the needs of patients. When the Government established new policies, the local NHS Boards needed to implement these policies by introducing changes. So the changes in the NHS are strongly influenced by political ideas. In the quote below this Manager describes the number of Organisational Changes which she has experienced throughout her career. These have made a series of

major impacts on the service provided to the people of Scotland inevitably to the staff who have been at the centre of the upheaval and implementation.

*“I think the NHS being a public body is always subject to political I was going to say interference, but political dogma to an extent. Every time there was a political change in the UK or in Scotland then it impacted upon the NHS, so there were quite a number of reorganisations or restructurings. I remember the first one back in 1974 and about every 8-10 years thereafter there has been a fairly major structural Organisational Change within the NHS. I’ve lived through about five or six major changes, culminating of course in a change to the terms and conditions of service through Agenda for Change, which in fact was a revolution in terms of where we were and where we wanted to get to. The change was quite massive. (Manager 3).*

However, this means that the changes have worked in only one direction as the Project Lead below makes clear where the NHS is influenced by political guidance, it forces change to be driven from national down to local level. This shows that the top down model leads to decentralisation. The changes within Health Care which are pre-planned and have a top-down approach. This centralisation has also been influenced by the local demographics.

*“What you’ll get is policies driven at a national level, and then you would have to look at how that impacts locally. But you’ll also have changes in terms of the local demands, the demographics of the society that we’re serving, so the changing needs that are required there, which might be an increase in, well, increase in elderly and how we treat them. We’ve also got national services like the sick children’s services, like oncology service where the regional service is. So some of the impact is increasing demand and different ways of working. So it can come nationally, it can come locally.” (Project Lead 2).*

The above quote also suggests that changes within the Public Sector are common and are at times driven by government policy. It also implies this change impacts on a range of stakeholders. It is important to note that all change is not negative because the impact of it on the care experience of patients and clients has in the main been a positive thing as this participant makes clear from her experience.

These continuous changes have improved patients care over the time. The NHS is now providing a different and improved patient services to meet their needs. This new care has encouraged dialogue between patients, their lay carers with professional careers. This has resulted in all these groups having a greater knowledge of their conditions and treatment which allows them to participate in

decision making about how they will be looked after and where. This response to an increasing awareness of peoples' rights but also their responsibilities within society. This also highlights the turbulent nature of society in which a repeatedly changing NHS has to exist and respond to.

*"The way we look after patients. When I was a student nurse in Psychiatry, which was my second job, standards were thought to be okay, but they weren't. People had no toilet doors on the toilets, there was a foot space between each bed, you'd one registered nurse for 60, 70 patients, and that's in my lifetime. People used to get a bath and nobody changed the water. Patients got clothes that didn't fit, weren't their clothes. You'd be there forever, and treatment models have changed, the technologies, computerisation. Patients' knowledge and their carers', their rights, people recognise they're not passive recipients of what we do to them; they're active engagers and deciders. So the whole society's changed, the Health Service staff's changed, the physical environment's changed, the technologies have advanced, and yet the core principle of caring for people's exactly the same. So why we come in is the same, what we do when we're here is different. I believe the end outcome is the same where we're providing quality care, and that's why we should always be challenging standards." (Employee Director 2)*

Some of the positive outcomes have been enhanced by the new technology which has meant that staff have required training. However, there have been major changes in communities engendered by the closure of hospitals leading to greater centralisation of services which has had an impact on both rural and urban settings. These provoke an almost emotional response in the participants evident in some of the terms used such as unbelievable. This is a response which most professionals try to hide. However the constant changes within the NHS, on so many levels have to a certain extent overwhelmed staff. This has such an impact because of the size of the workforce and the small size of the country. The quotes below illustrate this.

*"Oh I mean I've been in the NHS since 1979 both in [county] and in [site 1] and the changes I've seen are unbelievable, new technologies coming in, you know, hospitals closing, more care being provided in the community. I mean the last three hospitals I've worked in are now closed [laughs]." (Employee Representative 2).*

*"Oh yeah, system changes, like we didn't all have computers at one point, we've now got computers. Well, we've all got computers, I mean that's progressed over the years. Different systems that they introduce, so it's new technology or new systems that you would have to learn and train. How we record patient data; we're now looking so that information is that you have the right information at the right time, at the right place. And so the system's been introduced to*

*support that. So yes, there's continual changes, hopefully for the better all the time," (Project Lead 2).*

But the change was not just to do with technique and updating services and technology. There was a much stronger undertone relate to the overall culture of the NHS. As a Public Service provider, the NHS's culture has become increasingly a more business focused environment. This has arisen from an ageing population, increased numbers of patients with more complex conditions and a static or falling budget. These pressures have led to a realisation within management, and to an increasing degree, different levels of staff within the system, and society in general. This has resulted from a raised awareness and openness about the financial situation of each area being reported regularly in the media. This situation has meant that instead of only considering providing better patients care, the NHS has to control its budget as well as using the most suitable business management skills in its performance. The two quotes below describe this change:

*"What I was thinking was, do we run more like a business nowadays than we did before? I'm not sure I can quantify it in absolute detail, but I think there is something in there that we have to run more like a business than just as bottomless pit of money, you know, public money, you know and everybody is now more aware of this from the local and national press..." (Project Lead 3).*

*I think to be more like running like a business, recognising that we need to run like a business to be efficient, so you've got all the kind of...well, the most recent thing that's, obviously, been introduced is the continuous hours improvement work that's coming into the organisation..... Thinking about the things that are in place or being implemented, I think that's about making us much more efficient. And that's more where the business link comes into it, because a private industry would do that, because they can't afford not to." (Project Lead 3).*

Increasingly, everyone feels that the NHS must behave in a similar way to private business.

Some participants do not think that the changes are linear for in some instances old methods are reintroduced and so the changes appear to be more cyclical. Staff can remember certain techniques being used, discarded and then being reintroduced. One of the most obvious examples is in the sharing of information which, more recently, with the drive to increase partnership working and computer

technology has tended to mirror the old habit of groups of staff sharing information verbally several times a day. The quote below suggests this.

*“Many many changes, many changes. It seems to have gone the full circle because when I was working for the NHS we were in information services and in Partnership but they moved people into different departments and everything. But now it’s back into one big service and its health intelligence is now doing all the computer information and that for waiting times, things like that. So yes it has... I think there’s been so many changes I’ve seen.” (Employee Representative 3).*

## **Fear of Change**

The large number of changes has produced much tension and fear of the unknown throughout the organisation. One of the main responses to such discomfort results in staff not wanting the change and not accepting it. Despite the fact that change has been evident to such a degree, and over a prolonged period the fear factor experienced by staff did not appear to have diminished. It must be remembered that as the various quotations have made clear many staff members have worked in particular roles for a long time. They have developed a relationship with those who worked in particular departments or units and are feeling satisfied with their work. This was suddenly being challenged from above, without discussion or explanation. This produced feelings of pressure on the part of Managers to implement change despite the fact that they were not always clear as to why the changes were being introduced. Thus, despite the fact that people are experiencing constant changings through time, there is still fears of change. The participants represent these views below.

*“I think part of it is just that if people are long established in a job and they do it one way, it’s very difficult for them to understand the need to change. And I think that has to be managed very carefully.” (Project Lead 1).*

*“There are people in this world who don’t like change, who don’t like change, and they find it very difficult. I think I can say that Nurses are not like that because if you think of your Nurses training you’re going through from ward to ward. You change wards all the time, you change Sisters, you change staff, you change Consultants and you cope with that, but if you’ve got secretarial staff who are based in one unit they don’t like change, they find it very difficult.” (Management Representative 3).*

*“That’s one of the difficult parts because people like the sameness, they like to do the same every day and there’s always this fear of change. And particularly if a hospital is closing people’s immediate fear is I’ll lose my job and I don’t think I’ve seen...in fact I know I haven’t seen any compulsory redundancies with the closure of hospitals, people have just moved on, developed, been given other roles.” (Employee Representative 2)*

However, it should be noted that this fear is sometimes unfounded because despite hospitals being closed staff have not been made redundant but rather have been redeployed or retrained for a new role in a new setting.

## **Management of Change**

As has already been shown there have been difficulties in implementing change. The quote below highlights the lack of good management skills which existed throughout the NHS. This resulted from a lack of management training as at that point the NHS was not perceived or indeed run as a business. Then the prime aim was to provide good quality health care without any reference to its cost. Indeed, this resulted in a system run by tradition rather than by a management culture in the organisation which ultimately need to be created. The quote below from this Manager shows this

*“Well, that goes back to ’85, ’87. The NHS was not good man Managers. The NHS has been around since ’48. It was only in the 80s that the notion of managing the NHS came into vogue – for lots of reasons. They’re all in the literature. Focus on performance, the need for leaner, tighter NHS, the fact that Britain woke up to the fact that it hadn’t necessarily the best NHS in the world, that we got compared with others and when you did look outside it wasn’t always as flattering as we told ourselves it was. Therefore that created an input, well how can we make it as good as the rest, and that then had some tensions around private, public, nationals against what motivates...so all those things. But when you come from the outside, as I did, what you definitely saw was that we didn’t have a management culture.” (Manager 1)*

In addition to this there was an even greater problem in terms of how management worked with the Trade Unions which meant that their stance was one of opposition rather co-operation and working in partnership. The industrial relationship in the old context was very poor. The quote below highlights clearly the stances adopted by each group.

*“Well from an employer relation point of view very much...up until about the late ‘80s, early ‘90s it was very much a ‘them and us’ culture, the Health Board said, “We’re doing this,” and the Trade Union said, “No, you’re not.” (Employee Representative 2)*

This culture resulted in division between management and Unions with staff caught in the middle. As the process of decision making and planning change was a top down one resulting in each group being insular and making their own decision independently and then coming to a meeting where agreement was unlikely? The four responses below show how this process worked, the way in which each group behaved, the old bargaining structures as they were with the potential for friction as a consequence while carrying a gloss of partnership working.

*“Rather than management saying for instance, we want to design a ward, and rather than coming in with a sheet of paper and saying this is what we’ve got, this is what we’re moving to, what do you think – because you’ll just get resistance immediately.” (Employee Director 3)*

*“That was one of the issues that we had. We weren't really involved in the planning stages. We were seen as, we'll talk to them after we've decided what we're going to do.... that's what they saw the Trade Union's role. Once we've decided as a Health Board that we are going to do this, we'll go and tell them. That's what caused a lot of the frictions.... Now we're involved at the earliest opportunity.” (Employee Director 1)*

*“So I think it was quite unsatisfactory and it wasn't really Partnership it was really just the old bargaining structures with a kind of Partnership gloss on them. I think Partnership only really started to happen properly when the organisations were merged and when we had the first Employee Director, and things started to happen then, I felt.” (Project Lead 4)*

*“Before partnership working was introduced, the employer would come to us and say, 'I am going to do this and this is how I'm going to do it.' Whereas now they need to come to us and say, 'We're thinking of doing this, what are your views on this?' So we get right in there at the start.” (Employee Director 1)*

This culture of individual group decision making meant that joint discussions and decisions were totally impossible and in the main the source of most of the friction. The frustration for the individual groups was that they were looking for ways to work together but the environment would not support this.

*“.....There was no opportunity for the management and the staff side to sit down, agree together, what were the priorities, they agree to approach them jointly.....” (Project Lead 4)*

Unfortunately an added problem was that along with a 'them and us' attitude the Trade Unions Group was fractured. Some Unions only representing a particular staff group and not necessarily concerned with the needs of the remainder. Indeed there were at least four different Unions, all with their own agendas and voices who could not always reach agreement among themselves. This resulted in each Union making their own demands to a management group which did not have the ability to respond and achieve a unified view.

*"And there were lots of tensions within the staff side about which Union should be represented and who was going to be...you know, because all the Unions had their own agendas and some people wanted to talk about nursing and some people wanted to talk about admin staff, and some people wanted to talk about lab staff. It was very, very difficult for all the voices to be heard. And I think it was kind of thought that everything had to be resolved very quickly, and you ended up with meetings with long, long agendas where people were trying to resolve all kinds of things many of which couldn't be resolved locally because there wasn't the flexibility that there needed to be, and some of which could be resolved locally, and you got into very, very detailed discussions about pay and all kinds of things." (Project Lead 4)*

This Union Representative quoted below mirrors what has just been reported but also is able to provide a comparative picture adding the co-existing difficulty of being tied by making a local arrangement which then had to be taken to a national level.

*"What used to happen before, each Trade Union used to have their own claim campaign and do something. So from a staff side of view, that could be particularly disjointed. Whereas now within STACC we are putting forward Scottish wide claims on behalf of all Unions. And from an employer's perspective it means that they can have a bit more control over agreements because if we reach an agreement on a particular Health Board, which was our strategy at the time, we would attempt to roll that out in every Health Board. To say, well we've got it here, we want it there." (Employee Director 1)*

## **Section 2 Reasons for Introducing Agenda for Change**

Historically, there were some staff members who were unhappy with their pay scales but also about their terms and conditions. Indeed unfair conditions had cost the NHS a large amount money in compensation for inequality. The old Whitley pay system was also becoming increasingly susceptible of challenges

under equal pay legislation. The Equal Pay Act (1970) had previously outlawed any pay discrepancies between male and female employees doing the same work. The Equal Pay Act was amended to allow equal pay claims when the applicant considered that he or she was carrying out work of equal value (when compared under headings such as effort, skill and decision) to a higher paid male colleague. Based on this regulation, over one thousand speech and language therapists were unsuccessful in their equal pay claims in 1986 and 1987 by comparing their work to that of clinical psychologists and hospital pharmacists. In response to this they took their case to the European Court of Rights where eventually after a number of years they won the case and were awarded large sums of money. Findings show that this has become the main driver of implementing Agenda for Change. The Employee Director and a Project Lead explain below how the claim was the main driver for the implementation of Agenda for Change.

*“Because Agenda for Change was triggered by...I mean, one of the triggers was a Speech and Language Therapist case..... Very big case, which said that these Speech and Language, predominantly female workforce, didn't have the same opportunities as their male counterparts and that went through the European...that took 13 odd years to go through European Courts to say this is unfair. What happened there was that the Speech and Language Therapists then got a huge hike in salaries to try and address that, and it was at that stage they said, this is ridiculous, there may be others...what groups haven't we even thought about yet, and this is when Agenda for Change was an equality thing, and it has been proved just recently in a court case in England that Agenda for Change is gender neutral, you know, so it is okay for that.” (Employee Director 3)*

*“We had...Agenda for Change gives you...or the job evaluation part gives you an internal...a system to give you an internal hierarchy for jobs. Now, we had that before, but it was per category. So the Nurses were in their hierarchy, so was estates, so was facilities, so was admin. Everyone was in their own hierarchies by their own job evaluation scheme, but the schemes didn't speak to one another. And then, that resulted in the case that the speech and language therapist won, an equal pay case, because they compared themselves to psychologists, and they won that case. So that was, I think, the real...one of the big drivers for us to scrap all the [Whitley] job evaluation and go with something brand new, that was equal pay proofed, which is what the Agenda for Change scheme was.” (Project Lead 3)*

This large increase in pay for one group of staff led to a generalised fear on the part of Government that this might lead to other groups seeking similar awards. Therefore it responded with the implementation of Agenda for Change to unify pay and terms and conditions for the majority of employees in the NHS amounting to several thousand people in all.

The key purpose of Agenda for Change was to ensure that all employees were to be paid on a single national pay spine and have matching terms and conditions. No matter what job category such as administrators, Nurses, porters, speech and language therapists, all employees' jobs were placed on one of nine pay bands. However it also allowed a degree of flexibility to modify job roles and make for task flexibility. The following four quotes describe what pay scale were like, the confusion they caused, and the lack of unity within staff groups resulting in a perceived unfairness.

*"It's about harmonising all these different terms and conditions of service so they are the same for everyone. Same annual leave, same hours of work, same rates of pay but different grades but same single spine.... (Manager 3)*

*"Well, I think the key reasons have been around the differences that there were in the different and separate pay systems that we had for the majority of NHS staff. So we had different pay arrangements for Nursing, for Speech Therapy, for Radiotherapy or what have you, and there was no consistent approach, I guess. And therefore there were huge discrepancies I think, really, in terms of valuing equally the work that people were doing. So the implementation of Agenda for Change has, to a significant degree, eroded some of those historical differences between how we value jobs and how we reward people for those jobs." (Manager 4)*

*"People were doing, I guess now, what we would now think of similar types of roles at similar levels, and they were being paid and rewarded differentially for those, I guess. And each different profession had its own kind of career structure, and there was less similarity between the different groups. So I think one of the advantages is that you are able to value work in a more similar way across the different professions and the different support services in the NHS. We still obviously have a different pay system for Doctors and Dentists, and a different pay system for senior Managers. But the majority of staff in the NHS in the UK, particularly in Scotland, are on Agenda for Change. So we have the same set of terms and conditions; it makes it much easier to administer, and to manage, really, as well as providing a better career structure for the staff..... (Manager 4)*

*"What we had before, I can't remember the numbers but people used to quote them, we had nine or ten different staff groups, each with about, I don't know, four or five at least and some more*

*pay scales, so we're talking about forty five, fifty pay scales, and people were on them. And if you take it into, for example, into a Physiotherapist, you had a Basic Grade Physiotherapist which was somebody at university, you had a Senior 2 Physiotherapist, you had a Senior 1 Physiotherapist, you had a Chief 3, a Chief 4 and a Chief 5 and it just was like...there was so much demarcation. What they've now done for Agenda for Change is to create nine pay bands, and everybody regardless of background discipline slips into the nine pay bands. So it makes it a lot easier a pay system to deal with, it gives us more flexibility for moving staff around.”* (Management Representative 2)

Interestingly Doctors and Dentists are not covered in this system because they made their own arrangements (known as Modernising Medical Careers) with Governments. In addition, Doctors and Dentists' pay is also monitored by a separate body, known as, the Review Body on Doctors' and Dentists' Remuneration (DDRB) advises government on rates of pay for doctors and dentists, and is sponsored by the Department of Health. The Employee Director below points out the level of unfairness that existed before Agenda for Change. This was particularly marked on different sides of the border.

*“Through our discussions in STACC we were able to show that people worked more than 60 hours public holidays, because people may have to work 10 public holidays. And the national agreement meant that they couldn't get paid for those. Because if you work a public holiday you double claim time, plus your time off in lieu. But because that was limited to 60 hours, there was no scope to do anything. In Scotland we reached an agreement that anybody who was required to work more than 60 hours on a public holiday would be reimbursed in the same way within the 60 hours, which they still haven't got in England, but we've got in Scotland. So we were able to secure that.”* (Employee Director 1)

Despite the unity described above there were quite a number of people who were dissatisfied with the point on the pay scale on which they had been placed which led to appeals being made. As the participant below points out there are, in fact, quite a number of people whose cases are still outstanding some years after the implementation of Agenda for Change, which one could claim is hardly fair.

*“There's thousands of equal pay claims that are still bubbling in the system, so it was an attempt to move from a potentially discriminatory pay system to a non-discriminatory. And one of the key factors of that was the job evaluation. Because in the past if you evaluated a job, you evaluated them differently. There was no common grading across the NHS.*

The Management Representative below rehearses the levels on which staff operated before Agenda for Change and the levels of pay and the agreed terms that followed its implementation. She also points out that this was achieved by setting up job evaluation to make sure that equality would exist.

*“The main reason as I see it, there was a need for an equal pay system or job evaluation. The old system under general, but the Council and all the functional, but the Council, was outdated. It had grown up. They'd all grown up independently of the other one. So you had all these, there's maybe 14 different groups of Councils covering all the different grades and different groups of staff. There was no consistency, you know, some people were on 40 hours, some people were on 36 hours. Some people had 20 days holiday, others had 15 days holiday. Some people had sick pay from the date they started, other people didn't. So it was crazy because it had all grown up in separate areas, had separate lives you know.*

*Whereas Agenda for Change was saying look, we need to sort this out, bring it all together, have everyone on the same terms and conditions, it will be fairer. It will be easier to justify in terms of defending equal pay claims and it's fairer all round.” (Management Representative 4)*

So Agenda for Change set out to have a single system of pay and terms and conditions but it was obvious that there had to be an agreed way in which these decisions could be made and this led to the acceptance of a reviewing system of all jobs to view the skills and knowledge that the individual had which might enable them to be placed on a higher point on the pay scale or offer the opportunity to develop new abilities. This mechanism was called the Knowledge and Skill Framework. By improving their knowledge and undertaking higher task jobs, employees can move to the higher level of the KSF, which leads to better pay and rewards. The Manager below explains that this is not as fully developed as it is intended to be.

*“Part of the Agenda for Change is obviously the implementation of the Knowledge and Skills Framework, and that is a common system, again, for all staff. And we're still going through the process of implementing that fully, but it does enable everybody to have the opportunity to review their personal development against the KSF dimensions, develop a personal development plan, and have that reviewed by their Manager on a regular basis. So it does give a framework for that, and an entitlement for everybody to participate in that.” (Manager 4)*

As a Project Lead points out below one of the drivers was to modernise the NHS management system in terms of pay and conditions. They point out that this was

to do with a suite of changes going on in the NHS and was not solely the outcome of Agenda for Change.

*“As an enabler for modernisation in the NHS. Agenda for Change doesn't, in itself, modernise the NHS, but its part of a suite of pay modernisation. .... So it was a suite...you know, it's part of a suite of pay modernisation, but it gives you the tools...that's why you use the word enabler, to be able to do modernisation. It gives you a job evaluation scheme and a way to pay staff that's common across all categories; because before, we had 20 different evaluation schemes. You know, we have one way of measuring a job through it, and we have KSF, you know, as a tool to not just develop our staff for the jobs that they're in, to prepare them for career development, and also to use that as a tool for service redesign; think about the knowledge and skills you need for the job and work back the way. Think about that and then work back the way to the actual role that you need. So to me, it's an enabler.” (Project Lead 3)*

Interestingly, not only was career development enabled but the possible pay reward was increased. This development allowed a Manager or an Employee-Director to have a better feel for the quality of a staff team but also any deficits which can then be corrected.

*And Agenda for Change in 2004, there was a ceiling above which financially you could never earn more than a certain level – you know, I can't remember, it was something around £50,000 say, you know, that was the top that anybody could ever achieve. Whereas Agenda for Change came in and said, we'll pay you what the value is, and now Agenda for Change goes up to £100,000, so it's changed that dynamic. The benefits that have got to be realised is that we've now got a skilled workforce, and that's measured on a yearly appraisal system, so you know the skills that your team have, you know the deficiencies your team has, and it does allow us to move into the higher ranks of specialists.” (Employee Director 3)*

Again this sounded and was perceived to be a positive element in the implementation of Agenda for Change with the opportunity to improve one's career advancement. However it also has a more negative interpretation for it can be used as a hidden agenda. It can develop a generic skilled workforce which allows individuals to do more flexible jobs. These individuals are available to work in different departments undertaking different tasks. This leads to the blurring of roles so that Nurses now carry out tasks such as obtaining blood samples, doing minor procedures which formally would have been done by junior Doctors. However the hidden part of this agenda could lead to employing fewer staff members to cover the same number of tasks. This policy allows the NHS to meet financial targets to save money by employing fewer staff members. Interestingly,

but perhaps not surprisingly it was Staff Representatives who spoke at length about this element of the reality of Agenda for Change. As all was important to understanding this concept both sections of the transcript are included.

*“But Agenda for Change was one of the big thoughts as well, we could create new posts, we could create new ways of working and we can have more generic type people doing a bit of this and a bit of that and this new pay system will reward them for that and it can do, it can reward them for that. But so far all I’ve seen is people being judged on their old way of working and scored for that and paid for that. And we’ve not really seen it move beyond that yet and it will do. In fact it’ll have to because under the current credit situation, and we’re facing massive financial cuts over the next two or three years and more then and we’ll have to look at the smarter ways of working where we’ll, get a more generic workforce so you might have a domestic who’s doing a wee bit of portering, who’s maybe doing a wee bit of Nursing Assistant work and stuff like that. And you could create this generic beast if you like and maybe pay a Band 3 and a Band 4 even, whereas in the old way you couldn’t, if you’re a Domestic you’re a Domestic and it didn’t matter what you did you’d still be a Domestic and your wage was there. With Agenda for Change we can build jobs and say, “Well a bit of that, bit of that and a bit of that,” and we can find a nice job, gives you your interest and by the way you’ll get paid a lot more as well. So that’s a big...and by doing that...we’re already starting to talk about that, I think that’s going to be my next job I’ve been told [both laugh], once Agenda for Change finishes is looking at how we can actually reduce the workforce but have people doing more interesting jobs and more rewarding jobs, so instead of having, you know, 100 Domestics in a hospital and 50 Porters and 200 Nursing Assistants, you might have 300 of these generic people who do a bit of everything, so you’re cutting your workforce, you’re probably cutting your overall spend but the individuals who are left are doing a more fulfilling job and getting paid more for doing it. And the...the trick in that is going to be doing that without losing people because obviously we wouldn’t make people redundant, it’d be a case of like a few leave and we’ll not fill your post, you know, and we’ll try and build these more generic jobs. And the same in Nursing, we’re trying to skill up more of our untrained Nurses or Unregistered Nurses to do a bit of what the Registered Nurses do, freeing up the Registered Nurses to do a bit of what the Doctors so we can get people working at a higher level. ” (Employee Representative 2)*

*“And again one of the big costs in the Health Service is medical costs, so if we can get Nurses working up to almost what a junior Doctor used to do, we don’t need as many junior Doctors, so we couldn’t...I mean it is driven by cost I have got to say which is not my flavour of the month but the Agenda for Change has given us the ability to actually deal with it in a sensible way, in a sensitive way by saying, “Well we’re not just slashing and burning here, we can actually renew our workforce and give them...well hopefully more fulfilling jobs and also give the individuals a wee bit more money for doing what they do,” so...and under the old pay system that was impossible, you couldn’t have done it.” (Employee Representative 2)*

However, it should be noted that, although the NHS is expected to save a net of £1.3 billion in the first five years of moving to Agenda for Change (National Audit Office, 2009), this has not been achieved by creating flexible workforce under the Agenda for Change framework. There are two reasons for this: 1) by the time this research was conducted, Agenda for Change implementation was not completed; and 2) there was lack of an evaluation system for Agenda for change, so interviewees could not say if all had been implemented.

## **Implementation of Agenda for Change**

In the early stages of the implementation of Agenda for Change there was a continuing habit of both Unions and management drawing up their own agenda and making decisions on each item in a pre-meeting. This meant that when the joint meeting happened there was difficulty in getting even an agenda agreed never mind agreeing or even properly discussing the items on an agenda and so joint decisions could not be made. As the two participants below reveal a fractured system of decision making or even partnership working.

*“The partnership working was very very weak and poor and to me it was like stepping back ten years in time because you’d go down to a Partnership group but there would be a management pre-meeting and a Union pre-meeting and then they would get together and then they would depart and they’d come back together.” (Project Lead 1)*

*“But even then she was the Employee Director for the whole of Site 3 but we were still operating as two Trusts and a Board at that time. So people were only coming together once every three months for the Area Partnership Forum. There were discussions going on in town, separate discussions in the Primary Care, and they weren’t joined up at all because people in hospital had a different agenda. So it was very fractured and very inconsistent.” (Project Lead 4).*

This fractured decision making must be seen against the background of the Labour Health Minister who was keen and tired hard to instigate and spread the notion of partnership working as a means of improving the delivery of health care at all levels. Not only was it seen as a way of improving delivery of health care but also as a powerful tool to break the cycle of poor industrial relations and so stop grievances and strikes and causes of sick leave. The quote below shows this clearly.

*“As you’ll know Partnership was introduced by the Scottish Executive as it was then, the Health Minister Malcolm Chisholm, and Susan Deacon, were very, very keen for partnership working, but their reason being that industrial relations in the Health Service had been in a very, very bad state, especially during the years when the Conservatives were in power, there were very, very poor industrial relations, a lot of grievances, a lot of strikes, a lot of days lost through sickness, all that kind of thing.” (Project Lead 4)*

This also demonstrates that it was not a straight forward process to implement partnership working which was intrinsic to the acceptance of Agenda for Change. It is important to note that one of the things that the Labour Government in Scotland decided was that it had to be through partnership working. Part of what underpins the Labour Movement is about fairness and standardisation which explains the need for both partnership working and Agenda for Change. Meanwhile, partnership working is different between Scotland and the rest of UK. In the NHS in Scotland, political devolution appeared to be a crucial factor in encouraging the adoption of National level partnership agreement, reflecting the ambition of the devolved Government to include Trade Unions in plans to improve public services. Research findings also suggest that, although these systems were expected to be implemented UK wide the Employee Director below points out that there were differences north and south of the border as far as partnership working went.

*“Partnership working in Scotland is somewhat different to partnership working in England. Partnership working was introduced in 1999 at the start of the Scottish Government, the Scottish Parliament. And there is now enshrined in law things like staff governance and a whole Partnership arrangement. (Employee Director 1)*

When the Agenda for Change with its partnership working was implemented across the UK it became clear that Scotland, despite the comments above did in fact have a more developed practice of partnership working than their colleagues in England. The Scottish devolution in 1997 provided great opportunities in terms of political autonomy and financial flexibility, as well as the opportunities for addressing local needs with greater determination and focus. Since devolution, Scottish ministers have expressed a high commitment to partnership working. The introducing of the Health Act 1999 established a different internal market structure for Scotland comparing with the competitive market forms of the NHS in England. The aim of doing so is to reduce private sector involvement north of

the border, and encourage collaboration rather than competition. After that, a series of written agreements which seeks to define the broad principles, shared priorities in terms of engagement with a range of partners had been introduced. As the biggest employer in the public sector the NHS has led in developing and growing partnership initiatives. Thus, partnership working isn't new in the NHS in Scotland. It has been embedded in the organisation. One Project Lead expressed her opinion as quoting below:

*"I've worked across the four countries and I think Scotland has always been ahead of the game in partnership working. We've always had really good relationships with our Trade Union colleagues and I was quite surprised when I started working on the UK basis how little Partnership there was..... I mean partnership working is so embedded in the Health Boards. It was already there." (Project Lead 1)*

### **Section 3 Partnership Working Prior to the Implementation of Agenda for Change**

#### **How Did it Work?**

As previously mentioned above, partnership working is not new to the NHS. Although it is a fact that the industrial relationship between the management and Unions was not quite a collective working approach before 2000. The research data still shows evidence that this working approach has existed in the NHS for a long time. An example of this was given by the Agenda for Change Project Lead above who has been working across the four nations within the UK who thought that Partnership has been embedded in Scotland before Agenda for Change was in place. Partnership working is considered to be a working relationship to provide employees from different settings or staff groups with the opportunity to sit down together to reach decisions about the way forward and as a by-product it broadens each party's knowledge.

*"(with partnership working) part of the knowledge is working with other people.....to actually sit down with people who are a Domestic, or a Secretary, or a Lab person, you learn so much about the NHS and it actually broadens your knowledge base". (Project Lead 4)*

This interviewee has been working in the NHS for many years and believes that Scotland was always ahead of the other nations when Agenda for Change was implemented because partnership working was already in place. This relationship helped the NHS in several ways. First, there was an approach and structure practicing partnership, albeit that it was not uniformly embedded, it did make both parties familiar with this working approach. Secondly, both parties had built up a good relationship by working together. This contributed to making the partnership stronger. Because the Agenda for Change agreement states that the whole change process needs to be agreed and implemented by both management and Unions working in partnership. The long standing approach had worked and been seen to work for years. They know how to communicate and work with each other to deal with issues. It made implementing changes less of a challenge for both parties. These three participants make this situation clear.

*“Because we had the basis of partnership working in place beforehand it was easy for us just to carry that forward into Agenda for Change. And I have to say that both management and staff side readily got together and worked together. Now had we not had that Partnership process in place beforehand it might have been very different, but we had and therefore it was ready?”*  
(Manager 3)

*“So there is a long-standing working relationship between myself as Human Resources Director and the Employee Director, and we’re both obviously members of the NHS Board.”* (Manager 4)

*“I think it almost is in our organisation. I think with every year that passes it goes deeper and deeper into the organisational culture.”* (Project Lead 4)

As the following Employee Director demonstrates the small size of Scotland has been a benefit for it allows for people from different geographical areas to provide support to one another. The major benefit of this has been that it has helped the national arrangement of partnership working. Also the Health Minister was enabled to consolidate the national arrangements.

*“But I think what helped us... it’s easy, the national agreement saying, you all do this in Partnership, almost prescribing you do it. It’s then more difficult to get the sides to actually do it. I think what helped in Scotland is we had three or four years of a different [form of] industrial relations, where we were working in Partnership to an extent. Therefore it was easier for us to get involved in it.”* (Employee Director 4)

## Roles of Teams

To implement Agenda for Change a series of teams was set up at three levels. Firstly there was a National Agenda for Change Team; namely —the Scottish Team Agenda for Change Committee. This supervised the implementation of Agenda for Change for the whole of Scotland. Its orders and decisions were then passed to each NHS Board Partnership Forum. This second level is responsible for the implementation of the Agenda for Change throughout each Board Region. The third level, where each NHS Board had established Agenda for Change Panels. These Panels are responsible to the day-to-day Agenda for Change implementation tasks, such as job evaluation, job matching, and reviewing appeals at local level. However, the Panels were not responsible for making decisions on Agenda for Change. If there were concerns from Panels, these would go up to the Partnership Forums and the Agenda for Change Teams at local NHS Board level. A Project Lead and an Employee Director describe the system of the various levels below.

*“So you would go to the Partnership Forums, if there was...because that's our negotiating body. So if there was something there that needed to be discussed in a very formal setting like that, I would attend to speak to that paper, you know, about Agenda for Change. And then, the project team would be the next layer down, and that would be...was a higher level committee, just in the Agenda for Change implementation structure. And that was a chaired, so the...well, HR Director, who you've just met, and Employee Director, who you're just about to meet, were the joint chairs of that committee meeting time about. And I was a member of that. And you can't help but be a major player in that committee, because of the role that you're doing. You know, because you have the knowledge, so you are influencing that discussion and decision, but you take away the decision to implement.” (Project Lead 3)*

*“If we feel that there is something [site 2] would like to do, we have got to convince the other Boards in Scotland that this is the right thing to do, and that's done through the Scottish Partnership Forum which is, if you want, one of the Partnership structures which has got management, governance and staff side; so it's got three bodies, all have to agree something there, so you can have staff and management coming up with an idea, but they've still got to convince the Government it's right, so there are three partners in that one.” (Employee Director 3)*

The Job Matching Panel don't hold a particular position of matching people to jobs, but rather they matched a particular job with a specific point on the scale. The jobs were evaluated in terms of skills, academic and professional

qualifications required to carry it out. The two participants below describe how partnership working on the Job Matching Panel operated in practice. It is interesting to note how different participants commented on the need for training to carry out this role. It is also worth noting that partnership working in the true sense was not a component because as one of the two quotes below points out it was a technical exercise of placing a job description at a particular point on the pay scale.

*“Well you don't need training on partnership working to sit on a Job Evaluation Panel. Because it was part of a technical exercise and we did train up - I was the lead job evaluation person for Scotland for Unison. I don't know what other Trade Unions did, but I trained up loads of Trade Union people to sit on Panels. And that's what we've done. We equipped them with the skills to actually do the job.” (Employee Director 1)*

*“So for me, staff side weren't holding a particular position of matching, they were just acting as job matchers. They'd been trained in the scheme...like the next person, sitting next to them, whether I'm staff side, you're management, and we're both trained exactly the same way; we've got a job description in front of us, we need to match it, that's just the role we're here to do. And there was never this well the staff side, I think; there was never that kind of language in the Panels.” (Project Lead 3)*

## **Agenda for Change Positive Outcomes**

Naturally most people perceived Agenda for Change as a positive change since they saw improvement in the organisation and employees' conditions. One Manager put it thus:

*.....It's simple, it's straight forward, it's similar, so people feel that they are being treated in the same way, so that helps to drive motivation, working together and delivering health care to the people of the area.” (Manager 3)*

This standardisation, though positive in itself, also lead to a greater level of cohesion in the organisation. It is good for the organisation in terms of being able to show how different roles are similar. It also makes the job of Manager easier. As the Manager below put it:

*.....Yes, I think it's good for the organisation in terms of cohesion. It's good for the organisation in terms of people being able to see how different roles in the organisation are on a similar kind*

*of level, and how they can make contributions that are valued in the same way, to patient care, or to support services. I think that's very positive. And I think from an administrative perspective, in terms of recruitment, for example the application of policies and other terms and conditions, then it's much easier to administrate if everyone's under the same system, rather than having different rules and regulations for different groups, which is how things were historically.”*  
(Manager 4)

Another Management Representative compared past and present situations to demonstrate the positive outcomes:

*..and instead of having a massive raft of allowances and additional payments we used to make to staff, then it's very much regulated that these are the allowances that are payable and nothing else is payable, so we've got a very much more streamlined pay system now, and we know that if it's not in the Agenda for Change handbook then we don't make the payment.....What had happened was that although we originally had a national pay system, when we were in trusts previously, in the earlier part of the 1990's, Boards or Trusts went off on their own and changed the terms and conditions and put in a local agreement here and there, and we ended up with a massive raft of things, all being paid very differently and nobody could really understand well why they were getting that payment and I work here and I don't get that payment, and it was just horrendous. But it has brought it together into one pay system now so it's a lot easier to understand where people are what payments they are getting.”* (Management Representative 2)

The Project Lead showed, in the contribution below, that the setting up of the system had, because of the openness of it and the fact that it is a reviewed one, meant that there could be no dubiety of the 'rightness' of decisions about fair conditions of work. Certainly, one of the outcomes has been that there cannot be problems of staff raising claims of unfairness or inequality. This also saves the NHS Boards having to pay out compensation. It gives Managers security. As the Project Lead says below:

*“I think the key principles are...I think it's fair. I think the job evaluation system is extremely fair. It's very robust. It accurately measures all the jobs in the NHS which we didn't have before – we had a basic grading system. I think it's fair in that it gives everybody the same terms and conditions. The job evaluation system has been equality checked so we know that there are no biases between male or female workers no matter what job they do. And we have a big equal pay agenda in Scotland from the previous system, so it's good to know that going forward we have that. Well hopefully. We've got a huge influx of equal pay claims.”* (Project Lead 1)

## Winners and Losers

Although Agenda for Change has been seen as a step forward on staff's pay conditions, equality, training and development, there are still some negative outcomes shown in the research. These discrepancies arose because of a number of factors which were directly related to the uneven expectations of individual staff members in terms of what Agenda for Change would offer them. First, Agenda for Change brought different groups of staff under one single pay scale. However, as the two quotes below demonstrate there were "winners" and "losers" as a consequence of the change. While some staff may have gained financial benefits others lost certain entitlements. As has been reported earlier prior to Agenda for Change some staff were working longer hours and had different levels of recompense for working extra hours.

*"Well, it has different effects on people. The key group who have mainly been disadvantaged have been admin and clerical workers, where a number of their jobs now pay less than they did in the former arrangements. For other workers there's been good gains. An example, ancillary workers. Ancillary Workers gain an extra six days' holiday out of Agenda for Change because there were different holiday arrangements. Ancillary Workers are now nearly on £7.00 an hour, which previously they were nowhere near. So that was a group of staff who genuinely gained. Nurses to an extent were fairly neutral, Nurses maybe got an extra increment or two increments. But what it allowed for was better career development within the grades that wasn't there beforehand." (Employee Director 1)*

*".....because inevitably any grading system you will have people, staff that will perceive they've been winners or losers in any new pay grading system, and even the ones that, in the face of it you might think are winners, gainers, whatever word you want to put round that, they will maybe perceive that they should have gained more. So you will have people who bluntly saw Agenda for Change as only a re-grading exercise to, in their mind, remedy the past mistakes of the previous grading system." (Employee Director 4)*

However, as the Project Lead below points out the expectations of people would only be met over a period of time as they worked their way up the new grading system. This gap between expectations and realisation was difficult to manage.

*"....I think people's expectations were...people saw Agenda for Change as a massive pay uplift. Because it was a new pay structure. And I think for me it gives far better conditions of service for everybody. The vast majority of people either went instantly on to higher pay bands or will through time work their way up. But I think because there was a delay in getting it through, people's*

*expectations were way up there about getting some massive pay hike which didn't materialise and that was very difficult to manage.” (Project Lead 1)*

In fact it was a common misconception among staff that they would notice an immediate improvement in their take home pay which sadly did not materialise for many. Interestingly, the two Employee Representative point this out below.

*“...I think staff saw this as being wonderful and everybody was going to get huge pay rises, but it was never about that, it was about making sure people were getting paid the same for doing the same type of job, making sure there was a quality among their pay.....” (Employee Representative 2)*

*“For example, we had Medical Secretaries who were on Amin and Clerical grade four, some of these when they were evaluated under Agenda for Change came out at band three. So people wrongly assumed that if they had been a four previously that a three, a band three, under Agenda for Change, that it was less, less of a pay band which wasn't the case because the band three encompassed in the main, the pay range that they were already on, so there was a big hang-up about the number. So they automatically seen that as coming down.” (Employee Representative 4)*

## **Challenges of Implementation**

Another problem with Agenda for Change came particularly from the management side. It related to the amount of staff time required to carry out the various stages of job matching. For each individual member of staff a job description was compiled and then matched each individual employee to the new post. Additionally, because decisions were taken in Partnership staff had to be released to attend meetings, many of which took a long time to agree decisions. So meeting Government targets actually put immense pressure on Managers. Although the national negotiations before implementation were slow, local implementation was rushed. Timescale for implementation was optimistic to Board Managers, they had to rush the process to accommodate pressure from their strategic health authority and the Department of Health. For example, one of the Management Representatives who also sat on the Job Matching Panel reflected on the realities of implementation through these years. This participant thinks that the amount of work and deadlines which came from the Scottish Government produced much pressure:

*“For me Agenda for Change has created a huge amount of additional work. We started working on it in about 2002/2003 I think was when the work began to commence on it..... But to get Agenda for Change implemented we had to have written for every employee in the organisation a job description, so that we could match that job description. Now job descriptions were used in the organisation, some weren't good, but it had to be in a set format so we had a huge amount of time with Managers and working with staff to write job descriptions. I mean we're dealing with an organisation with 28,000 employees, it was no mean task. And then all these job descriptions then needed to be matched, then once they'd been matched the (unclear) move everybody across on to the new pay ranges, so it's been a massive task for us to do that, and we concluded all of that work to move everybody off the old pay scales on to the new pay scales in the Christmas of December 2008.” (Management Representative 2)*

*“Because to be perfectly honest with you the size of this project was far too large for every Board to do every post that they had. And that was my view at that time, it is my view now and I think that was a serious mistake from our national bosses, not to realise the amount of work that was associated with this. And I've so far not seen anything that demonstrates that I was wrong. We twice wrote to those controlling the situation nationally and twice they said 'No', and I think that's a great shame. Because we could have condensed the period of time used for implementing the Agenda for Change by more than half if we'd done what I had said.” (Manager 3)*

*“The whole service just kind of slowed down for years until that all worked through. So we've done them individually, but taking them all in one group, bringing different professions together on Panels, bringing different staff side people together on Panels. It was like, I mean it's actually quite amusing, you know, it's a huge job that's being done, and there was some discontent around some of the outcomes in terms of the grade bandings.” (Management Representative 4)*

This view was supported by another of the Managers, who believed Agenda for Change was a good idea but claimed it was hard to follow the process through in practice. In fact, the differences between Health Board areas which resulted in Boards of disparate sizes produced particular difficulty for both very large areas and very small ones. This problem of size was compounded by the timescale set by Government for implementation. Indeed, the Agenda for Change project was too large to be completed in such short timescale according to one of the participants below. Interestingly, the first Manager did make suggestions to the National Agenda for Change team to simplify the job matching process, but these were not accepted. There was an added pressure on time produced by the number of people who were actively involved in the various levels of working groups or committees and required to be released from work to attend these. This

demand had to be balanced by a Manager requiring to provide a service with less staff

*“The barriers is about getting people released to be...well, getting people to be reps and getting people. Managers need to understand, they need to release the staff. And I'm not saying that's not difficult for Managers; I think that must be extremely difficult if you've got a busy Department and you're having to release people for duties that you're potentially getting no benefit from, which might be their view. So the barrier is the number.” (Project Lead 3)*

An Employee Director commented that the financial constraints within the NHS are such that this will mean that the numbers of staff will have to be reviewed and presumably cut. This suggested that partnership working at workplace level did have tensions. As the NHS faced challenges of restructuring, which resulted in a turbulent industrial environment, where local NHS Boards faced Human Resource and financial pressures. In order to meet performance targets, management attempted to exploit partnership at workplace level. The impact of this decision was that the system set up by Agenda for Change using partnership working suffered from a lack of attendance and ultimately had an effect on the overall pay and conditions on which the staff were graded.

*“One of the potential barriers at the moment, of partnership working is the test at the moment, because the NHS is under so many financial pressures, is will partnership working make it easier for the NHS to get through these difficulties? Or will the fact that budgets are going to be less and less and we're going to be talking about staff numbers at some point, will that put excessive strain on partnership working where the Trade Unions can't then be involved in somebody's discussions because as good as partnership working is, our first job is to try and preserve the members' terms and conditions.” (Employee Director 4)*

There are some participants who felt that partnership working, though valuable, was being taken too far and that the result was that Managers could not take decisions and manage. One of the Managers has expressed this view below

*“The comment that said I suppose is that sometimes we take partnership working far too far and sometimes you lose the ability of Managers to actually manage a situation and take a decision. There is a danger that you work so closely in Partnership that Managers don't do anything about outside or deciding to do anything without speaking with a Partnership Representative. Sometimes that causes difficulties and if a Manager does try to manage a situation and maybe hasn't involved the Partnership then there's some difficulties because they believe they should have been involved. It's getting that fine line between yes I am going to sit down and discuss*

*stuff with you and work through things, but at the end of the day I manage that service, I am paid to manage it and that's the way it's going... and that sometimes.” (Manager 2)*

This quote raises concern that the management may lose power on decision making. Although partnership working is adopted as a hierarchy architecture where Central Government hold power of decision, managers at local workplace level are tied to the partnership agreement. However, this also suggested that workplace employees were empowered to be involved in decision making.

## **Benefits of Partnership Working during Implementation of Agenda for Change**

As the material already presented has pointed out there are benefits to be derived from partnership working. The quote below gives an example of how partnership working helped the Trade Unions to work as a collective rather than as seen earlier in this chapter as a fractured group which could not agree agendas or indeed work together.

*“We used to have, and again you can research this, we used to have a [site 1] Joint Trade Union Liaison Committee. It wasn't always good, we used to be fighting with the employer, but that was mostly because of Government policies, rather than the employer. On the whole, the individual relationships were good, and it was called Liaison Committee, Joint Shop Stewards' Committees. And again, it was about mutual respect, it's been added to through partnership working, which has allowed Agenda for Change to work. It wasn't done in [site 1] through Agenda for Change, it has in some parts of Scotland been the catalyst for improved working relationships, because the other relationships prior to that had always been formal meetings and adversarial.” (Employee Director 2)*

Partnership working enabled Unions and Managers to be involved in discussions from planning through to implementation of the whole change process. This resulted in Unions being involved in the agreements arising from decision making to the implementation of that change which meant that the voice of the workers was clearly represented.

*“So even at the sort of gathering the data point of view, it was all Partnership. And then, when we began to implement it, it was all done in Partnership. And that's the cascade trainer role that I mentioned earlier, Boards were asked to cascade train in Partnership the job evaluation*

*scheme..... And then, all our decision making around Agenda for Change was done in Partnership. So all our group structures, from our project team, through to all our subgroup structures was all in Partnership. And then, the actual panel composition itself to management and to staff side. All piles had to be in some form Partnership, but you can have between three and five members, but we were four, and it was two management and two staff side. So the whole of implementation is done, or has been done in Partnership, yeah, from the actual stand up and deliver training, to making decisions around it.” (Project Lead 3)*

*“Well staff were round the table from the very, very beginning, they were involved in the remote and rural pilot which [site 3], was one of the pilot sites. So they were engaged from the onset in that.” (Employee Representative 4)*

*“And what the Partnership arrangements allow us to do is to have meaningful engagement at the earliest possible opportunity..... Let’s say it’s about a redesign of a service, we get in before they’ve written up where they want to be, and we can influence it at a lot earlier stage, which has been extremely helpful.” (Employee Director 1)*

Working in Partnership needs both parties to work together with common agenda. So both parties would sit together to raise issues and after discussion reach a joint conclusion. This also shows the benefit of getting Agenda for Change implemented. The Manager below makes this clear.

*“It’s been done with a joint approach where different people are being representative but are working together on that common agenda. So I think there is a key issue about having a common agenda to work on, understanding different people’s perspectives on that agenda, and agreeing together a process for implementation. I think that’s generally been very successful in relation to Agenda for Change.” (Manager 1)*

The outcome of partnership working is positive from the Unions’ perspective. It allowed them to be involved in the discussion and decision making but is also gave them the opportunity to have a unified and more realistic understanding of their own but also the Managers’ point of view. This meant that the people involved in such decision making had a much wider understanding of a range of issues within the NHS resulting in an openness in how decisions were made within the organisation. As the third quote below points out this results in a more pleasant working environment.

*“I think in terms of Partnership I think because we were always involved, I suppose it helped the Unions because they were able to sit around the table and be part of the discussions of how we implement it, and be part of the implementation, which in a sense helped them with their*

*representation of the Managers because it gave them an understanding of what it was.” (Project Lead 2)*

*“We actually sat down and said with the team there, you know, this is what we’ve got and this is where we want to migrate, and get the staff side input into what is the right skill mix, what is the right numbers, etc. Because once that group have then said, yeah, we’re happy with it, then it can happen. So that’s the philosophy behind the Partnership approach”. (Employee Director 3)*

*“I just think it’s made it a lot better environment to work in where we’ve had the employees or the employee’s voice involved at the outset of the discussion. Then they feel as though they’ve had a say in how things have been developed and shaped and therefore they’re more likely to then accept it and work it forward and take it forward in practice”. (Manager 2)*

Partnership working had also positive outcomes for the management. The previous conflict and industrial relationship had caused problems with the NHS transformation. Since partnership work was established, there had been less conflict between the management and Unions when implementing change. It also resulted in the Employee Director being made the Vice Chairman of the Health Board thus blurring the roles of Union and management. It is also interesting to note in the second quote below how the involvement of all levels from the Chief Executive down has resulted in the benefit of partnership working which is exemplified by his practice and open support of it.

*“Because as well, if you go back into the literature around the NHS at that time it was about people and transformational management and all this, but nobody really had a view as to how you got that. So the notion of working in Partnership, not in conflict, inviting the Unions in, working as colleagues as a means to an end, was the right approach. What has happened over the last decade in the last six or seven years is that it’s worked so well, and being the NHS and being a public organisation, we’ve crystallised partnership working as the end and not the means to an end.” (Manager 1)*

*“I mean I’m the Vice Chair of the Health Board, which does not happen anywhere else in Scotland. So the Trade Union, Employee Director, Partnership person, I chair the Board, sub committees of the Board, I chair the Staff Governors’ Committee, [site 1] Partnership Forum, I co-chair it with the Chief Executive. The executive management team are full members. When we meet the Cabinet Secretary for our annual review of [site 1] we do not have a separate meeting with him. We could have, but it would make a mockery of it. Why would you need a separate...if it’s the Partnership Forum? And that includes the Executive Management Team. It needs to be that when you’re meeting Government. You can’t go in and say, ‘well, we don’t really like them,’ because we do. So the whole ethos in [site 1] is that, and Chief Executive has also been staunch in his support for partnership working, and that makes it easier. So he values it.” (Employee Director 2)*

Despite this apparently rosy picture of everybody working in harmony and partnership there are some dissenting voices about how the decisions were made. As the Employee Representative below makes clear the decision making came from the Chief Executive down. However, it is important to note that it is perhaps difficult for Union Representatives to give up a long held rhetoric that the 'bosses' make the decisions. Indeed, partnership working has been seen as a top-down management method of making changes, so it could be argued that it is a managerial perspective where middle and workplace Managers have to follow the instructions of Chief Executives. On the other hand the Chief Executive is in fact employed to make decisions and to set agendas for change which may be in response to Government Policy which is also handed down.

*"From a management side I think there still is a bit of top down. I mean Chief Executive's word is law, the Chief Executive, as far as the management say...if he puts it in to his Managers to do something, if they don't it they'll know about it, you know, and we sometimes have quite a giggle about it because some of the ways that the senior Managers deal with their junior Managers could by no means be classed as partnership working because it is very dictative, it's like, "You will do this because I'm telling you." The trouble being for us it tends to be they're doing that because we've told them to do it because the Managers not playing ball, you know [laughs], so...and we have very good Managers, we've got some excellent Managers, and when you see a really good Manager." (Employee Representative 2)*

## **Section 4 Describing how Partnership Working Affected Agenda for Change**

For some participants the whole concept of how partnership working affected Agenda for Change was a matter which required no great explanation or debate. This is put by a Manager quite simply as being:

*"Partnership working for me is where we work alongside out staff side organisations to resolve, work through developments, changes in service and we do it in a joint basis." (Manager 2)*

Indeed, some would argue it is just a new way of managing, an art of being able to have debate and discussion and a way of influencing decisions but ultimately reaching a joint decision as demonstrated in the two quotes below.

*“And what it is, it’s a different way of managing. That in essence that’s what it is. .... The art of having that debate and discussion and the role of a Manager is to pursued and influence staff through good reason and sound reasoning that things need to change. Now if they can present a proper case and if they can persuade and influence people appropriately because of the strength of their case, then in my experience over many years the majority of staff will sign up to that.” (Manager 3)*

*“So what is partnership working? It’s a means to an end. It’s a means to ensure that management know how to manage.” (Manager 1)*

The practice of partnership working was intrinsic to the implementation of Agenda for Change. This allowed management to work with Unions together to make plans, decisions, solve problems and make changes. The idea and practice of partnership working had operated well in other spheres within different areas of the NHS and so there was a foundation in place on which to build the level of partnership required for Agenda for Change. The Manager below makes this clear.

*“I think partnership working has been something we’ve been discussing in [site 3], I guess, for the last eight to ten years, so yes, there was a very solid foundation on which to build, when we moved to implement Agenda for Change, which had already been established and embedded in the way we work and the culture of the organisation, the way we do things.” (Manager 4)*

As reported later in this section other participants, both management and Project Leads, explain exactly how partnership worked for them and the importance of personal relationships.

It’s clear from the Manager below that there had been some partnership working between Managers in Human Resources and the Unions for the quite specific task of making sure that the interests of particular staff members were being managed appropriately.

*“I guess it’s working together with our staff side colleagues and representatives from professional organisations who represent staff, for them working together with management and, in this case, with HR professionals as well, on a particular agenda in terms of identifying how we made... in conjunction between the management and Unions representing employee’s interests.” (Manager 4)*

## Transparency and Concealment

Close working using the concept of partnership working has resulted in an openness and achieving positive outcomes had been a reality for some areas. As the Project Lead below points out

*“And I think because of the way we work, and because partnership working is very strong within [site1], I think we’re able to resolve things quite easily. That’s not to say that there may be issues in Partnership from the Unions. Some may have concerns with outcomes, they put forward a case, but we listen to the case and deal with it. So from my perspective, I don’t have any problems, and I’ve not had any problems.” (Project Lead 2)*

His quote suggests because Employee Directors were engaged in the beginning of each change process, they shared truthfully information with the management, so employees were informed through the whole change process. Sharing information needs to exist through the whole change, not only at certain stages. Another Employee Representative agrees with this opinion and thinks Unions were engaged at the earliest opportunity. They attended meetings, got meeting minutes, discussed issues and got feedback. All these allowed them to influence and communicate with employees what had been happening.

*“We’re involved in all these, which is good. It allows us to influence, but more importantly what it allows us to do is communicate to colleagues what’s happening. Because if you’re not on a group and you’re not getting them minutes, then you don’t know what’s happening. Whereas if you’re there, you’re participating, you’ve got the minutes, you put the minutes out, people can read. They may want to put a better narrative around it, it’s entirely up to you. But people can really see what’s going on.” (Employee Director 1)*

When sharing information, both partners needed to be open and honest about it, which allowed for intelligent and informed discussion. One Employee Director thought being honest about information shared between partners was fundamental to partnership working.

*“And also things like, when it comes to, why we are doing something – well actually we’ve been given instruction from the Scottish Government to do it. You won’t find it on a bit of paper, but there’s been a meeting and they’ve said, look, you’ve got to reduce your activity of whatever by whatever. You know, so be really upfront and honest about what the rationale is behind things, and I think that makes a big difference, if I’m being quite honest. And I think we’ve got into that way of working here.” (Employee Director 3)*

However, despite openness in some forums this could not be universally maintained since there was some information which was not at a stage in its development where it could be shared throughout an organisation or indeed apply to a very small group of individuals whose privacy had to be respected.

*"I mean good communications are the core of anything. And I think that's why we have...you know we have our official meetings but I also have sideways meetings with the heads, staff side people and the Scottish Terms and Conditions Committee. We have one to ones where we air issues. I'll share issues that I hear rumbling. They'll share issues that they hear. And we try and really stop them before they hit a crisis point." (Project Lead 1)*

Other occasions required an off the record discussion which was not relevant to all who attended the Partnership meetings. The onset of partnership working had in the opinion of this Employee Director enhanced communication which in the past might have been debated more publically and resolution not achieved.

*"But I think some of the trust in partnership working is around forming constructive relationships with management where you can – I hate to use the term – off the record discuss things without formally having to discuss it in a Forums. And I think that's a maturity of partnership working where both sides have, if necessary, the ability to go to either side and talk honestly about something without having it completely in the public domain. I think that's a maturity of partnership working." (Employee Director 4)*

However, in the main, it would appear from the data that major decisions, even difficult ones, like closing a hospital or difficult budget decisions were the subject of open debate from the earliest stages as the Employee Representative and Project Lead below suggested.

*"....And in fact I've got a meeting today at 11 o'clock with the Chief Executive just to go through the next phase of the changes and it's a case of keeping the staff abreast of what's going on. Whereas in the past they'd just have been told, "The hospital's closing and we'll get back to you later, we'll let you know what's happening when we've made up our minds." Now you're actually right in there from day one, so you're discussing how things are going to progress and how we're going to change the services, change the staffing profile, stuff like that so..."(Employee Representative 2)*

*"Well, management, are very honest and transparent with information. Because you know, we're £34 million in debt this year, and staff side know that; it's not hidden from them. They see all the financial stuff, the same as anyone else does. It's not hidden, it's this is our problem, how are we,*

*Partnership wise, going to solve this? You know, how are we going to work together to do that?"*  
*(Project Lead 3)*

Yet, this utopian perspective was not universal as the Management Representative and Project Lead below explain. It's clear that in their experience there was an element of dictatorship as decisions had already been made at a higher level and that those decisions had to be implemented without comment. Or indeed where individuals tried to usurp the process laid down by going directly to Government.

*"So nationally the agreement was done in Partnership between Trade Unions and management at national level and basically said this has been agreed nationally, people have voted to go with this, so just get on with it." (Management Representative 4)*

*"Well you can make it difficult by trying to push something through without getting agreement on it. And that still happens even although they say you shouldn't. It still happens. And I think that can stop a lot of good happening and that can affect morale Some of my trade Union colleagues might try and impose things themselves or they'll cut the route and not come through us and they'll go to Scottish Government directly. And I think they are in danger of destroying partnership working by making it complex. It's not. I've never had a problem working in Partnership. You have to work on some people to understand the benefits. And you'll always get people who would prefer to do their own thing on all sides." (Project Lead 1)*

However, there were those who thought that although the system intrinsically was sensible dictatorship was preferable but was realistic to know that although this approach was efficient it had a great cost.

*"Well, I'm speaking now purely as managerial. It takes far too long. The best process and the quickest process is a committee of one: me. Whoever 'me' happens to be. In other words, the dictatorship is the most efficient form of governance; it's just a hell of a price to pay." (Manager 1)*

It is important to note that from the Employee Director perspective, reported below that their advice had always been sought on a variety of issues which produced responses which did not agree with the view being put from the other side but that advice still had to be given. This provoked a dilemma for the Union representatives.

*“They’ll come to the Union reps for advice, which they always did for anything, even Agenda for Change, and you’ll give them advice to the best of your ability - giving that advice is not necessarily agreeing with them.” (Employee Director 4)*

Finally, it is interesting to note that at least as this Manager reports below that the prime function of partnership working is for the betterment of patients since the NHS exists for this purpose.

*“In my mind it’s about staff and management working together to make the service better for the patients at the end, because that’s why we’re here, it’s for the patients. So if we are working together everyone will benefit. So that’s how I would see it.” (Management Representative 4)*

## **Characteristics of Partnership Working in the Context of Agenda for Change**

The participants in this section report what their perceptions of the characteristics of partnership working are. The findings show that there are several key factors which they thought were essential to understanding partnership working. These characteristics are ultimately what they believed makes partnership working successful.

### **Respect**

Respecting people is a key value underpinning partnership working. There are several other factors which also build connection to respect, including trust, being honest, and understanding each other. The concept of respect was the most commonly mentioned characteristic of partnership working in the implementation and functioning of Agenda for Change.

*“Respect, again respect is always important. If you respect someone then it’s easier to do business with them. If you don’t respect, well what is your reason for not respecting them? So you’re going to have something that’s going to hold you back from being open and working with them freely. So yes, you need respect.” (Management Representative 4)*

*“So it’s about respecting people. It’s about valuing you as you. It’s about basically making sure you’ve got good personal space, that you’re comfortable. I now feel that you – and I’m a*

*Psychiatric Nurse as well by the way – that you’re far more comfortable now that you were the beginning, and you’re also probably saying, ‘I’ll never get this done in an hour.’ So it’s about how do I as a partner in this engagement value you, so that when I feel there’s something incorrect, like what’s not an opinion, it’s a fact, you present that in a way that doesn’t offend you, but equally well doesn’t devalue the view that you’re asking me about. So it’s respecting people, valuing people in their entirety.” (Employee Director 2)*

Honesty was perceived as a key component to the development of trust. This had to be demonstrated by being prepared to participate openly in the discussion. But it was this process based on trust which helped to get the system delivered.

*“And I suppose the thing about it is, because we’re open and frank, any decisions that we take get delivered, and I think that’s the big benefit in Partnership at all levels.” (Employee Director 3)*

Other aspects of trust are openness and commitment which were reported by the Employee Directors below who explained that when a commitment was given it had to be followed through timeously.

*“So if I say I’m going to do it, I do it, and I’ve always done that. So you bring that value in, and then because of that, everybody else who’s involved knows and understands what they’re doing, why they’re doing it, and the timescales in which it’s expected to be done. And that, we’ve tried to get...” (Employee Director 2)*

*“And I suppose the thing about it is, because we’re open and frank, any decisions that we take get delivered, and I think that’s the big benefit in Partnership at all levels.” (Employee Director 3)*

## **Building Relationships**

One of the by-products of honesty and openness was building working relationships. Partnership was a joint working approach which covered areas which were wider than pay and conditions. However, there are many times in a working career when one has to work openly and honestly with individuals with whom one has little in common. Such challenges were pointed out by one of the Employee Directors who accepts that this is part of the job and that in the event such behaviours are essential for successful partnership working. Not only this but respect had to be earned and this whole process took time as noted by a Manager in the second quote below.

*“Well, because if I've got no respect for you, how could I sit round a table with you and try and negotiate a deal? Because it would end up a shouting match. So if I don't respect you I'm going to find it very difficult. I might not like what you do, but I understand you're doing something on behalf of your constituency. Whereas employers will see that I am doing something purely for my members. But if I don't like you and we've had bad feeling, bad blood, then it's more difficult for us to sit down and have genuine debate and attempt to resolve differences that I might be able to do with somebody else.” (Employee Director 1)*

*“Again I think that's another good thing about partnership working and how it's evolved because again our working relationships with staff side has allowed respect to build up on both sides, because they don't see all HR are the bad guys. Before they might have said HR management are the bad guys and we are the good guys. But I think we've had to earn respect from the staff side before they could work with us really. So that takes a while to build up these relationships.” (Management Representative 4)*

Another Agenda for Change Project Lead thought that making partnership work required a good relationship with the Unions. Because partnership working was for solving problems and making changes, having a good relationship allowed them to go to the Union Representatives and be honest to show them what the issues were. They were able to have joint discussion on the issues. This Project Lead gives examples of how relationships worked with the Managing Director and Employee Director.

*“I think you need a good relationship with staff side. You need to be able to go to staff side and say...and have a bit of a discussion. Now, that's where I...that's the relationship I've got with [first name]. I could pick the phone up to him and say what do you think about this, you know? And equally, I could pick the phone...I could have picked up the phone to [first name], before he retired, and said exactly the same question, what do you think about this?” (Project Lead 3)*

*“So I think it's...for me, being...using both sides equally, if I can describe it like that, being seen as approachable by both sides. So staff side can...so [CE]can pick the phone up to me and say I've heard about this, what is that, what does it mean, what do you know about it? Which he still does, you know. You know, he can ask me that type of thing. You know, have you heard anything about that, what is it, what's going on about that issue? You know, and having that discussion with him.” (Project Lead 3)*

## **Understanding Each Other**

Accepting each other's perspective and the ability to see both sides of an

argument is important for building up relationships between partners. To understand in appropriate situations it was vital to be able to comprehend the background to the views being expressed and to be prepared to work with them. However, there were times such as those described by the Project Lead below when these simply had to be taken on trust because the constraint was a financial one imposed by Government.

*“Everybody has their principles, and also to understand two sides of the debate. Whilst we have our staff that we want to look after, management have to work within quite clear policies, budgetary, financial constraints, and sometimes the financial constraints can go against the principles that we’re holding in terms of staff, but you’ve got to understand that because no matter what we do, if you’ve not got the money you can’t pay for something. So it’s about understanding the two sides of the debates, and the issues.” (Project Lead 2)*

A more concrete example is provided below by an Employee Director.

*“A concrete example, I respect that the Chief Executive has a legal requirement, he must keep within his budget. So the fact that I think that some people are badly paid, I have to respect he can’t just go into his back pocket and produce £2m and say, ‘give them that,’ because he is statutorily required to play by the rules. I also respect he’s the Chief Executive, I’m not. I’m the Employee Director, he’s not. So there’s understanding each other’s roles and responsibilities, and it’s about bringing added value..... You need to understand what the Health Board there is for, people need to understand why they’re there. We often send people to do things without the knowledge to be able to go and do it. So I would be showing disrespect...” (Employee Director 2)*

However the Manager below while agreeing with the points above thought that there were different views but they had in fact, a shared goal which made the arrival at a unified decision easier.

*“I think a willingness to acknowledge that there will be different views, but that actually probably overall, we are trying to do the best we can in the circumstances for the staff that we are responsible for supporting and managing.” (Manager 4)*

Some of the participants, though accepting that working relationships required to be close and open, did note that it was impossible to ignore the particular staff group from which the view were coming. This meant that the participants in a particular decision making Forum had to have a breadth of understanding.

*“I think you can’t take the individual working relationships out of the equation, but it’s recognizing that people do have a contribution to make, we may not always see things exactly the same way, but having that breadth of view, and being able to understand and appreciate a whole range of different perspectives, I think, gives a richness and a diversity that we wouldn’t get if we didn’t have this kind of approach to partnership working.” (Manager 4)*

## **Trust**

Trust was perceived as another key factor which was seen to operate on a number of levels. For example, one Employee Director thought that within the Union movement trust existed between members and their representatives who worked hard to achieve the best outcome possible. However, this may be to ask a lot of ordinary Union members to accept that where decisions are being made in a non-confrontational manner with management that the optimum outcome can be achieved. This is a by-product of years of history where confrontation was thought to be the only way of interacting with management by Unions.

*“I think there are varied levels of trust. I think what partnership working should enable is the employees, workers to trust the reps to get involved and do the best for them. There’s an equal trust within even the trade Union cohort, the reps, that do they trust say those that are in positions, the Chairs and that, to do it? That doesn’t remove the need to still report back on what’s happening.” (Employee Director 4)*

The quotes below from two Managers underlined a shared view of how positive relationships were based on trust, respect and good communication despite people coming from different backgrounds with different but similar agendas being able to find a resolution together.

*“I guess any kind of positive relationship has to be based on mutual trust and respect, and a common understanding of the different but similar agendas and the different perspectives on that. I think if you don’t trust somebody, fundamentally, then it’s very difficult to have a positive relationship with them, so I think that is very important, and that trust takes time to build up. But certainly I think it is there.” (Manager 4)*

*“I think communication is a critical principal above all others, because people don’t understand what you’re doing and why you’re doing it. And if they don’t understand and appreciate the*

*difficulties that you face in providing a service and how to make it better then there'll never be acceptance, so communication is vital." (Manager 3)*

## **Summary**

In this chapter the findings have been presented in three sections. In section 1 there is an explanation of the participant's understanding of the Organisational Change which provided the context for introduction of partnership working and Agenda for Change in the NHS. This raised such items as the level of change over the years the resulting fear of change in the staff and the remaining need for management change. Then Section 2 elucidates the reasons which participants gave for the introduction of Agenda for Change and partnership working. It also clarified the role of the various teams involved in the implementation and what the expectations of staff were in relation to that change and the challenges of the implementation. Section 3 developed ideas of how intrinsic partnership working is to Agenda for Change and its implementation. It also gave an understanding of the characteristics of partnership working as well as the attributes which made it work and also an explanation of how this organisational change was achieved.

## **Chapter 5 Discussion**

### **Introduction**

In this chapter the material is presented in four main sections. The first discusses organisational change in the NHS. The second section is concerned with the introduction of Agenda for Change, including the needs, expectations as well as the challenges of implementation, and understanding the change model adopted. The third section deals with partnership working and its relationship to Agenda for Change. It explores partnership working in the past and current contexts, the concept of partnership working and the participants' perspective of the characteristics of it. The final section concerns the limitation of the design and conduct of the study.

### **Organisational Change in the NHS**

The perception of staff was that the NHS had experienced continual change over a long period of time. These changes have included alteration in service, organisation and structure some of which have resulted in improvement. Service changes can be small scale but occur on a continual basis, while structural and cultural changes are large scale which can take several years to establish.

The organisation was unstable for long periods of time where participants felt that they had always to be prepared for changed. The data confirms the frequency and rapid nature of organisational change and its resulting distress and anxiety particularly in relation to job security. It should be noted however, that the data also revealed that much of the anxiety was misplaced because even where hospital closed other posts were found or staff were retrained in a different role.

The changes in the NHS were mainly driven by two types of need; public and political. As the NHS is a public service it must provide the facilities which respond to the health requirements of the public. However, when such services are put in place there is a requirement to modify them so that they react to the changing health needs of the population. Of course, these health needs are not static and

the service must be able to respond quickly when a situation requires it and is offered to a total population. Such situations have arisen where there has been a rise of parents not immunising their children against chicken pox or where immigrants arrive in the country with a condition like TB which had been eradicated in the home population but now requires immunisations to be carried out on a much wider scale.

On the other hand, the changes which occur though driven by public policy result in the Government having monitored the NHS services then implement new policy or guidelines to address the needs. Government's policies have been proved to be the main drivers of both structural and cultural change. This has been achieved through the use of guidelines which have made for standardisation of policy and service across the country. It remains true that this highlights the fact that some policies have arisen from changes in the Government reflecting a particular political party's philosophical stance. One of the policies, which had a major impact arising from a Labour political stance, was the important requirement to work in partnership, which was then introduced specifically in the health service. Farnham *et al.* (2003) support the changes engendered by both Conservative and Labour Governments. Much of this work centred on the development of managerial elements within the health service to introduce a business culture. This was enunciated by a number of the participants who spoke of the need for the health service to be run 'more like a business'. These findings support similar findings from the DoH's (1999b) report which encouraged the implementation of "best practice" human resources and performance management (Mason *et al.*, 2004, p652).

In addition to this the findings also highlighted the realisation that there was a serious lack of management skills evident throughout the NHS. This was because a large number of staff had been promoted to managerial roles from previous roles in clinical practice without specific management training. They then faced challenges of managing major change and getting their staff to adopt such changes. Literature (Munro, 2002, Mason *et al.*, 2004; Young *et al.*, 2011) identifies the change of culture to the "best practice", but did not point out the needs of instigating a management culture to assist the implementation of these changes in the NHS. In fact, two DoH Guidelines (1999a, 2000) point out that

frontline employee should be actively involved in decision making. Yet there were no guidelines on how to develop the managers and prepare them for managing change. The current findings highlighted that several managers felt working in partnership with Unions was a way of training managers in how to manage change and so reduce employee resistance.

Current literature presents major shifting from planned change to emergent change in the NHS (Wilkin *et al.*, 2001, Senior, 2002, McWilliam and Ward-Griffin, 2006, Massey and Williams, 2006, Wallace and Schneller, 2008). The traditional planned change often needs managers to 'tell' learners to follow change required. It may end up with an employee stance that is widely renounced as unlikely to work. But emergent change, especially transformational change, can encourage employee participation (McWilliam and Ward-Griffin, 2006). Thus, the newly fashioned 'bottom-up' change approach becomes popular in the current literature (Ackerman Anderson and Anderson, 2001, McWilliam and Ward-Griffin, 2006). However, the universal perception of the participants was that, all of the changes within the NHS over the years has been strongly driven by the political agenda and therefore adopted a top-down approach. The Government with its new strategies for the NHS, decentralised to local NHS Boards the power to implement the new policy. These findings have proved the approach of decentralisation which was driven by the Westminster Government for the purpose of human capital (DoH, 1999a). Mason *et al.*, (2004) suggested that these guidelines have aimed to encourage local Health Boards to enhance public service quality through providing greater workforce flexibility and co-operation through creating high commitment employment relationships. As one of the biggest change in the NHS history, Agenda for Change was a pre-planned organisational development. In order to manage the change, the NHS had to carefully plan the whole change process. This assisted change implementation and reduced resistance with the managers needing to involve frontline staff in the change planning and design stage, this is where partnership working came into its own.

## **Agenda for Change- The Needs to Change**

As identified in the data the Whitley Council system was originally set up during the First World War as a way of dealing with pay and conditions for the Civil Service. The Council was set up in response to the introduction of the shop stewards movement and widespread protest action being taken in industry (Ewing, 1998). These were authorised to cover any issue which related to pay and conditions of service and to take matters through to arbitration if required (Scottish Executive, 2003). However, the Whitley system was never designed for the expansion and complexity experienced by the NHS. The method by which the system worked had remained essentially unaltered since its inception. It was not surprising that the participants reported that it had been criticised over the years because of its complexity, over centralisation and lack of flexibility (Scottish Executive, 2003).

Another motivation for implementing Agenda for Change was the dissatisfaction with pay and terms and conditions of various staff groupings. Indeed, one major stimulus in response to a group of speech therapist failing nationally to gain satisfaction with various layers of complaint ultimately took their case to the European Court of Human Rights and won (DoH 2004a; National Audit Office, 2009). In order to prevent further staff groups following suite the Government reviewed the whole system of pay and conditions which had been in place since 1948. This resulted in the drawing up of Agenda for Change (Scottish Government 1997, DoH, 2004a). The previous Whitley Council system was complex and inflexible with numerous job descriptions, working hours, benefits and allowances (National Audit Office, 2009). The participants spoke at length about this complexity and universally agreed that it was an unfair system which needed to be updated and that a new system was required to provide fairer pay and conditions.

Agenda for Change was a more transparent pay system (DoH, 2001), it was applied to all employees' jobs which were categorised in 9 bands. Not only was this about pay it also re-examined every job description which was matched with a new one at the appropriate level but also identified the skills and qualifications

which are required to fulfil it. This single system makes it more straight forward for staff and management to assign people to specific posts. It also gives employees opportunities to develop new skills and ultimately to extend roles and ensures a fairer pay and allows all employees to work under the same term and conditions. It avoids the previous pay barriers caused by gender or location. Interviewees did feel that Agenda for Change allowed new roles to be developed, which encouraged teamwork and motivation.

In addition, Agenda for Change has also been seen to benefit the organisation in terms of human capital needs. As Edwards *et al.*'s (2009) study suggests, Agenda for Change was expected to create new roles with extended responsibility and new ways of working. This research identifies that this involved the blurring of roles through development opportunities which enabled staff such as nurses to extend their practical skills so they could carry out clinical tasks which previously had been done by medics. Thus, an era of reducing budgets has led almost inevitably to fewer jobs being available. As the result, in theory, the organisation could make financial savings through the improved human resource capital.

## **Expectations of Agenda for Change**

However, Agenda for Change also faced and continues to experience challenges in its implementation and embedding. Despite the positive messages from promoting Agenda for Change there was resistance to the new system. This arose from at least some of the employees having unrealistic expectations of the rewards which it would bring. It was reported that a number of staff members wrongly assumed that the pay reward on the new grading system would come into immediate effect. This expectation is also raised in the literature (Buchan and Evans, 2007), that Agenda for Change was expected by some to offer better pay and implementation benefits. However, participants pointed out that Agenda for Change was never designed to provide an increase in pay. It was purely a re-grading process to solve problems caused by the existing Whitley Council Scale. This was why some employees felt disappointed about the Agenda for Change outcome as it did not meet their expectation. Thus, there were “winners and

Losers” through Agenda for Change (May *et al.*, 2006, Buchan and Evans, 2007, Edwards *et al.*, 2009). This research confirms the same outcome, in the event there were “winners and losers” where some groups gained immediate improvement their pay while others lost out or had to adapt to longer hours and other work conditions. This provoked challenges for some managers having to address these difficulties.

## **Challenges of Implementing Agenda for Change**

Some of the literature (Buchan and Evans, 2007, Edward *et al.*, 2009, National Audit Office, 2009) argues that the implementation of Agenda for Change was time-consuming and costly. These challenges were also identified and confirmed in this research. There are large number of staff employed in the NHS and all their jobs have to be reassessed and reassigned to a new scale. It was a large amount of work to assign, move and provide opportunity for appeal to all these employees. Meantime, the central government had placed very tight deadlines for the completion of this process, which was considered optimistic by local managers and the participants on this study. The implementation teams had to drive the progress of this process rapidly. Another element of difficulty for staff members was providing a service whilst releasing people to work in partnership on Agenda for Change implementation teams. Managers had to find additional funding to cover this cost. Although the participants did not identify the specific financial figure of this implementation, they did raise concerns about the cost.

## **Agenda for Change as an Organisational Development Process**

Agenda for Change was a pre-planned organisational level change which was designed for five years before it officially started at national level. In line with the theory of organisational development as defined by Beckhard (1969) the change was considered and managed from the top through planned interventions in the organisation’s processes. Although Unions were involved in designing Agenda for Change the initial concept and direction of that change was driven by the NHS

and Government. The overall aim of undertaking change was to improve organisational performance and individual's behaviour. This clearly shows that Agenda for Change was a managerially driven top-down change approach.

In terms of the fundamental aim of change, the implementation of Agenda for Change was to create equity and fairness in employees pay conditions and development. However, it is suggested from this research that the hidden aim underpinning this change was much more complex - to create a system which allowed employees to work more efficiently in flexible posts. Thus, although there was not official evaluation on the Agenda for Change impact at the time of research data was collected for this study, the findings suggest that the strategic aim of Agenda for Change was to improve organisational performance, create a patient focus culture, and improve the individual employee's behaviour of working. The aim of this change is therefore beyond simply planned change.

As discussed in chapter 2, the result of organisational development is to improve organisational performance, culture, and behaviour, and the method of doing so is to involve individuals in the organisation to change its behaviour (French and Bell, 1999, Burnes, 2004, Senior and Fleming, 2006). This characteristic has mirrored in the current research findings demonstrating that Agenda for Change required that individuals contributed to the long-term aim of changing organisational performance, culture, and behaviour.

Another characteristic of Agenda for Change was the establishment of change agents. This role was mentioned by Beckhard (1969) as behavioural-scientist consultants and also by French and Bell (1999) as change agents. Change agents in this research were clearly identified by participants as being in lead positions. The Agenda for Change Project Leads were internal change agents. They played an important role in the Agenda for Change team on all respects.

In contrast to the traditional planned change models, organisational development is funded by humanistic value, and proclaims the importance of the individual, for example to see all members having potential for development. This type of collaborative relationship can be developed around democratic values, where change agents are seen as consultants working in conjunction with organisation members to jointly identify and take action on problems, rather than simply act in

the roles of practitioners as in the action research or three-step model (French and Bell, 1999). In the current research, although the Agenda for Change Project Leads did not make direct decisions on change, they acted as consultants to influence and monitor implementation. As described by French and Bell (1999), Burnes (2004), and Senior and Fleming (2006) the co-learners and collaborators relationship was established between the Agenda for Change Project Leads and other partners. Change agents worked with other members in order to discover what needed to be changed and how to change it.

In terms of involving individual employees, Agenda for Change was completed in partnership working between the NHS employers and Unions who represent the NHS employees. Findings from Chapter 4 illustrated how Unions were involved in the whole change process, including change design, piloting, implementing and evaluation. Although Agenda for Change was a top-down change model, all individual employees who were represented by their Union were involved in the change, including determining change needs, devising the change processes and implementing and job matching. This high degree of employee involvement became a distinguishing difference between organisation development and other bureaucratic and coercive approaches to change, which only involve members in simply communication and information gathering (Burnes, 2004). Agenda for Change was a collaborative and participative model which allowed individuals to be involved in decision making, analysing, and evaluation.

## **Partnership Working in Different Contexts**

It has been noted that although partnership working existed before Agenda for Change the participants were keen to underline that Scotland has always been a step ahead of the rest of the nations in partnership working in clinical settings (Buchan and Evans, 2007, Osborne *et al.*, 2004; Fenwick *et al.*, 2012;). However, Agenda for Change provided a completely new setting for partnership working where management and Unions sat together and planned and reached joint decisions instead of being adversaries in the field of pay, terms and conditions. There is also evidence in the current data which highlights that the relationship

between management and the Unions before Agenda for Change was not as strong as it was subsequently.

Unions used to represent employees in the old working context. They were often seen as the opposition party who worked against the management (Boxall and Haynes, 1997, Cully *et al.*, 1998, Payne, 1998, Bacon and Storey, 2000, Miller and Ahmad, 2000). Research findings recognised that different interests did exist between management (capital) and employee (labour). Because the management wanted to maintain their power, they had to ensure a consequence of that power is likely to be some redistribution of surplus value. In order to do this, management uses Unions as employee representatives to encourage employee participation, which is acknowledged as a pluralist perspective (Guest and Peccei, 2001). Meantime management also provided a legislative framework and agreement, which restricted the power of labour. So this approach was from the management's perspective one that directly pursued participation (Guest and Peccei, 2001).

However in the new context, the NHS had to establish a formal joint governance system with management and the Unions working collaboratively. The Unions' role in organisational change was altered from negotiation to joint working. The current findings support the theory of the Labour Government encouraging a hybrid approach, where Unions have more influence in organisational change in terms of decision making and facilitation. Current findings also supported the view that Unions were partners with management in designing the core principles of Agenda for Change to promote change needs, and to communicate to employees and so implement it. By bringing Unions to the joint governance system, the NHS had established a hybrid approach which allowed long-term employee involvement (Guest and Peccei, 2001).

As discussed above, the differences on partnership working approaches between the past and current context can cause alterations in organisational behaviour, such as employee ownership, communication, managerial style, organisational policies, and relationships between management and Unions. As a result, these differences may lead to the modifications in organisational change. Previous

characteristics promoted top-down organisational structure. This could be considered to be used in the context of planned change or Kaizen, where change is managed in a hierarchical structure. The shift from a pluralist approach to a hybrid one increases Unions' involvement through the change. Management now jointly accomplish change with Unions, who represent the interest of employees. Instead of letting managers demand change, unions contribute in partnership in terms of to communicate with employees on the change needs, change plans, and their implementation. In return, employees therefore have influence and input on planning and implementation. It creates ownership and long-term employee involvement (French and Bell, 1999, Guest and Peccei, 2001, Burnes, 2004). These characteristics of organisational culture and relationship assist organisational development models such as Agenda for Change where individuals are involved in making long-term organisational transformation (French and Bell, 1999; Burnes, 2004; Senior and Fleming, 2006).

The current research findings confirm that there are now differences in terms of communication between management and Unions. This shows there have been changes in previous and current communication systems and organisational structure. Previous partnership working was based on different interests existing between management and employees. Partnership was fractured and inconsistent. While, in the current context, management and Unions have developed consistent communication. They don't need to have pre-meetings before attending Partnership Forums as issues are jointly raised and discussed at meetings. Moreover, current findings reveal that at the beginning the two parties felt that having joint meetings was difficult, yet, in this new context there are formal Partnership Forums and Committees where partners have regular consultations. As a result, of this the organisation has created an openness in communication.

The current approach of partnership working has assisted organisational development by empowering employees to create openness in communication, facilitate ownership of the change process and its outcomes, and promote a collaborative culture with continuous learning (Burnes, 2004). By reflecting on the characteristics partnership working in the current context is a better approach to

implement Agenda for Change and achieving long-term organisational development and cultural change. Agenda for Change was one of the biggest and most complex changes in NHS history, partnership working was fundamental to its success.

Current research findings presented three key constituents of partnership working that facilitated Agenda for Change. These key constituents are: partnership working principles of joint working, a suitable top-down approach, and enablers of partnership working. These will be discussed below.

## **Partnership Working Structure**

Partnership working literature (Stoker, 1997, Sullian and Skelcher, 2002, Johnson and Osborne, 2010, Barnes *et al.*, 2007, Bovaird, 2007, Osborne *et al.*, 2010, Skelcher and Torfine, 2010, Fenwick *et al.*, 2012, Lloyd, 2014) suggests that, although the public service delivery involves the Government, Local Authorities, and citizens, partnership working is encouraged at Local Authority level. Citizens are enabled to give consent to and pass judgment on the exercise of authority by that Government's entity. Thus, partnership working exist at local level, and between local authorities and citizens. However, Stuart and Martinez-Lucio (2000) and Farnham *et al.*, (2003) suggest that Labour-Management partnership working should exists at different levels. Farnham *et al.*, (2003) recommend the national level and local level, while Stuart and Martinez-Lucio (2000) identify strategic level, functional level, and workplace level. All this literature shows that there is a hierarchy of working in partnership. However, the exact working structure is not consistent. The current research identified that partnership working existed on three levels. This is seen in the figure below which illustrates the National level, with the strategic role of Agenda for Change planning, the local NHS Board Level, with the functional role of local Agenda for Change decision making and implementation and the Workplace level with the role of job matching.

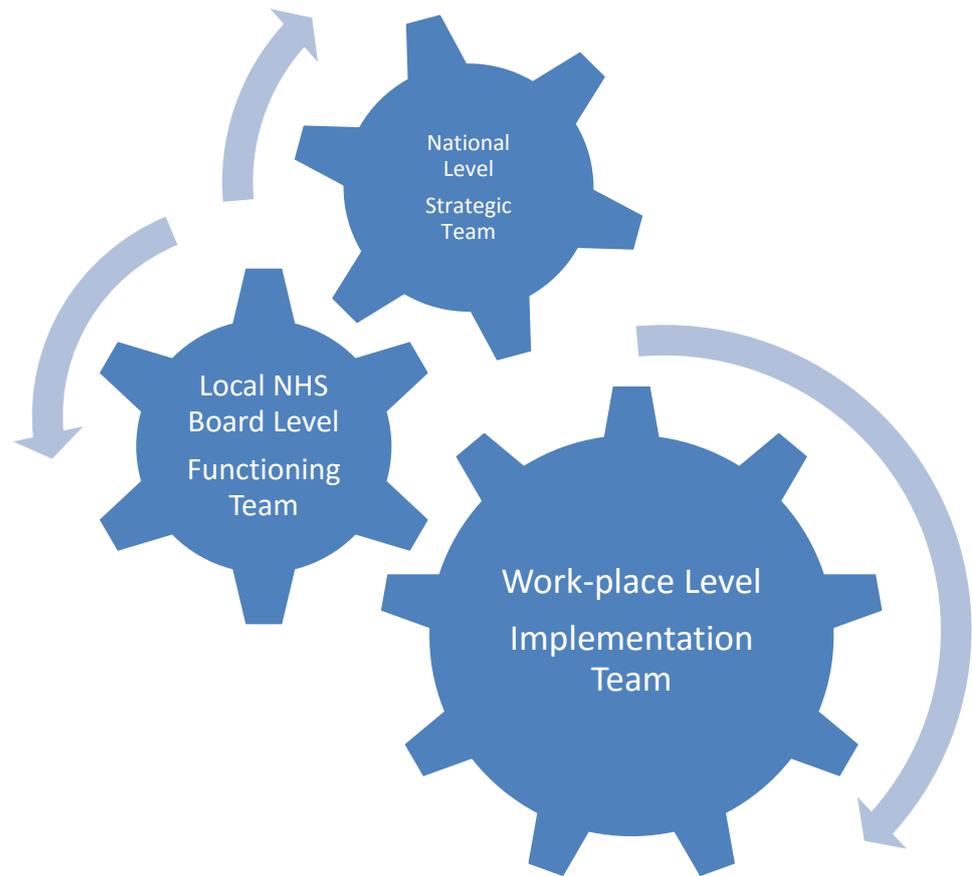


Figure 15: The Three levels of Partnership Working in Agenda for Change

Figure 15 depicts the direction of the slowly moving wheels represent hierarchy within the organisation, demonstrating the nature of a mutual gain approach, changes are implemented in a top-down direction where new services are introduced as partnership is arranged (Mason *et al.*, 2004). Agenda for Change was planned at national level. These changes were passed to Regional NHS Boards. At the regional level, local Agenda for Change teams were responsible for its functioning within their region. The bottom cog represents the implementation, Job Matching Panels which completed the day-to-day task of matching individual employee's job to the new pay bands. Although the new public sector governance allows partnership activities at local level, policies were driven straight from central government to local actors (Stoker, 1997, Sullivan and Skelcher, 2002, Johnson and Osborne, 2003, Barnes *et al.*, 2007, Bovaird, 2007, Osborne *et al.*, 2010, Skelcher and Torfine, 2010, Fenwick *et al.*, 2012, Lloyd, 2014). However, the current research suggests that, there was an extra layer of partnership at the national level. When change needs were recognised by

Government and the NHS, decisions were made jointly by both sides at the national level. They played a strategic role in designing change. It did not disturb local partnership activities.

However, being different from Stuart and Martinez-Lucio's (2000) study, the current work illustrated that there was little partnership working involved in job matching. The partnership working relationship appeared to be stronger at the higher level compared with the lower one. For example, each job matching panel was made up of two management and two employee representatives. This working approach was set out in the Partnership Agreement at the beginning. Although the panels were a combination of both parties, they did not have the opportunity to work jointly on individual cases. There was 'teamwork' and 'climate of co-operation and trust' (Stuart and Martinez-Lucio 2000) identified in the research, but one of the most important partnership activities namely, 'problem solving' is not shown at this level. Chapter 4 presented quotes in which interviewees suggested that the relationship between management and union representatives were so good that they did not notice any differences between them. But this practice is not partnership working. It was only when problems occurred that panel members reported to the Agenda for Change Project Lead, who then discussed it at the higher level. If these issues were not solved at a functioning level, they were taken to the national level for discussion and decision.

## **Managerial Perspective**

Working in partnership can be an effective way to regulate work and the labour market (Johnstone *et al.*, 2004). The Health Service Report (Industrial Relations Services, 1998) suggests that, partnership allows employees to be involved in the drawing up and executing policies while managers retained their rights to manage. In association with the Government's policy of the NHS modernisation, managers use partnership working to restrict employees while achieving formal policy and procedural change (Tailby *et al.*, 2004). This research identified that partnership working is a managerial method of carrying out change. Participants confirmed that the aim of partnership was to achieve change and manage people through that change. By bringing unions into the partnership team management

had union support to promote change thus minimising change resistance. This is the hidden aim of partnership working which given the history of industrial relations and the culture of management in the NHS was necessary. Partnership working is a training process for new managers who did not have managerial knowledge, to manage their departments better. In order to encourage Unions to join partnership, the management have to enable mutual-gain for both parties. However, managers need to be able to balance keeping control of change and working jointly with Unions on decisions.

At this point, the findings present two questions for consideration:

- 1) Do employees benefit from working in partnership (Kochan and Osterman, 1994, Boxall and Haynes, 1997, Acker and Payne, 1998, Knell, 1999; TUC, 1999; Guest and Peccei, 2001) or are unions negatively impacted by working in partnership (Taylor and Ramsay, 1998, Oxenbridge and Brown, 2002, Tailby *et al.*, 2004)? And
- 2) Is partnership working a democratic approach (Hughes and Carmichael, 1998, Miller and Ahmad 2000) or is it a hierarchical one (Jessop, 1999, 2003, 2004, Stoker, 2004, Whitehead, 2007, Fenwick *et al.*, 2012)?

This research shows partnership working enabled Unions and Managers to be involved in discussions from planning through to implementation of the whole change process. This has resulted in Unions being involved in the agreements arising from decision making to the implementation of that change which means that the voice of the workers is clearly represented. Findings identify that the outcome of partnership working was positive from the Unions' perspective. It allowed them to be involved in the discussion and decision making but is also gave them the opportunity to have a unified and more realistic understanding of not just their own but also the Managers' point of view. This meant that the people involved in such decision making had a much wider understanding of the range of issues within the NHS resulting in an openness in how decisions were made within the organisation.

However, this research also recognised that partnership working had a managerial perspective of managing change. In line with the notion of

transformational change and involving front line staff in the change process the literature suggests that managers in the NHS needed to learn a new way of managing change, to reduce conflict by inviting Unions to participate in the implementation. (Davies *et al.*, 2000, Wilkin *et al.*, 2001, McWilliam and War-Griffin, 2006, Massey and Williams, 2006, Esain *et al.*, 2008, Wallace and Schneller, 2008). Thus, working in partnership does not mean the management lose the power of making decision but rather partnership working has been seen as a top-down management method of making changes. Current literature (Jessop, 1999, 2004; Stoker, 2004; Whitehead, 2007; Fenwick *et al.*, 2012) argues that the partnership hierarchy is from Central Government to Local Authorities. However, it can be argued from the current findings that partnership working from a managerial perspective is where middle and workplace managers have to follow the instructions of Chief Executives. On the other hand the Chief Executive is in fact employed to make decisions and to set agendas for change which may be in response to Government Policy which is also handed down. Thus, partnership working can be understand as a managerial method to implementing change, where decisions and control are made through a hierarchical design.

## **The Approach of Partnership Working**

### **Mutual Gain**

It has been suggested that partnership working in the NHS is the cooperation between unions and management using a 'mutual gain' approach (Kochan and Osterman, 1994, Stuart and Lucio, 2000, Bacon and Samuel, 2012, Kinge, 2014). This has been supported by the current research findings, the NHS invited the unions into a joint-working relationship. So instead of dealing with staff directly, managers now work with unions on workplace issues. Unions then communicate results with their members.

Kinge (2014) suggest that mutual gain allows both management and unions to benefit from partnership working.

1. There is a formal joint governance system (Agenda for Change Implementation Team), in where the management and Unions are two main partners and both have power to jointly decide and implement change. There is an official partnership working agreement identifying roles and responsibilities of each partner. This is a formalised representative arrangement to sustain the Partnership process and to prevent exploitation by management (Guest and Peccei, 2001).
  
2. The representative system of unions being in the middle between the management and employees establishes communication in the organisational hierarchy. By working in partnership, unions have become stronger in terms of interacting at the level of NHS governance. Unions now have an extended involvement, a legitimate and expended role. Unions and employees are now in a better position of job security, training, and quality of jobs. This is a modern approach of unionism, which has been highlighted in the literature (Kochan and Osterman, 1994, Knell, 1999, Trade Union Congress, 1999, Guest and Peccei, 2001).
  
3. Management and unions' partnership working has a long-term benefit on employee involvement and is an effective human resource practice. As stated in the Agenda for Change Agreement (DoH, 2004a), all decisions and implementation were done jointly between the management and unions. Meanwhile, management has also benefited by having support for management changes. Once Agenda for Change was agreed, unions played an important role in supporting the management by undertaking road shows, setting up the Agenda for Change webpages on unions' websites, and explaining the needs in implementing this change. The end result of the management-union approach was to develop a healthy industrial relationship with less conflict and better employee training and development, communication and ownership in NHS (Knell, 1999, Guest and Peccei, 2001).

However, it is important to acknowledge that although this research identified that partnership working is perceived to be a mutual gain (hybrid) model, there is also evidence that the shadow of pluralism continued to exist, in two ways

1. Government's policies and regulation were distinguished by the impact of a pluralist approach (Guest and Peccei, 2001). In the context of Agenda for Change, the Scottish Government had strongly influenced it. The Government was not directly involved in the governance system (Agenda for Change Team), but its influence is demonstrated in the way it set up the Partnership Agreement, monitoring implementation process, and the setting of targets for the team.
2. Some managers still believe in management controlling decision making. Quotes such as "the art of management" do suggest the distinguishing power differences between capital and labour.

## **Enablers and Barriers of Partnership Working**

So far, the discussion has addressed the partnership working theoretically in a practice context. Here, the researcher focuses specifically on enablers and barriers to partnership working. The literature identified several key factors of partnership working, including trust, honesty, openness, common understanding, partnership structure, and partnership forums (Osborne *et al.*, 2004,, Skelcher and Torfing, 2010, Young *et al.*, 2011, Bacon and Samuel. 2012). These key factors are components of theoretical models of partnership working. The participants of this current study suggested key factors which they considered important. These included respect, building relationships, communication, trust, sharing information, engaging, and Partnership Forums. These are practical characteristics in the context of NHS.

For example, respecting other partners was not a distinguish factor shown from previous literature. Yet, in the current study having regard for other partners, their issues and interests were considered of great importance. Johnstone *et al.* (2004) has acknowledged the different interests of workers, and encouraging the

representation of these different interests. This study identified employees having different interests to management, as well as the role of unions in representing workforce interests. However, this view was presented as a theoretical opinion of partnership working principles. The practical perspective was not extended in terms of how this is linked to human behavioural science. But this research did recognise that partners have to acknowledge and respect other partner's opinions. Respecting is a general term and to be able to show respect needs individual partners to value others for who and what they are. In addition, all partners have to be honest with each other to be able to show their respect.

Trust was shown as a theme in the research findings. It existed between the Agenda for Change team members as well as between the unions and their members. As suggested in the literature (Guest and Peccei, 2001), trust enables partnership working in terms of better communication between partners, respecting others and building up relationships. Both management and unions agreed partnership working facilitated the implementation of change (Guest and Peccei, 2001).

Partnership working was introduced across the UK but about the same time the Labour Government gave the Scottish people the opportunity to vote to set up a devolved Government centred in Edinburgh. This resulted in the Health Service becoming the responsibility of the Scottish Government whilst being funded by Westminster. Because of the special context of Scottish devolution, partnership working in Scotland is seen to be different to the rest of the UK. (Buchan and Evans, 2007, Osborne *et al.*, 2004, Fenwick *et al.*, 2012). There had been a history of co-operative relationship between management and unions at senior levels in Scotland before Agenda for Change. Thus partnership working can be more positive under informal rather than formal arrangements. (Dietz, 2004; Oxenbridge and Brown, 2004, Samuel, 2007). Thus, although Partnership agreement was recognised as an important factor in the literature (Oxenbridge and Brown, 2002, Martin *et al.*, 2003), it was not a key factor to the implementation of Agenda for Change in Scotland. As Scotland had a small population both sides felt they had previous experience of working with each other, as well as having good personal relationships based on trust. Working in

Partnership became something they adopted automatically. However, a Partnership Agreement was necessary at the beginning of the Agenda for Change process, which identified the roles and responsibilities of each of the partners which both management and unions were happy to accept. The Agenda for Change Implementation Team members did not need the agreement to remind them. However, they did accept that this agreement did promote partnership at the beginning. During the change process, how partnership was adopted depended on the existing trust, communication, and good personal relationship that existed rather than the Partnership Agreement *per se*.

Partnership Forums have been raised as a factor to impact good communication. As Osborne *et al.* (2010) suggested, proper partnership structure with regular forums are an essential mediating factor to communicate local issues, especially for rural areas. However, this can also be a challenge in terms of time and cost.

Figure 16 highlights the factors of partnership working which should not be studied as sole individual aspects rather as the diagram shows they are related to and impact on each other. For example, mutual respect based equity should make trust easier; while trust is mediated by the characteristics of environment and the respective power of the parties (Guest and Peccei, 2001). The research findings also showed the dynamic of different characteristics of partnership working. While respecting other partners and requiring them to be open and honest, they also needed to understand each other. This needed to be done through good communication, which allowed partners to engage with issues, through mature discussion, and share truthful information. On the other hand, communication needed to be assisted by having suitable partnership working forums, where partners could have the opportunity to discuss issues. As a result, this built good working relationships and trust between partners, which led to better communication and understanding. The dynamic of partnership characteristics working can be seen in Figure 16.

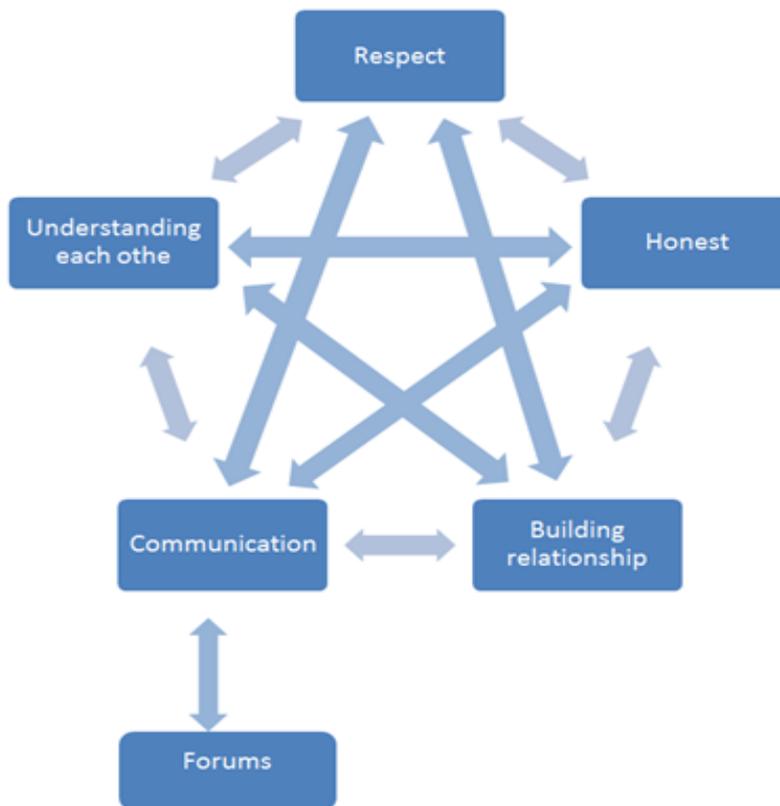


Figure 16: Dynamics of Partnership Working in the context of Agenda for Change

## Challenges to Partnership Working

Within the literature (Guest and Peccei 1994, Kelly, 1998, Mason *et al.*, 2004) concerns have been raised on the financial pressure and employee shortage resulting from partnership working. In order to meet the performance targets, management attempted to focus on completing targets on time, rather than working as a true partnership. These challenges were also evident in this research. In order to manage implementation of Agenda for Change great emphasis was placed on the value of partnership working. This required both management and employee representatives carrying out the task of job matching.

The commitment to partnership working also demanded that both managers and unions worked together to reach agreement about all the decisions being made. This approach prompted some disapproval from managers who felt that

partnership working was been taken too far and was stopping them managing. It is interesting to note that a system deliberately put in place to develop management was in fact perceived by some as a hindrance to making quick decisions to resolve problems. This finding supports similar results in the Labour Research Department's (1998) study which reported little evidence that Partnership Agreements were fully supported by managers at workplace level. However, as well as that the partnership working was seen by participants as the means of developing stronger working relationships.

This research also had similar findings to Kelly's (1998) and Buchan and Evans (2007) studies. Participants agreed that there had been a large amount of preparation and negotiation between the NHS employers and unions before implementing Agenda for Change. However, during the implementation process, especially at the later stages they were under great pressure from the Scottish Government to complete on a tight time scale. In order to use the available resource, they had to reduce the size of the panels and create more panels. Although findings did not suggest partnership working was weakened by doing so, it showed the management's attempt to exploit partnership at workplace level to meet performance targets (Kelly, 1998). Thus, resource issues and pressure from the strategic level did challenge partnership working, and impact the effect of working in partnership. Finally, it is necessary to acknowledge that, although the National Audit Office (2009) suggested Agenda for Change was costly, findings did not show concerns over the financial cost. However, this did not mean Agenda for Change was not costly. It only suggested that Agenda for Change implementation teams did not themselves directly face financial challenges although the Boards did. Evaluations of the actual cost was not mentioned from data.

## Generalisation of Findings

<b>Partnership working approach</b>
<ul style="list-style-type: none"> <li>• Union and management working together for mutual gain (Bargaining and pre-meetings versus collaboration and joint decision making)</li> <li>• Proper 3-level structure -Strategic, functioning and implementation.</li> <li>• Top down political impact</li> <li>• Previous experience and relationships</li> </ul>
<b>Partnership working outcomes</b>
<ul style="list-style-type: none"> <li>• Unions working as a collective moving from Individualistic culture to a collective one</li> <li>• Union and Management jointly planning changes moving from pre-meetings to joint decision making</li> <li>• Common agenda</li> <li>• Better work environment with less conflict</li> <li>• Transparency rather than concealment</li> </ul>
<b>Partnership working enablers</b>
<ul style="list-style-type: none"> <li>• Proper partnership working approach</li> <li>• Respect and honesty in engagement</li> <li>• Building relationship with open communication.</li> <li>• Understanding each other's perspective</li> <li>• Trust</li> </ul>
<b>Partnership working barriers</b>
<ul style="list-style-type: none"> <li>• Fear of change</li> <li>• Resources of staff and finance</li> </ul>
<b>Agenda for Change</b>
<ul style="list-style-type: none"> <li>• Political influence with top down and national decision making</li> <li>• Wrong expectations leading to winner and losers</li> <li>• Transforming the NHS from unfair to fairer pay system</li> <li>• Moving from a complex fixed job system to a single system with flexible job opportunities.</li> </ul>
<b>Organisational change</b>
<ul style="list-style-type: none"> <li>• Constant change of a turbulent nature</li> <li>• Improved service</li> <li>• Fear of change</li> </ul>

Figure 17: Key Findings for Generalizing Research Findings Model

The previous section discussed key findings in relation to the current literature related to partnership working and organisational change theories in the case of Agenda for Change. In Figure 17 above the key findings which together form the basis of the contribution of this thesis to knowledge and ultimately the development of the conceptual model which follows are summarised. It is compiled of six boxes entitled partnership working approach, partnership working outcomes, partnership working enablers, partnership working barriers, Agenda for Change and organisational change. Each box contains the various aspects explaining the six key categories.

## **Development of a Conceptual Model**

The logical structure used to describe the main findings within the various categories identified above from the literature and data analysis provides the starting point for the development of a conceptual model that indicates how the three key outcomes interrelate and combine to form the dynamics of partnership working and Agenda for Change. For clarity, the outcomes relating to partnership working dynamics are represented in blue, those relating to people's views of Agenda for Change are in green. The third group describes the context of organisational change which happened in the NHS in Scotland and appears in red. Research findings have suggested that partnership working has made changes to the industrial relations in the NHS in Scotland. There were conflicts and bargaining between unions and management prior to the implementation of Agenda for Change. Each union acted as an individual unit rather than a collective one and this is depicted in the diagram as the small grey arrow on the left hand side. However, by working in partnership industrial relationships have been transformed to be more effective and efficient. Unions and management are now able to make joint decisions resulting in a fairer and simple pay structure within the NHS. All unions now act as a collective and this has resulted in a better working environment which is depicted in the large blue arrow on the right hand side of the diagram. The organisational change, which is the context of this study is shown by the red arrow on the periphery representing movement from left to right with the left end sitting beside the 'before' partnership working the service

requiring to be improved and individual culture and the right end sits beside the 'now' where services have been improved and the organisation working more as a collective. The circle is completed by the green arrow which also works from right to left representing the implementation of Agenda for Change which moves from 'before' (small grey arrow) a system being unfair and complex to one to the 'now' (the large blue arrow) which could be described as being fair and simple. The enablers (in blue) and barriers to partnership working (in grey) which exist at the same time are represented in the centre of the diagram with the partnership working depicted as a seesaw. As the enablers outnumber the barriers they tilt the seesaw towards the enablers, positive implementation and outcomes.

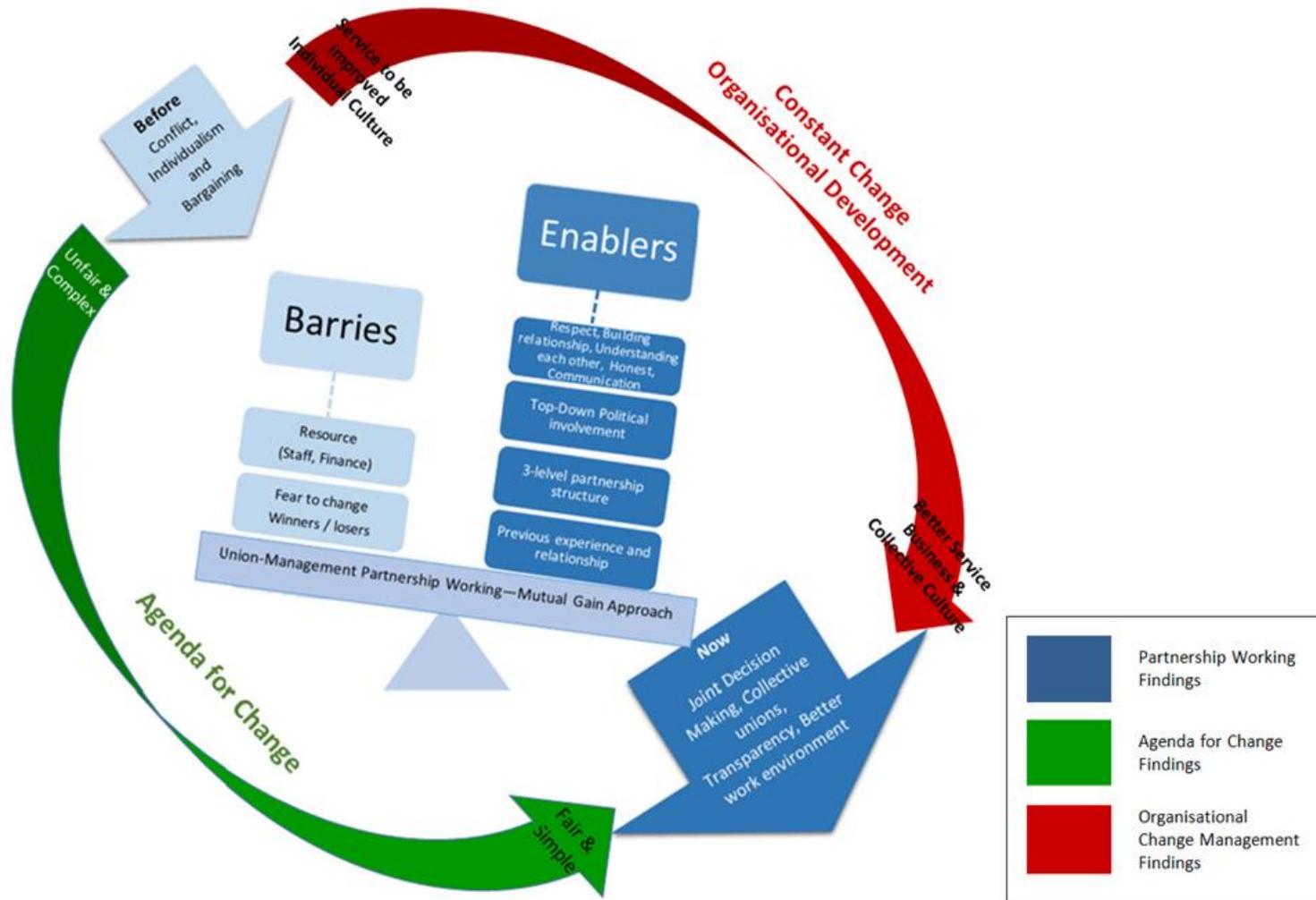


Figure 18 Conceptual model of overall research findings

## **Limitations and Suggestions for Future Research**

The qualitative nature of this research design implies that the report is a subjective view of a purposive sample of the participants. That said, the depth explanation would not have been forthcoming if the design had employed a more quantitative approach. The study does not add to the evaluation of Agenda for Change *per se* but it does highlight a number of key issues in more detail. The focus of the work was to examine in some detail the organisation change environment and how partnership working affected this. The contribution to knowledge here is related to the identification of the organisational change which facilitated the implementation of Agenda for Change and the part that partnership working played in this process. It is acknowledged that the participants were from a managerial or union level and that the voices of the recipients of the change were not heard in this instance although this is addressed in recommendations for future research.

From a personal perspective the experience of conducting this study was challenging because of my own experience was within the administration section of the NHS and trying to understand the roles of the various health care workers was difficult. In addition, understanding Scots speaking quickly and sometimes using jargon which was unknown to a Mandarin speaker was also a challenge. Transcription of the interviews provided some clarity but it took a very long time. In the event, I learned a great deal about the process of conducting qualitative research in relation to data collection, analysis and interpretation. It is acknowledged that another may interpret my data differently and the findings only provide a snapshot view. However, there is a sense in the findings of the depth of feeling and satisfaction that a very difficult extensive change was implemented which provided fairer conditions for the staff who work in the NHS.

## **Chapter 6 Conclusion**

This research thesis has explored the perceptions of different levels of Agenda for Change Implementation Teams in relation to organisational change and partnership working in three NHS Boards in Scotland. It focused on the concept of partnership working, while consider this concept in the context of organisational change and Agenda for Change. Thus, the research focused on three topics: organisational change, partnership working, and Agenda for Change.

### **Conclusion to Research Findings**

This research concluded that, the previous Whitley pay system was out of date and was complex to manage. Staff could not be flexible or moved around between job roles or departments. Moreover, a large equal pay claim on gender equality and working time equality left the NHS with vast bills. Since 1997, the NHS has gone through a process of transformation making it more accountable to the public and being more financially effective with the services it provides. This was primarily achieved through implementing public governance, partnership working and staff co-operation. Partnership was conducted between health organisations, the public, and more importantly, with the staff and unions within the NHS.

Agenda for Change achieved a radical change in the way in which pay and conditions for staff in the NHS were managed. This new programme was perceived, in the main, as a positive outcome in terms of fairer pay and conditions and it was easier to administer. Terms and conditions are now much simpler, clearer to understand and compare across standards.

However, this is not to deny that there were 'winners and losers'. Agenda for Change were welcomed by some people who benefited from fairer terms and conditions and easier administration, while some people were left disappointed at the level of their remuneration or working conditions. The disappointment resulted from unrealistic expectations of Agenda for Change. While the NHS promoted the view that Agenda for Change would provide better pay terms and conditions to staff, some of whom expected to get a pay rise. There is no doubt

that this expectation caused disappointment when the increase in pay was not forthcoming, however, it was fairer for whole groups.

Findings relating to the concept of organisational change related to the debate within the NHS about whether planned change or emergent change should be adopted for the purpose of partnership working. Although current literature pays great attention to the idea of shifting from planned to emergent change for the purpose of encouraging better employee participation (McWilliam and Ward-Griffin, 2006), this research shows evidence that for large scale structural and cultural change, planned change should be adopted as the way of organisational development. This type of change has to be planned at the beginning, where employees and unions, jointly make decisions. Current research findings reveal that Agenda for Change is in fact an organisational development type of planned change. Partnership working was fundamental to the development, implementation and embedding of Agenda for Change. In line with the partnership model MEL 59 (Scottish Executive, 1999) unions were involved in the decision making steps to formulate organisational change. And in fact, for a large scale radical change such as Agenda for Change, this needed to be planned and implement using a top-down approach.

Although literature such as McWilliam and Ward-Griffin (2006) suggests a bottom-up approach is the most suitable for employee involvement changes, this research shows that partnership working is still possible and effective using a planned change form of organisational development. This research identified that partnership working was adopted as a hierarchical structure which included national level (strategic team), Local Board level (functioning team), and work place level (implementation team). Partnership working was a top-down hierarchy working approach, where decisions were made at top level. The Executives still had control of making decisions, while unions were invited to contribute organisational change implementation.

Partnership working was done using a mutual gain approach between the management and unions. It has resulted in closer relationships between these two parties. By doing so, mutual gain was obtained. The success of this approach had a calming effect on the working environment in which health care was

provided. This inevitably impacted on patient care which was the key aim of the health service.

There were recognised characteristics which existed in partnership working groups within the context of Agenda for Change, such as respect, good communication and relationships, proper partnership structures and understanding of each other. The research findings shows the dynamic of different characteristics which were related to and impacted on each other. Thus, each individual characteristic can be used to build a broader picture of partnership working.

Given the background of political and policy devolution in Scotland research findings confirmed that partnership working with its longer history was more prepared to be implemented in Scotland than in the rest of the UK. It made working in partnership became a natural element at all levels which did not need to be enhanced. Partnership, especially at the national level and Board level, was even more developed and it enhanced trust, respect, understanding, and communication between the management and unions.

Participants viewed the outcomes of partnership working positively. However, there were some barriers such as the vast amount of time it took to implement and the time required to job match and more recently the time it took to deal with grading appeals and continual attendance at partnership meetings. There was transparency in the realities of the challenges being faced by the current NHS in terms of budget, quality of working conditions and the time required to maintain partnership working. It was also clear to some of the participants that there was a hidden agenda which ultimately will reveal further change in terms of the blurring of roles and the number of jobs available.

In conclusion, in the continuous change environment, Agenda for Change was a radical modification to the NHS. It was achieved by partnership working in a three-level hierarchy structure which obtained in the NHS. The positive outcome has overcome disappointment. Meanwhile, it should be pointed out that partnership working was a method to manage change, it had been built and developed through the implementation of Agenda for Change. It is now a culture and natural relationship in the organisation, and it will continue to function now that Agenda for Change has been embedded.

## Contributions to Knowledge

This contributes to current knowledge in terms of understanding the perceptions of Organisational Change and Agenda for Change and how partnership working interacted with both. The following contributions have been made:

Firstly, previous literature on the Agenda for Change was limited, among most of which focused on views from the NHS and employees (Pollard, 2003, Walmsley, 2003, DoH, 2004b, McMahon, 2005, May *et al.*, 2006, Ipsos MORI, 2006, National Audit Office, 2009, Chartered Society of Physiotherapy, 2009, McClimens *et al.*, 2010, Buchan and Bell, 2011). This research provides a picture of Agenda for Change from the perspective of people who were actively involved in that change, (Agenda for Change Implementation Teams). It tells the inside story of how this change was planned, implemented and experienced.

Secondly, in the debate of whether organisational change should be implemented using a top-down (Ferlie *et al.*, 1996, Garside, 1998, Hurley and Hult, 1998, Allen and Stevens, 2007) or a bottom-up approach (McWilliam and Ward-Griffin, 2006, Massey and Williams, 2006, Whittle and Hewison, 2007, Esain *et al.*, 2008, Gillies and Maliapen, 2008, Wallace and Schneller, 2008). In the context of the NHS, the literature debate suggests that partnership working employed a bottom-up transformational change. However the current research provides examples and descriptions of how partnership working was in fact achieved by a top-down approach. In addition, the findings suggest that employees can and must be involved in the change planning stage.

Thirdly, this research was able to provide a picture of the three levels of partnership hierarchy (national level, Board level, and workplace level). In addition to the current literature (Stoker, 1997, Skelcher, 2002, Johnson and Osborne, 2003, Barnes *et al.*, 2007, Bovaird, 2007, Osborne *et al.*, 2004, Skelcher and Torfine, 2010, Fenwick *et al.*, 2012) which argues that policies are driven from central to local government, this research suggests that, partnership working at national level is also important. When changes were identified as being necessary by government and the NHS, decisions were made jointly by both

sides at the national level. They played the strategic role on the design of those changes.

## **Suggestions for Future Research**

While this research focused on the perceptions of the Agenda for Change implementation teams in Scotland and now it would be useful to do a comparative study on the experiences of the Implementation Teams across the UK.

Future research could also consider investigating the impact on all levels of staff who have experienced the continuing impact of the implementation of Agenda for Change to investigate the expansion and blurring of roles

Agenda for Change was expected to have long-term benefits of providing higher quality care, however there is only limited evaluation of Agenda for Change (Buchan and Evans, 2007). Since this research has identified that Agenda for Change was designed to modernise the NHS, it would be valuable to extend this investigation and evaluate the impact of Agenda for Change on patient's care, such as length of waiting time, treatment experiences, service provided.

Finally, this research identified that Managers and Unions faced financial challenges arising from releasing staff to work in partnership. Future research could consider examining the cost of developing and implementing partnership working in the context of Agenda for Change.

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## Appendix 1 Email to the Gatekeeper to seek access to sites

**From:** Zhou, Ada

**Sent:** 02 November 2009 18:32

**To:** [REDACTED]

**Cc:** Zhou, Ada

**Subject:** AfC research from Edinburgh Napier University

Dear [REDACTED],

I'm a PhD student in Edinburgh Napier University. Me and my supervisor team are working on a research on the partnership working approach during the Agenda for Change process. The study is sponsored by the Edinburgh Napier University. It aims to explore the role of partnership working during the AfC programme. We are interested in collecting information on people's views and experience of working with other partners during the AfC project. In order to do this, we have to know that who are the persons or teams that working on the AfC.

I was advised by the SPRIG team that you are the Service Lead overseeing the AfC project. Thus I am writing to seek your advice, will you please help us to identify which teams have a role in the AfC and who are the best persons we should contact? This can be the information about the team's name, lead person's name, or their email address. Your advice will be very important to this study.

At the moment, our research team is focusing on the following four target groups.

1. The **Employer**. The employer is the NHS, and those board members/ directors/ senior managers can represent the employer. Will you please advice who are the persons from the NHS overseeing or responsible for the AfC ?

2. The **Facilitator**. This means the departments or teams that actually doing the change. We think SPRIG have a important role on the implementing. If I'm wrong, will you please advise me which is the team that implement the change? and who is the contact person?

3. The **Union**. Will you please advise us who are the union representatives overseeing the AfC?

4. The **Stakeholders**. This means that those departments have a role during the AfC process. I have found some teams from my research: Pay Modernisation Team, The NHS Staff Council, The NHS Review Body. Can you please advise me that if there are any teams you know that have a role during the AfC? such as pay negotiation, HR, Finance, Strategy, Planning...

I know this may look like a lot of information. So any kind of advice will be appreciated. If you feel you need to know more about our research, please do not hesitate to contact me. I would also be happy to meet you personally to discuss this.

Once again, your advice will be very important to this study, we really appreciate your help on this.

A big thank you in advance, and I'm looking forward to hearing from you.

Regards,

Ada Zhou

***Ada Zhou***

*PhD Research Student*

*School of Management and Law*

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*Edinburgh*

*EH14 1DJ*

*Tel: 0131 455 4371*

*Email: a.zhou@napier.ac.uk*

## Appendix 2 Information sheet

Dear.....

I would really appreciate your participation in a study which aims to explore the roles of partnership working during the “Agenda for Change” programme. This is a PhD study sponsored by the Edinburgh Napier University Business School. I am interested in collecting information on your views and experience of working with other partners during “Agenda for Change” programme. Your views and experience are genuinely considered important in this study and I do not aim to judge the perceptions and the views you hold.

The study involves collecting data by interview and would take about 60 minutes of your time. For this purpose I would ask you participate in an interview at a time and place convenient for you. To aid me in the analysis of information collected I would like to tape record the interview. If you do not wish to be recorded, notes will be taken instead. Interview tapes or notes will be coded and individual participants will not be identified by name. My supervisors and me will be the only people with access to the information collected during the course of this study. To ensure continued confidentiality all tapes and transcripts will be secured in a locked filing cabinet throughout the study. To ensure anonymity, all tapes will be identified by a code known only to the researcher.

On conclusion of the study a PhD thesis will be written and submitted to Edinburgh Napier University. In the thesis no participant in the study will be identified by name or the specific location of the areas that the study took place.

If you agree to participate in the study you retain the right to withdraw from the study at any time. If you wish to ask any further questions about the study you may do so either from myself or my Director of Study Dr Lois Farquharson in School of Management and Law at Craiglockhart Campus of Edinburgh Napier University. My email is [a.zhou@napier.ac.uk](mailto:a.zhou@napier.ac.uk) , telephone number 0131 455 4371

Thank you in advance for your help.

Ada Jiami Zhou PhD Researcher

### Appendix 3 Participant Consent Form

**Project Title** Organisational change, Partnership Working and Agenda for Change in the Scottish NHS: A Phenomenological Study

**Investigator** Ada Jiami Zhou

**Phone** 0131 455 4371

The purpose of this research project is to explore the current factors influencing partnership working within a local NHS change environment. An interview will be conducted on one occasion and will last approximately one hour. During the interview questions will be asked regarding you perceptions of partnership working experience during the implementation of the “Agenda for Change” project. These tapes will not be shared with any other individual except my university supervisors, but the final thesis, containing anonymous quotations, will be available in the form of a university Doctoral thesis.

There may be no direct benefit to you as a participant of this study, but there may be positive impacts on the ability to reflect on your own practices towards partnership working.

THIS IS TO CERTIFY THAT I ..... (Print name) hereby agree to participate as a volunteer in the above named project.

I understand that there will be no health risks to me resulting from my participation in the research and hereby give my permission to be interviewed and for the interview to be tape recorded. I understand that, data will be stored at the completion of the research, the tapes will be erased. I understand that the information may be published, but my name will not be associated with the research understand that I am free not to answer specific questions during the interviews if I so choose. I also understand that I am free to withdraw my consent and terminate my participation at any time.

I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction.

Participant.....

Researcher.....

Adapted from Morse and Field (1996)

## Appendix 4 Ethical Approval Letter.

### South East Scotland Research Ethics Service

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148 Pleasance  
Edinburgh  
EH8 9RS  
Tel: 0131 536 9067  
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Name: Ada Zhou  
Address: Room 1/38  
School of Management and Law  
Edinburgh Napier  
University Business School  
Craiglockhart Campus  
Edinburgh  
EH14 1DJ

Date: 07/12/2009  
Your Ref:  
Our Ref: NR/0911AB10  
Enquiries to: Alex Bailey  
Extension:  
Direct Line: 0131 536 9050  
Email: alex.bailey@nhslothian.scot.nhs.uk

Dear Ada,

**Full title of project: Agenda for Change: Building Capacity through Partnership in NHS Scotland**

You have sought advice from the South East Scotland Research Ethics Service on the above project. This has been considered by the Scientific Officer and you are advised that, based on the submitted documentation (Summary of Doctorial Research for Interview, For Alex Bailey), it does not need NHS ethical review under the terms of the Governance Arrangements for Research Ethics Committees in the UK. The advice is based on the following:

- *The project is an opinion survey seeking the views of NHS staff on a service development*

If this project is being conducted within NHS Lothian you should inform the relevant local Quality Improvement Team(s).

This letter should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements. However, if you, your sponsor/funder or any NHS organisation feels that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further. Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS.

You should retain a copy of this letter with your project file as evidence that you have sought advice from the South East Scotland Research Ethics Service.

Yours sincerely,

Alex Bailey  
Scientific Officer  
South East Scotland Research Ethics Service

## Appendix 5 Developing Interview Questions from Literature

Question No.	Interview Questions	Subjects of Research Interests	Literature
Question 1	<p>First, can you describe your job? What is your role in the NHS (your organization)?</p> <p>How long have you been working for the NHS (in this role—if not NHS)? Do you work for the NHS or for any other organizations?</p>	N/A	N/A
Questions 2	<p>So during your time working in the NHS, what changes have you experienced?</p> <p>What kind of change have you experienced? (giving them examples if needed, e.g. cultural changes, services</p>	Organisational change in the NHS context	<p>Iles and Sutherland (2001), Greener (2004), McWilliam and Ward-Griffin (2006), Massey and Williams (2006), Whittle and Hewison (2007), Esain <i>et al.</i> (2008), Gillies and Maliapen (2008), Wallace and Schneller (2008)</p>

	changes, structure changes, IT changes, process changes...etc.)	Collaboration as managerial approach to change	Wilkin <i>et al.</i> (2001); Massey and Williams, (2006), McWilliam and Ward-Griffin, (2006), Wallace and Schneller, (2008)
Question 3	As you mentioned these changes, how about Agenda for Change? Can you tell me anything about it? What do you think the key principles of Agenda for Change are about? How do they affect your job (your organization)?	Agenda for Change definition and principles	DoH (2004a)
		Core Elements of Agenda for Change	DoH (2004a), DoH (2005), National Audit Office (2009)

		Implementation of Agenda for Change	Buchan and Evans (2007), DoH (2004a,b), House of Common. Public Account Committee (2008); Buchan and Evans (2007);
Question 4	Do you think Agenda for Change needed to be implemented? Why? Tell me more (examples)? --If they answered No, What was better before?	Needs of Agenda for Change	DoH (2004a), House of Commons. Public Account Committee (2008), National Audit Office (2009);
Question 5	What do you understand by partnership working? What role do you think that partnership working plays in Agenda for Change? Is it important? Why do you say it's important to your job (organization)?	Concept of partnership working	Lloyd (2014), Fenwick <i>et al.</i> (2012), Skelcher (2005), Skelcher and Torfing (2010), Brandsen and Pestoff (2006), Bovaird (2007), Kernaghan (2008, 2009), Johnstone <i>et al.</i> (2009), Bacon and Storey (2000), Dietz (2004)

Question 6	Now, can you give me more detail of partnership working? For example who are the partners? What is your role in partnership working? What departments do you work with? How does the relationship work? What is your experience in working with partners?	Mutual gains or uneven benefits to employers, unions, and employees	Johnstone <i>et al.</i> (2004), Kelly (2005), Oxenbridge and Brown (2004), Guest and Peccei (2001), Bacon and Samuel (2012), Stuart and Lucio (2000), Mason <i>et al.</i> , (2004)
		Trade union representative capacity outcome	Martinez-Lucio and Stuart (2002), Munro (2002)
		Positive outcomes of union-management relationship	Oxenbridge and Brown (2002), Bennett (2013);

Question 7	So what do you think are the key factors to make partnership working successful? For example somebody may think the agreement is important, and somebody think communication is important. What do you think is the most important factor? Why? Are there other factor can make successful partnership working? Why?	Factors of partnership working	Dietz (2004), Johnstone <i>et al.</i> , (2004), Heery (2002), Bach (2004), Tailby <i>et al.</i> (2004);
Question 8	Or is there any case makes you think that partnership working did not made the expected efforts? Have you seen any barriers to partnership working?	Negative impact of partnership working	Cully <i>et al.</i> (1998); Lucio and Stuart (2002), Johnstone <i>et al.</i> (2004), McMurray (2006)
		Negative impact on union's demonstrating	Tailby <i>et al.</i> (2004), Taylor and Ramsay (1998), Oxenbridge and Brown (2002)

Question 9	Did you get any training in partnership working in prepare for Agenda for Change?	Key actors of partnership working (training)	Farnham <i>et al.</i> (2003)
		Pre-existed working relationship	Bacon and Evans (2007)
Question 10	Is there anything else you want to add?	N/A	N/A

