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A new workforce in the making?

A case study of strategic human resource management in a whole-system change effort in healthcare

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Received 21 May 2009
Revised 20 October 2009
Accepted 21 October 2009

Abstract

Purpose – This paper seeks to describe the exploration of human resource issues in one large-scale program of innovation in healthcare. It is informed by established theories of management in the workplace and a multi-level model of diffusion of innovations.

Design/methodology/approach – A realist approach was used based on interviews, ethnographic observation and documentary analysis.

Findings – Five main approaches ("theories of change") were adopted to develop and support the workforce: recruiting staff with skills in service transformation; redesigning roles and creating new roles; enhancing workforce planning; linking staff development to service needs; creating opportunities for shared learning and knowledge exchange. Each had differing levels of success.

Practical implications – The paper includes HR implications for the modernisation of a complex service organisation.

Originality/value – This is the first time a realist evaluation of a complex health modernisation initiative has been undertaken.

Keywords Human resource management, Health services, Change management

Paper type Research paper

In carrying out the independent evaluation of the Modernisation Initiative, the authors received support and co-operation from a wide variety of sources, and many people generously gave their time to discuss ideas and experiences. The authors are grateful to the staff and service users involved in the program; stakeholders in the four Trusts; and Trustees and officers of the Charity and others who contributed to the Evaluation Advisory Group. They also thank Petra Boynton and Patricia Connell who were part of the original academic team undertaking the MI evaluation. In particular they would like to thank Fran Woodard for her help with the evaluation and valuable feedback on this paper. The Modernisation Initiative and the independent evaluation were funded by Guy's and St Thomas' Charity. The views expressed in this paper are those of the authors and do not necessarily reflect those of the MI staff, its partner Trusts, or the Charity.

Journal of Health Organization and Management
Vol. 25 No. 1, 2011
pp. 55-72
© Emerald Group Publishing Limited
1477-7266
DOI 10.1108/14777261111116824

Background

It is a truism in the management literature that organizations are built on human capital and that change depends on people (Gratton and Ghoshal, 2003; Handy, 1993). Within healthcare, both academics and policymakers have emphasized the importance of a skilled, knowledgeable and committed workforce for both the patient experience and health outcomes. In an upbeat book chapter "A new workforce in the making", Celia Davies suggests "ten high-impact human resource management [HRM] changes" (Davies, 2003). The Department of Health encourages managers to think proactively and systematically about "strategic HRM" – that is, about the recruitment, development, deployment, management and retention of staff (Department of Health, 2004a; Department of Health, 2005).

The upbeat tone of contemporary policy documents on developing the healthcare workforce contrasts with the literature on failed innovation projects in this field. Typically, an idea is mooted and a project begins with great excitement, but the hoped-for changes fail to materialize. Post-hoc rationalizations include "We just couldn't get the right staff"; "people in department X conspired to wreck the project"; or "clinicians did not engage" (Brown and Jones, 1998; Robson, 1995; Van de Ven *et al.*, 1999). All this begs the question of why 'people issues', which everyone agrees are important, are so ubiquitous and so hard to solve – and what might be done to optimize workforce performance in complex change efforts in healthcare.

The evidence linking strategic HRM practices and organizational performance in healthcare is well established. West *et al.* looked at staff appraisal, employee training and team working in acute hospitals in 61 English hospital trusts and showed a strong association between these practices and overall patient mortality, though the study was not designed to determine whether this association was direct and causal or linked to some unmeasured variable (West *et al.*, 2002). Bartram *et al.* in Australia explored the link between strategic HRM and outcomes in healthcare organizations and found some correlation between these as well as wide variability in the value placed on strategic HRM by managers (Bartram *et al.*, 2007). In only a few examples was HR performance data systematically collected and linked with organisational performance management processes. The authors suggest that the strategic HRM paradigm has been "lost in translation", particularly in large healthcare organizations, and consequently opportunities to understand and develop the link between HRM and improved organisational outcomes are likely to be missed.

Not everyone is positive about strategic HRM, however. Critics suggest that while HRM initiatives such as role redesign are typically presented as a way of lowering inter-professional barriers, improving productivity, getting the best out of staff and achieving patient-centred care (Davies, 2003; Stubbings and Scott, 2004), such practices are actually being used to reduce labour costs and substitute skilled professional work with input from protocol-driven "healthcare assistants" (Bach, 2004; Prowse and Prowse, 2008; Charles-Jones *et al.*, 2003).

This paper describes how we explored strategic HRM policies in one large-scale program of innovation and change in healthcare. Our fieldwork and analysis was informed by a number of different theoretical approaches, especially McGregor's widely-cited "Theory Y" – that most people at work, most of the time, are seeking to do a good job and it is often system-level constraints that stop them (McGregor, 1987). We also drew on whole-systems perspectives on organizational change – i.e.

that organizations can be thought of as living systems with parts that interact and evolve (Pratt *et al.*, 2005). Pratt *et al.* exhort change agents to pay particular attention to the relationships between the parts of the system – for example by developing partnerships and encouraging interprofessional dialogue. This draws (implicitly if not explicitly) on Checkland's notion of accommodation – where each partner understands where the others are coming from and commits to some degree of give and take – which is often a more realistic goal than agreement or consensus (Checkland and Holwell, 1998). Hutton *et al.* (2003) propose five "keys" for successful whole-systems change:

(1) leadership;

(2) public learning;

(3) accommodating diversity;

(4) meeting differently; and

(5) following through.

In addition, we used a multi-level model of diffusion of innovations in healthcare organizations developed previously by our group (Greenhalgh *et al.*, 2004). The key features of that model relating to workforce and human resource management can be summarized on four levels:

(1) *Individual.* Organizational actors vary in their capability, capacity and motivation, and in their interest in particular innovations.

(2) *Interpersonal.* The spread of an innovation within and between organizations requires communication and influence, which depends crucially on people such as opinion leaders (who may influence others either positively in favour of the innovation, or negatively against it); champions (people who back an idea, persuade others to take it up, and remove practical barriers); boundary spanners (people who work between organizations or groups to cross-fertilize tacit knowledge and best practice); and change agents (people with the personal qualities, practical skills and contacts to make change happen) (Rogers, 2005).

(3) *Organizational.* An organization's ability to capture and embed innovations depends on a number of properties, many of which are cultural (e.g. innovation is facilitated by a "risk-taking climate" – that is, one in which new projects are encouraged and failed ones seen as an opportunity for reflection and learning). It also depends on absorptive capacity – that is, the organization's overall stock of knowledge (both explicit and tacit) and the ease with which this knowledge circulates among its members and grows with time (Zahra and George, 2002). Promoting absorptive capacity is partly about organizing specific initiatives for knowledge-sharing (such as whole-team events) and partly about fostering a general climate of reflection and team learning.

(4) *External.* Organizations are constrained by such things as policies, legislation, the prevailing economic climate, and technological developments, and by "management fads and fashions" (i.e. by what other similar organizations, against whom they benchmark themselves, are doing).

Context and setting

In 2003, a charitable sponsor made £15 million ($22 million) available to health care providers in a deprived part of London for what became known as the Modernisation Initiative (MI). The program focused on two adjacent inner London boroughs, where healthcare services were provided by two acute teaching hospitals and two Primary Care Trusts (PCTs), responsible for general practice and other community based services such as family planning). Health care services were cash-constrained and of variable quality, with pockets of excellence coexisting with substandard practice.

Three different service areas – stroke, kidney and sexual health – were selected in a competitive bidding process to receive one-third of the total budget each for a program of "whole-scale transformation". The program was funded by the external grant but delivered largely by staff seconded from the local National Health Service (NHS), whose offices were located outside participating NHS Trusts. Hence the MI was both "internal" and "external" to the NHS service. Management and governance mechanisms were complex and are described in detail elsewhere (Greenhalgh *et al.*, 2008). The sponsor also funded an in-depth evaluation of the program (undertaken by our team), for which it stipulated that qualitative, formative and illuminative methods should be used.

The MI officially ran from January 2005 to April 2008. The sponsor's aim was that the generous funding should be used to make a "big difference" to local health services. Significant improvement was expected in terms of tangible change in the nature of services (e.g. new services, service options, processes or modes of delivery); the culture of services (in behaviour, relationships and balance of power between healthcare organizations, staff and patients); and the quality of care and service provision. These improvements were expected to extend across the whole care pathway; cover all relevant patient populations and risk groups; be sustained beyond the funding period; and generate lessons that could be applied elsewhere.

The MI included multiple work streams which merged and developed as the program unfolded and which were based on a number of different assumed mechanisms of change. There was a strong emphasis on creative problem-solving, "thinking outside the box", and developing new service models, as well as building new partnerships and networks across the health economy (e.g. with the voluntary and private sectors). Some initiatives emerging from this were highly successful and were sustained beyond the funding period; others failed to take off, did not last, or produced unanticipated consequences and were abandoned.

It was clear from the outset that both across the MI as a whole, and within every work stream and sub-project, the issue of strategic HRM loomed large. New roles were created; existing roles were enhanced or changed; and there was major investment in training and development. In our interviews, participants very often explained the fortunes of the different initiatives in human resource terms such as staff shortages, skill shortages, structural constraints to implementation of new roles or responsibilities, or the presence (or not) of a particular individual with key qualities and insights. We therefore decided that in addition to providing an evaluation of the entire program (reported elsewhere (Greenhalgh *et al.*, 2009)) we should address the issue of strategic HRM in its own right. Our research question for this sub-study was "What approaches were used in the MI to put strategic HRM into practice (i.e. to

recruit, develop, deploy, manage and retain staff), and how can the success, failure or mixed fortunes of these different approaches be explained?"

Method

The evaluation used a realist approach, which employs mainly qualitative techniques to address the question "what works, for whom, under what circumstances?" (Greenhalgh *et al.*, 2009). We used in organizational case study design, which allowed us to observe practices and evaluate processes in context (Robson, 1995). This required collection of data from multiple different sources to build up a rich picture of change in context over time. A realist approach to case study focuses particularly on identifying the mechanisms (or theories) of change that are in policymakers' minds as they pursue particular change efforts, and on asking how and why the same underlying change mechanism has different effects in different contexts (Pawson and Tilley, 1997). Our methods included approximately 100 in-depth interviews (using purposive sampling for informants so as to identify the full range of perspectives and issues) as well as around 1,000 hours of ethnographic observation and consideration of some 200 documents including letters, proposals, minutes of meetings, and the regular reports submitted to the program board by the managers of the MI kidney, stroke and sexual health projects. All interviews were recorded and transcribed; extensive ethnographic field notes were also taken, generating a large dataset of free text data. Qualitative data were analyzed using a thematic approach drawing on the theoretical perspectives outlined in the previous section.

Many of the initial interviews were open-ended, seeking an unstructured, first-person narrative about a particular event or project. In these, HRM issues were often raised spontaneously, and such issues also emerged as an early theme in our ethnographic observations and document analysis. We therefore undertook a subset of more focused interviews with senior and middle managers and clinicians, oriented specifically to exploring these issues further, and based on the following prompts.

Participants were invited to comment on the following areas:

- General impressions of the role of workforce in the modernization program.
- Challenges faced in efforts to develop clinical competencies in staff.
- Challenges faced in efforts to develop management competencies in staff.
- Challenges faced in introduction of people with specific skills (technical, change management, champions, project management, facilitation, clinical).
- Challenges faced in use of change agents, clinical champions, and boundary spanners in the program.
- Challenges faced in engagement of local staff in the modernization program.
- Barriers and facilitators in freeing up staff for training and development activities.
- Employment and change structural barriers.

We fed back our initial interpretations to participants and modified these in response to their comments. Overall, participants felt that our analysis captured the key themes relating to workforce, and most concerns they raised related to the local sensitivity of our findings rather than their accuracy.

Main findings

Outline of the three MI projects

The three MI projects all had the same high-level goal: to make care more effective, efficient, patient-centred and integrated – that is, to "modernize" (Greenhalgh *et al.*, 2009). Despite their different medium-term goals and varied approaches to modernization, all projects and sub-projects included a prominent focus on the recruitment, [re]deployment, development and training of staff. Our realist analysis identified numerous contextual factors which appeared to explain the fortunes of different initiatives, many though not all of which could be tracked back to the human resource policies and infrastructure in participating organizations and to the external influences (e.g. national policy directives) which constrained these.

Below, we briefly describe the three projects and then offer a cross-case analysis of how human resource issues played out within and between these.

The MI stroke project was shaped by the strong commitment to research among the clinicians involved. It focused mainly on systematically defining the steps in the patient journey (from prevention to rehabilitation) by drawing on published research evidence and guidelines; developing a framework of key competencies needed to address the patient's needs at each stage; and training the entire workforce (from healthcare assistants to senior doctors) in competencies relevant to their role. This approach was linked to the NHS Knowledge and Skills Framework (Department of Health, 2004b); it was highly systematic and seen by the project leaders as strongly "evidence based". A key challenge was that the frontline workforce for stroke care, especially in the community, included a high proportion of healthcare assistants – a geographically dispersed group characterized by high turnover, low levels of training, and variable supervision arrangements. There was also the problem that some of these staff were employed not in healthcare but in other sectors (e.g. local government home support teams), and were not managed through the participating NHS organizations. The MI stroke project also sought to develop peer support networks, improve the quality of information for people with a stroke and optimize patient flows (for further details see Greenhalgh *et al.*, 2009).

The kidney project included three major areas of work:

(1) prevention and early detection of kidney disease in primary care;

(2) management of end-stage kidney failure in hospitals and peripheral dialysis units; and

(3) end-of-life care.

A high priority was a conscious and explicit shift from a "production line" approach to hemodialysis (in which core tasks in the thrice-weekly dialysis sessions were done by nurses) to one centred on supported self-management (in which the nurse's role changed to supporter and educator of the patient, who was encouraged to undertake as many of the tasks as possible independently). To this end, the training needs of dialysis nurses expanded dramatically from a focus on the technical aspects of dialysis care to embracing a prominent "training the trainers" component. A need also emerged for leadership and change management training for the dialysis unit sisters. Other work streams included a new peer support program in which patients already on dialysis would be introduced to those with early kidney disease; again, staff development shifted from an exclusive focus on skills development to embrace a cultural and

attitudinal shift from "paternalistic professional" to "guide on the side". In addition, whole systems events (staff and patient "awaydays") oriented to making the service more patient centred were held periodically, and creative staff engaged patients in activities such as making a DVD called "Living life to the full on dialysis".

The sexual health project took on the difficult task of modernizing a heterogeneous and widely dispersed service that included hospital specialists, GPs, community and family planning nurses, pharmacists, and lay advocates and which was characterized by multiple internal tensions (clinical, ideological, and managerial). For example, some consultants in genito-urinary medicine saw sexual health in traditional terms as the prevention and management of sexually transmitted diseases. They conceptualized the service as a hierarchical pyramid with GPs playing a supportive and gatekeeping role and considered that the strategic direction of the service should be (like the stroke service) consultant-led, and that family planning and psychosexual counselling were separate specialties. In contrast, the project's inter-professional leadership group took what they saw as a more holistic and patient-focused view, in which "best practice" was defined as managing all dimensions of the patient's sexual health competently and sensitively. A key priority in workforce development for this project was to promote mutual understanding and dialogue, and work towards common standards and guidelines where these were achievable. In addition, there was much enthusiasm for (but not universal consensus on) the development of "generic" qualifications that could be taken by staff of different professional backgrounds and grades and which addressed all aspects of sexual health. Less emphasis was placed on developing the entirety of the hospital workforce.

One of our early findings was that some organizations involved in the MI seemed to find it easier to implement strategic HRM than others. For example, in relation to the implementation of competency-based training in stroke care, one organization quickly embraced the full range of skills development and made rapid progress in implementing agreed changes in the workforce. Another comparable organization took considerably longer to implement the "same" change, and participants raised more general concerns about how fully this organization would be able to deliver on the modernization vision. Similarly, different organizations (and different parts of the same organization) seemed to have variable levels of difficulty operationalizing plan-do-study-act cycles for team learning (Greenhalgh *et al.*, 2009). Where difficulties occurred, they were often though not always attributed by participants to problems in HRM strategy and infrastructure. This created a natural opportunity for cross-case analysis in which we could ask the realist question "what works, for whom, in what circumstances?" (Pawson and Tilley, 1997).

As summarized in Figure 1, five main approaches to strategic HRM (the mechanisms or theories of change) were employed by the three MI projects:

(1) recruiting staff with skills in service transformation;

(2) redesigning roles and creating new roles;

(3) enhancing workforce planning;

(4) linking staff development to service needs and priorities; and

(5) creating opportunities for shared learning and knowledge exchange.

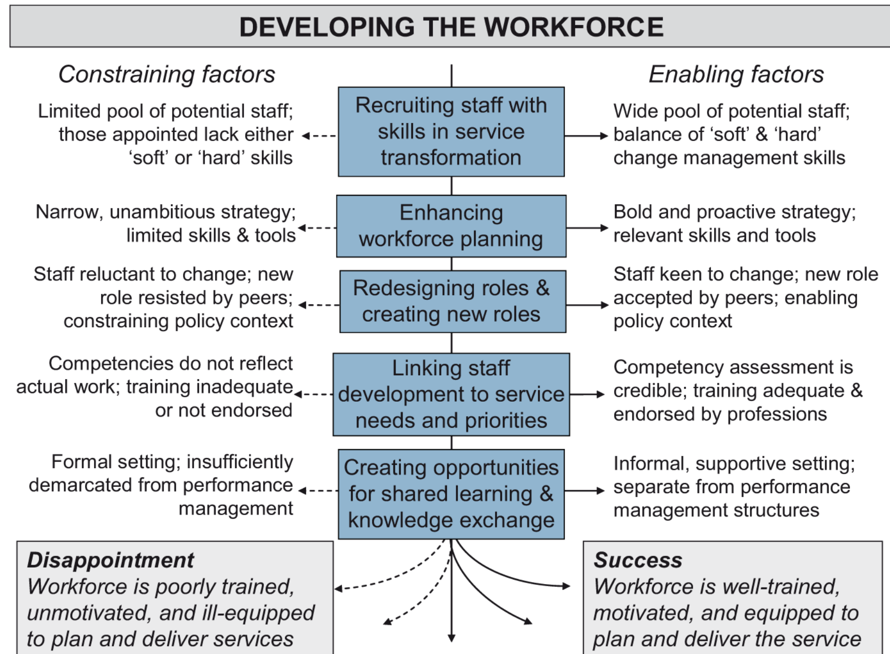

Figure 1.
Theories of change drawn on by MI teams in developing the workforce

Each of these approaches met with differing levels of success in the different sub-projects, and was enabled or constrained by both local and external factors. Below, we consider how each approach in turn played out in the different projects and sub-projects.

Approach 1: recruiting staff with skills in service transformation

The skills and attitudes needed to lead and participate in transformative change are different from those required to run an existing service. They include the capacity to imagine a different future; to enthuse others and bring them on board; to galvanize the energy needed for change; to work across multiple boundaries and encourage others to do so; to troubleshoot; to monitor progress; and to ensure that timely performance data are fed back to front line staff (Bate *et al.*, 2004; Belbin, 1993; Gardner, 1997). Transformative change requires both "soft" skills (people management, consultancy, negotiating and leadership skills, and the ability to bring people with differing perspectives towards the goal of accommodation) and "hard" skills (project management, process control, statistical measurement, quantitative data analysis). The success of the various MI projects was attributable to a large extent to the appointment of individuals – the MI Director, project managers, service improvement facilitators, and clinical champions – who possessed, between them, a balance of both types of skill.

An almost universal response when we asked about human resource issues was endorsement of the MI Director, whose credibility, vision, energy, emotional intelligence and sheer ability were widely admired. Some confided that without her,

the successes of the MI might have been considerably more limited. Importantly, this individual had previously worked for the NHS Modernisation Agency, which had been disbanded at about the time this project began, releasing a group of able, highly trained, and experienced senior change agents into the national health economy (Bate and Robert, 2003). Similarly, almost all participants considered the multiple and flexible skills of the managers in stroke, kidney and sexual health to have been crucial to the success of these individual projects.

A significant proportion of the MI budget was spent on new-blood service improvement facilitators (SIFs) on the grounds that sustainable change in the service must involve changes in attitudes, skills and ways of working among the regular workforce, rather than be delivered as a "bolt-on" initiative by short-term staff attached to the project. Hence new MI-funded posts were purposively oriented to facilitation rather than to direct implementation. The SIF role typically involved bringing groups of people together and getting them to contemplate, undertake and collectively evaluate new ways of working. For example, in a project to detect high blood pressure earlier (with a view to preventing both kidney disease and stroke), SIFs worked with community pharmacists and optometrists to extend their roles to include screening the local population for hypertension. They also worked at an inter-organizational level to identify funding incentives and targets for the extended role and integrate these into the professionals' pay contracts with the Primary Care Trust. In this example, the SIFs liaised with a pharmacy trainer who worked with individual practitioners to address their specific needs both in relation to this project and more widely in relation to other Department of Health initiatives such as the Long Term Conditions policy. Hence, the specific MI-funded work (screening for hypertension) was carefully woven into the overall training program for optometrists and pharmacists. The SIFs also worked to link the new service model to wider prevention work in hypertension, such as inter-organizational efforts to develop common protocols and guidelines for hypertension.

As this example illustrates, the role of the SIF was multi-faceted, complex and adaptive. In our interviews, respondents felt that on the whole the SIFs were talented and committed individuals who had made a major contribution to the modernization process, and had honed their skills further through experience and training in the MI. Initially, most had appeared to possess either "soft people skills" or the "hard analytical skills" but few individuals possessed a complete set of these skills, so senior managers needed to play each SIF flexibly to his or her strength and provide a focused program of training and personal development to address deficiencies (an approach that succeeded in some but not all cases).

Another key change role was that of clinical champion, which in this program was envisaged from the outset as a doctor working within the service who was an established opinion leader and whose time would be bought out for two half-days or more per week if required to support the MI change effort. This approach drew on a sparse but widely-cited literature on the role of champions within the organization in promoting acceptance of innovation (Maidique, 1980; Markham, 1998). In our interviews, respondents felt that this role had worked well in some cases but had two main drawbacks: the practical challenges of providing back-fill for senior clinical posts and the tendency for some individuals to follow a personal agenda rather than (or in

addition to) championing the values and goals of the project they had been hired to support.

In a number of cases, the MI project team identified individuals who would have been ideal clinical champions but whose day-to-day work pressures made it impossible to buy out any of their time for MI purposes. The recruitment process for the clinical champion roles was unsystematic, and in some but not all cases the potential incumbents had nominated themselves. The role was initially only offered to doctors rather than spread across different professional groups, and some applicants were too junior to have the necessary credibility with peers. The appointment of "unknowns" rather than established opinion leaders to clinical champion roles gave the unintended message that more senior clinicians lacked commitment to the MI. Having said that, one or two relatively junior doctors appointed to this role seemed to gain credibility with time and made increasing impact as the project progressed.

In summary, the goal of whole-scale transformation required, and was usually delivered via, a number of specific roles in leadership and change management. In the case of new full-time posts, suitable individuals were generally available in the health economy and were successfully appointed through targeted recruitment strategies (though in one or two cases their appointment left a skills gap somewhere else in the health economy). On the other hand, individuals suitable and available for part-time clinical champion roles were in much shorter supply. Our informants expressed concern that the human capital of the change agents would be lost to the health economy once the MI project ended. These fears turned out to be unfounded: the MI Director, project managers and SIFs were all quickly employed on mainstream NHS-funded projects when the MI funding period ended, with significant numbers staying in the local health economy.

Approach 2: redesigning roles and creating new roles

While much staff development centred on enabling staff to perform their existing jobs more effectively (see below), some work streams initiated radical role redesign or created entirely new roles such as extending the community pharmacist role to include testing for sexually transmitted infections or hypertension. Successful role redesign depended on the staff themselves being keen to take on extended or different roles; on adequate and timely training; and on acceptance of the changed role by other staff and organizations. In some cases, the expectations of the new role conflicted with an individual's identity or skills. For example, some sexual health nurses charged with supporting self management of minor sexual health problems felt de-professionalized when they were asked to work in futuristic "pods" (which lacked an examination couch or trolley of instruments) instead of in traditional consulting rooms.

Approach 3: enhancing workforce planning

All the MI projects took a systematic and proactive approach to workforce planning. Their efforts met with variable success. Demand and capacity analysis exercises helped identify burden of need and highlight patient flows, bottlenecks, waiting times, staff workload and skills gaps. Business planning and economic modelling tools were used to project future demographic scenarios (e.g. an increase in demand for dialysis, demand for sexual health services) along with changes in treatment options and

workforce implications. This work involved local commissioners, who took account of economic realities beyond the MI.

In our interviews, participants felt that insufficient workforce planning was occurring across the participating organizations. They anticipated that as the modernization effort unfolded, project teams would find it difficult to match the demands of a changing service with a workforce that was fit for purpose. They felt that this would inevitably lead to skills shortages in key areas. They also questioned how it would be possible to modernize services without thinking about workforce issues across the whole health economy. Our respondents also highlighted the time element of workforce planning. They explained that there was a need to undertake workforce planning and action from this very early as the changes to services occur. The tension is getting the change and workforce changes to happen at once and ensuring that the training is delivered in a timely fashion.

Approach 4: linking staff development to service needs and priorities

A modernized service requires staff who are fully trained and supported to deliver on their role. An important component of the MI's HRM strategy was to maximize the contribution of front line staff to the patient care pathway. For example, the stroke project provided training for 100 relatively junior health and social care staff working across the stroke pathway. Having identified bureaucratic delays in stroke patients' access to equipment for rehabilitation, the MI developed a "trusted assessor" training program to widen the pool of staff who could order aids and simple home adaptations. At a different stage in the pathway, the stroke project also invested in training for ambulance staff in the management of transient ischemic attacks. Similarly when the sexual health project's assessment of the user experience identified significant room for improvement in the area of "customer care", priority was given to providing such training for receptionists and healthcare assistants. Less commonly, senior-level training was seen as a critical factor in service improvement. The kidney MI, for example, provided leadership training for Band 7 nurses (managers of dialysis units) after they identified leadership as a key driver for implementing dialysis self-care and further service improvements.

Two of the MI projects articulated competencies required by staff and used these as the basis for redesigning both training and administrative support across primary and secondary care. As described above, the stroke project conducted an extensive competency assessment, particularly of community roles. However, progress on this was slower than hoped, partly because some staff were not convinced that the framework captured key elements of what they actually did, and partly because it was difficult to release front-line staff to meet all the training needs identified. In addition operationalizing the framework and embedding it in wider HRM practices was a huge task (see "structural barriers" below), and because the impact of the competency training on workforce performance and patient care was extremely difficult to measure.

A key dimension of a "modernized" service for some conditions is holistic (whole-person) rather than disease-focused care. Training in sexual health, for example, involved redefining skills and competencies in relation to overall patient needs rather than in relation to disease-specific categories. Traditionally, qualifications in this field were split into "sexually transmitted diseases" or "family planning" and

also by professional group (doctors, nurses and pharmacists taking different postgraduate qualifications for example). One of the most radical efforts of the MI was the development of a common "generic" qualification in sexual health which addressed all dimensions of the patient experience and was open to doctors, nurses, pharmacists and other groups (though this did not seek to replace traditional qualifications).

Approach 5: creating opportunities for shared learning and knowledge exchange

As recommended by the literature on whole-systems approaches to change (see Background), the MI projects made extensive use of bringing people together for learning both in formal meetings and more informally in away days and seminars. These events often included service users and/or voluntary sector organizations. Many respondents felt that one of the MI's greatest achievements was to break down inter-organizational barriers by facilitating groups to work together on the modernization projects. Most obviously, the sexual health project established a virtual network and employed a Network Development Manager to raise awareness and facilitate its use in inter-organizational collaboration (Alessio, 2006). Inter-organizational networking on a smaller scale was also evident in specific sub-projects. Respondents gave examples of where senior clinicians from the two acute hospitals (which had a long tradition of inter-organizational rivalry) had worked successfully together on a strategy for common standards and pathways.

Another approach to shared learning was whole-team visits to other centres to see service models in action elsewhere. These sometimes provided the time and critical distance needed for teams to reflect together on aspects of the service and begin to envision alternatives. In addition, these joint visits enhanced individual understanding of other's roles and the whole pathway. Towards the end of the MI, the three MI projects also hosted frequent visits by teams from elsewhere, and found that "being visited" was often a stimulus to reflect on their own progress.

Structural barriers to workforce development

Our evaluation of this complex change effort strongly supported McGregor's assertion that barriers to effective performance usually lie in the system, not in individual staff members (McGregor, 1987). Staff were mostly keen, creative, comfortable with new ways of working if these improved patient care, and hungry for training and development that would help them do their jobs better. But structural barriers at both national and local level were multiple and pervasive, and they accounted for more delayed or diverted initiatives than any other single factor in our overall analysis.

Efforts to modify existing staff roles, for example, were constrained by a context of wider restructuring in the NHS, which was associated with a general climate of unwanted, externally-imposed change and frozen posts in both acute hospitals and Primary Care Trusts. Changes in key personnel, uncertainty about job losses and unfilled posts all exacerbated the challenge of gaining commitment to the MI work. It was hard to get people to accept changes in their job description or take on new roles, and when people did agree to this, in a number of cases they, either left the post, or found that they did not have time to undertake the new tasks they had taken on.

Our respondents gave numerous examples of creative attempts to introduce new, inter-organizational roles intended to work across boundaries. However, such plans often faltered because of local bureaucracy, with each organization having a different

system for describing and recording duties and job descriptions and for completing pre-employment checks. In one example of a shared senior nursing post, the human resources department in one organization refused to accept the references and criminal records check that were on file in the partner organization, so a three-month delay ensued while they repeated these measures, during which period the individual was told to "not touch patients, only observe". More generally, efforts to compare and align posts with similar titles across organizations (with a view to developing boundary-spanning posts) had the unintended consequence of alarming the incumbents of these posts, who felt that their performance and salary grades were under scrutiny.

Another major barrier was the national workforce policy, Agenda for Change (Department of Health, 2004a), which requires that all newly created NHS posts be classified and the grading approved before recruitment begins. Redesigned posts could not be instigated until they had been banded and graded as part of Agenda for Change. In some cases, this delayed the appointment of staff and held up projects for up to six months. Thus, ironically, a national policy which was intended to support strategic HRM in public-sector healthcare in reality provided little more than red tape. The specific outcomes which Agenda for Change allowed (e.g. a clear role and job description for the staff member) were only recognized and supported within a single organization (the person's main employer), and not across the entire health economy. This substantially reduced the impact of the new, cross-boundary posts that had been created with the intention of achieving a "seamless" patient experience when moving from one healthcare organization to another (e.g. when discharged from secondary to primary care).

These operational hurdles were rarely insurmountable, but they meant that while enthusiasm for the principle of new posts linked to new organizational forms was high, the practical difficulty of establishing such posts was seen as a huge challenge.

While the MI was unusual in having generous external funding, it was operating within a health economy that was very cash-constrained. Since the MI's guiding principle was to embed the change in the individuals and systems of the NHS, it would have been counterproductive for it to operate as a "freestanding" program. Hence, even though the MI provided numerous training and development opportunities for NHS staff, they were not always able to take these up. For example, three of the four participating organizations would only release their own staff for training if this training had been designated as "mandatory" (meaning, essential for patient care). "Non-mandatory" training had to be undertaken partly or wholly in own time. This had a palpable impact on enthusiasm for, and uptake of, training activity. For example, several non-mandatory MI-funded courses were poorly attended, but a leadership training course for renal unit nurses which following significant negotiation was successfully designated "mandatory" had almost 100 per cent attendance; all staff obtained the qualification and the project supported by this training was seen as one of the MI's greatest successes (Hughes *et al.*, 2008).

Another generic structural problem was that as an externally-funded change program the MI had not been able to develop effective links with the human resources infrastructure in the various participating organizations. It was hard to utilize the HRM expertise within these organizations to obtain specific advice, even though the program had the strong backing of the chief executives; the initiatives being planned were

intended to bring benefit to these organizations; and there was an explicit and transparent plan for successful projects to continue with mainstream NHS funding.

Structural arrangements for funding had a powerful impact on cross-boundary working between organizations. For example, renal consultants from the two acute hospitals were keen in principle to work together on a joint strategy for kidney disease, but they made little progress on this project – mainly because the prevailing funding arrangements effectively placed them in competition with one another for patients, hence both sides had a vested interest in maintaining separate referral pathways. Interestingly, financial disincentives in the kidney project did not appear to block interactions between nursing staff from the two hospitals, and since dialysis services are traditionally nurse-led and nurse-run, much effective cross-boundary working was achieved at operational level despite significant challenges at strategic level.

The pool of suitably qualified and motivated staff available to apply for key posts was a key factor in explaining the fortunes of many projects and sub-projects of the MI. Looked at in relatively narrowly terms (did the MI manage to recruit the staff it needed?), the answer was generally "yes", perhaps because posts were generously funded and tended to offer slightly more than the going rate. However, taking a somewhat broader view (was there a net gain in the local health economy?), the MI's gain in recruiting good staff was sometimes another organization's loss, and the post at the latter remained unfilled. Such considerations are of course driven by the demographics and economics of the public-sector workforce.

The national context set by professional bodies occasionally stymied local change efforts. For example, the sexual health project team met considerable challenges in their goal to develop a new, generic qualification in sexual health. Royal Colleges were unhappy that the qualification would not be "exclusive" to their own members, and imposed criteria and standards which were felt to be outdated and irrelevant.

Not all the barriers to developing the workforce and maximizing staff performance in this change program were structural. Despite an overall climate of risk-taking and widespread experimentation with new service models, some parts of the service had a deeply traditional culture and were inherently resistant to the MI's radical ideas. For example, within the stroke project, some staff appeared to be closely wedded to their existing ways of working and organizational forms; they were highly resistant to the introduction of a care pathway that traversed traditional organizational and functional boundaries. Influencing such individuals proved more difficult than anticipated, even for the SIFs who had been selected for their personal qualities and change management skills. Extra support for the SIFs in terms of mentoring and line manager back-up was provided, but the inherent difficulty of achieving change in an adverse cultural milieu made the pace of progress slow.

Discussion and conclusions

This study has confirmed the findings of numerous previous management researchers – that an organization depends on its workforce and it is usually people who make or break efforts at complex change. People gave the MI its values, its vision, and the energy that got the work of transformation done. Talented individuals were successfully recruited into senior positions and given the personalized training and support needed for their complex roles, and they generally rose to the occasion and drew others into the change effort. Ideas were sought, captured, operationalized and resourced. The front-line

staff on which much healthcare work depends were prioritized and developed in specific competencies, and by the end of the funding period, the training had begun to make a measurable contribution to the quality of care. Boundary-spanning roles, interpersonal networking and "sharing the learning" events that underpin the intra- and inter-organizational circulation of knowledge were encouraged and supported. New qualifications and training programs were developed with careful attention to their contribution to human capital in a modernized, patient centred service.

The day-to-day work of individuals and the impact of their ideas and efforts met with numerous structural constraints at both national and local level, as well as some pockets of deep cultural resistance. Whole-scale transformation was hampered by prevailing policies and politics; by crucial shortages in the availability of staff (especially for backfilling senior clinical posts); and by the sheer pressure of resources in an increasingly cash-constrained health economy. In such a setting, some individuals' primary concern was to protect their jobs and ensure continuity of their family income, however valuable the MI vision was seen to be.

Our realist analysis (Figure 1) suggests that workforce development efforts for complex, inter-organizational change are likely to meet with greater success when the following contextual features are found:

- There is an adequate pool of appropriately skilled and qualified individuals either already working in the organization or available to be recruited.
- Provider organizations have good human resources support and a culture that supports staff development and new roles / role design.
- Staff roles and identities are enhanced and extended by proposed role changes, rather than undermined or diminished.
- The policy context (both national and local) allows negotiation of local development goals, rather than imposing a standard, inflexible set of requirements.
- The skills and responsibilities for achieving modernization goals are embedded throughout the workforce, rather than exclusively tied to designated support posts.

In reality, however, the optimum conditions for modernization (the right hand side of Figure 1) are rarely found. Some of the soil will be fertile, while other key preconditions will be absent. Innovation and change are often said to require strong leadership. Leadership includes all the traditional human components including selecting and organizing staff so that work matches their capability and capacity; building motivation; championing the innovation (for example by continually articulating and re-articulating a shared vision); facilitating a risk-taking climate; modelling and enabling the essential knowledge-sharing activity that characterizes a learning organization; and bringing clarity and judgment to strategic decisions about whether and when to adopt particular innovations (Greenhalgh *et al.*, 2004).

In the context of a large, inter-organizational whole-systems change program, leadership also depends on developing strategies and systems geared to overcoming the complex structural and other constraints that are inherent to such initiatives (the left hand side of Figure 1) (Hutton *et al.*, 2003). In particular, good leaders will negotiate compromises when national policies or local bureaucratic practices get in the way of

progress. They will bring chief executives together using a judicious combination of charm and coercion to enact the realpolitik of "shared" posts and protocols, and not let up until the ink is dry on contracts. They will know where, when and how to advertise in order to maximize applicants for posts which require a rare mix of skills. They will mobilize resources promptly and flexibly, with careful attention to overall governance but not to petty rules. They will use their rhetorical skill to argue for particular staff to be released into key positions as boundary-spanners or champions. They will subtly sideline individuals with entrenched views and high wrecking power in each participating organization, and bring together players whose ability to listen and learn is high.

The MI thus offers an important worked example of how the laudable principle of strategic HRM is played out in practice to achieve whole-system transformational change. Charles Handy's concept of "resourceful humans" was greatly in evidence at senior and middle management level and in front-line clinical care (Handy, 1993). A significant finding of this study was the numerous, pervasive structural constraints at both national and local level which inhibited effective strategic HRM. In particular, top-down, legally binding policies which were introduced with the specific intention of supporting strategic HRM actually served as powerful barriers to achieving this very goal at operational level. The literature on whole-systems change offers a theoretical explanation for this in terms of how rigid, externally-imposed policies necessarily reduce the give-and-take of accommodation and dialogue at local level (Checkland and Holwell, 1998; Pratt *et al.*, 2005; Hutton *et al.*, 2003).

On the basis of our empirical findings, we predict that the future success of strategic HRM in the UK public healthcare sector lies not only in the extent to which the NHS continues to attract talented, creative staff and develop and support them, but also in the extent to which national policymakers are willing to shift from a mechanical, deterministic model of change (with talk of "levers" and "re-engineering" and a focus on the separate parts of the system) to an organic one (where the focus is on the system itself and how the different parts inter-relate and dovetail). We have previously distinguished between the "make it happen" and "help it happen" models of change (Greenhalgh *et al.*, 2004), and others have distinguished between the "logic of determinism" and the "logic of opposition". We believe it is time to ask hard questions at national policy level about how best to promote and support strategic HRM in an increasingly complex and dynamic health economy.

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