Me, Us and Them? From Bipartite to Tripartite Devolved HRM in Professional Service Contexts: Evidence from Hospitals in Three Countries

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Abstract

This article explores devolved HRM in a professional service hospital context. Findings challenge theoretical conceptions of devolution as a bipartite relationship between HR and line managers, identifying a tripartite model with: (1) HR practitioners, (2) line managers and, (3) senior professionals (managers and specialists) implementing HR.

Involving senior professionals reflects longstanding concern regarding managerial legitimacy in overseeing professional work. Each party has scope to contribute to people-management: HR practitioners to provide a strategic framework and delineate HR activities; line managers to implement HR practices and interface between HR and front-line professionals and; senior professionals to act as line managers' advocates and provide expert knowledge, judgment and credibility to inform people-related decision-making. However we illuminate practical challenges in role clarity and coordination within the tripartite structure, based on 128 interviews conducted in nine hospitals across three European countries (Ireland, UK and the Netherlands). Interviews examined roles and responsibility for HR under devolution and coordination between those involved in delivering HR in day-to-day service-delivery; implementing policy priorities (sickness management); and service-improvement change. Findings challenge the relevance of the bi-partite model of devolution in professional organizations. We extend the model and offer a theoretical framing linking tripartite relational involvement to enhanced HR performance.

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Professional Service Contexts: Evidence from Hospitals in Three Countries

Human resource management (HRM) helps organizations to survive and prosper by delivering strategic, managerial and operational value, through people management (Boxall & Purcell, 2011; Valverde, Ryan, & Soler, 2006). Operational responsibility for HR is typically devolved to line managers, a practice accepted as 'received wisdom' (Larsen & Brewster, 2003). However, there is debate regarding the specific roles HR and line managers should undertake under devolution (Harris, Doughty & Kirk, 2002; Teo & Rodwell, 2007), and insufficient knowledge regarding what supports effective collaborative working relationships in their execution of HR (c.f. Khilji & Wang, 2006; McGovern et al., 1997; Purcell & Hutchinson, 2007). There is also a specific deficit of empirical knowledge on the practice of devolution in professional service contexts, and particularly in the healthcare context considered here (detailed later).

The expert knowledge of professionals requires that their managers have legitimacy and understanding to manage their work (Raelin, 2011). In healthcare, one practical response has been an increasing prevalence of 'hybrid' clinical managers (Llewellyn, 2001), who undertake both clinical and managerial roles (e.g. a clinical nurse manager; clinical director). However, there has been little systematic consideration of who should undertake people management roles in healthcare, and the influence of professional reporting hierarchies and the managers and specialists within them (e.g. medical director; director of nursing etc.), on the implementation of HR (c.f. Townsend, Bartram and Wilkinson, 2011). Responsibility for HR is a particularly significant issue in the healthcare sector, where despite the human-capital intensive nature of service-delivery, the HR function has been found to be underdeveloped and lacking credibility and capacity (Fitzgerald et al., 2006; Hyde et al., 2009; Hyde et al.,

2007; McDermott & Keating, 2011). The research questions addressed in this article are therefore: *Who is involved in the provision of devolved HRM in hospital organizations, what do they do, and how do they coordinate their roles?*

Our findings contribute to the HRM literature in three ways. First, given scope to enhance management of hospital HR (Townsend et al., 2011), we add to the limited research on HRM in healthcare contexts (Bartram & Dowling, 2013). We do so in a methodologically novel way. To date research has predominantly focused on the use, implementation and effectiveness of hospital HR practices (see Bartram & Dowling, 2013; the special issue of the International Journal of Human Resource Management, Volume 24, No, 16; West et al., 2006). Rather than analyzing HR practices, we identify practical people-related organizational concerns − and use these as a lens to consider who is involved in HR delivery, what they do, and how they coordinate their roles. Second, empirically, several authors (Maxwell & Watson, 2006; Valverde et al. 2006) have considered devolution from the perspective of the HR department, while others have focused on line managers (Renwick, 2003; Watson, Maxwell & Farquharson, 2007). Our article considers the relationship between line managers and HR professionals from both parties' perspectives, as well as those of senior professionals (managers and specialists) also involved in delivering HR. Our empirical contribution is strengthened by strong similarities in the findings across three national contexts, and across HR implementation in day-to-day service-delivery, service-improvement and the implementation of policy priorities. Third, theoretically, our article challenges conceptions of devolution as a bipartite relationship between HR and line managers in professional service contexts. Instead, we develop a tripartite, relational model. We illustrate that HR practitioners, line managers, and senior professionals (professional-managers such as the Director of Nursing, Medical Director, and specialists such as consultants and occupational physicians in the hospital context) all participate in people management under devolution.

4

Studying the division of HR roles and the complex, demanding nature of collaboration in tripartite relationships provides insight into the practice of HR in professional service hospital contexts. It also identifies a need to revisit conceptions of the stakeholders involved in the implementation of HRM in other professional service organizations.

The remainder of the article is structured as follows. First, we consider the nature of and rationale for devolution, detail common challenges and discuss the contingencies affecting its efficacy and implementation in professional service contexts. Second, we detail our methods of data collection and analysis. Third, we present our findings, illustrating on a country-by-country basis for Ireland, the Netherlands and the UK, who is involved in the provision of devolved HRM in hospitals; what they do and; how they coordinate their roles to deliver HRM. We conclude with cross-case comparison. This leads to the identification of the tripartite relational model of devolution in the professional service hospital context. Whilst the roles of HR professionals and line managers have been previously delineated, the input of senior professionals (managers and specialist professionals) is premised on the provision of expert knowledge, judgment and credibility. Thus, each of the three groups contributes important and differentiated knowledge and skills. However, our relational lens identifies pragmatic challenges in delivering effective tripartite HRM.

Devolution: What is it and why do it?

HR theory increasingly recognizes that attention must be afforded to both the strategic design of HR systems, processes and practices and their *implementation*, to elicit desired employee reactions and behaviors (Guest, 2011; McDermott, Conway, Rousseau & Flood 2013; Mossholder, Richardson & Settoon, 2011; Purcell & Hutchinson, 2007). This 'implementation perspective' emphasizes the central role of line managers in mediating between the HR architecture and organizational performance (Becker & Huselid, 2006;

Watson et al., 2007). This is because operational responsibility for the implementation of HR policies and practices typically lies with line managers – a practice known as devolution (Mesner Andolsek & Stebe, 2005). Under devolution the role of the HR function is to act as a strategic partner, offering business expertise, change agency, knowledge management and consultancy roles (Ulrich & Brockbank, 2005). Concurrently, line managers are responsible for bringing HR practices such as recruitment and selection, training, staff planning and appraisals to life (Harris, Doughty & Kirk, 2002; Purcell & Hutchinson, 2007) and for coordinating, directing and motivating staff to increase their ability and opportunity to perform (Boxall & Purcell, 2011). Line managers must also engage in appropriately aligned leadership behaviors so that employees develop strategically appropriate psychological contracts (McDermott et al., 2013). The line manager's influence is such that 'poorly designed or inadequate policies can be 'rescued' by good management behavior in much the same way as 'good' HR practices can be negated by poor FLM (front-line manager) behavior or 'weak leadership' (Purcell & Hutchinson, 2007: 4). This is because an employees' relationship with their line manager provides the 'lens through which the entire work experience is viewed' (Gerstner & Day, 1997: 840). Where effective, devolution can speed up people-related decision-making, reduce costs (Renwick, 2003), enhance the reputation of the HR function (Kulik & Perry, 2008), and the quality of people management outcomes (Hutchinson & Purcell, 2010).

Challenges to devolution: Achieving consistency and coordination

Well-functioning strategic human resource management systems deliver coherent signals aligned across levels (organization, business unit, employee groups and individual employees), about what is expected and valued in the employment relationship (McDermott et al., 2013). This poses the challenge of creating consistency in employees' experiences of

devolved HRM. Variations in institutional support from HR professionals (Brewster & Larsen, 2000; McGovern et al., 1997), training and ability to handle HR issues effectively (Hutchinson & Purcell, 2010; Larsen & Brewster, 2003), and willingness to accept responsibility for people management responsibilities (Teo & Rodwell, 2007; Renwick, 2003) can lead to diverse practice by line managers. To address this, line managers should be well prepared and supported by the HR department. However, this does not always occur (Brewster & Larsen, 2000; Hutchinson & Purcell, 2010), with specific deficits in line manager career planning, training and support (and consequently readiness) identified in hospitals (Townsend et al., 2011). The challenge of consistency is exacerbated by the fact that HR tasks are among a range of middle management responsibilities now frequently devolved to the line (Hales, 2006/07). In health care, line management roles are expanding (Townsend et al., 2012), and now commonly encompass HR, budget, quality and policy-implementation roles, as well as service-delivery responsibilities (Bolton, 2005; Watson et al., 2007). Line managers often feel that new responsibilities are being "pushed" upon them without reduction in existing roles (Harris et al., 2002). This can leave them subject to role overload, role conflict and stress, and with insufficient time for personnel responsibilities (Hutchinson & Purcell, 2010; Maxwell & Watson, 2006; Watson et al., 2007).

In the light of these challenges, previous research has identified that beyond line managers understanding of, and belief in, the rationale for their involvement in HRM (c.f. Conway & Monks, 2010), two factors support effective devolved HRM. First is line managers' role clarity and capability for sophisticated implementation of the HR role (Conway & Monks, 2010). Second is a well-functioning relationship between the HR function and line managers. Concerns in this regard include how HR professionals can support line managers in their people management roles (Hutchinson & Purcell, 2010) and how to coordinate HR professionals and line managers, to ensure consistency in the application of

HR practices (Khilji & Wang, 2006; McGovern et al., 1997; Purcell & Hutchinson, 2007). However, there is deficit of evidence regarding how effective working relationships can be established. To conclude our consideration of extant theory, we consider who undertakes people management roles in professional service contexts.

Contingencies affecting devolution in professional service firms: How do you supervise a specialist?

Little research has specifically focused on devolution in professional service firms. This is a significant omission due to the particular challenges of managing professionals (Raelin, 1985). Much healthcare delivery is premised on the autonomous practice of professional knowledge work, characterized by specialist knowledge and skills and the application of discretionary judgment to address complex problems (Swart, 2007). Autonomy in professional practice is enabled by the standardization of skills through training; hierarchical career structures; professional specialization; and ongoing self-supervision and peer-review (Raelin, 1989; Scarbrough, 1996; Teece, 2003; Von Nordenflycht, 2010). Under a professional model many supervisory functions are addressed through self-supervision and peer oversight. Professionals are assumed to be best-placed to solve problems related to their practice, as many 'just don't feel that their managers know enough about their work to exert any meaningful supervision' (Raelin, 1985: 156). Where help is required, professionals have recourse to their peers (c.f. Raelin, 1989). This raises challenges for devolution in professional service firms – namely, how and who can supervise a specialist?

Balancing professional autonomy with managerial oversight and organizational goals is an enduring challenge for professional service organizations (Raelin, 1989). Together, the specialist knowledge inherent in professional practice combined with the tradition of professional autonomy, have made it difficult for managers to gain legitimacy (Abbott, 1988; Freidson, 2007). This has led some to argue that the control of results is 'really the only

effective means [for managers] to control professional behavior' (Raelin, 1989: 220). In healthcare, a range of organizational strategies have been adopted to manage tensions between the managerial imperative to 'control' and the professional imperative for 'autonomy' to pursue specialist practice (Raelin, 1989). The impact of these changes have been shown to be variable, with professionals frequently reasserting their control of professionals by professionals (Fitzgerald & Ferlie 2000; Freidson, 2001), in a variety of ways such as introducing clinical directorate structures (Fitzgerald & Dufour, 1997; Kitchener, 2000) and hybrid clinical management roles that require clinicians to undertake managerial and clinical responsibilities (Llewellyn, 2001). However, in spite of the burgeoning literature on managing professional service organizations, little is known about how devolution operates in these contexts including: who takes responsibility for HR (e.g. clinical/non-clinical actors); the nature of their roles; and how coordination occurs between those involved. The characteristics of professional work, together with sustained critique of the capacity of the hospital HR function to manage core professional groups (McDermott & Keating, 2011) and support service-delivery and improvement (Fitzgerald et al., 2006; Hyde et al., 2007) provide an imperative to explore those involved in devolution in professional service hospital organizations – and what they do.

Our focus builds on the two core issues identified above as affecting the HR/line management relationship: consistency and coordination. First, consistency in devolution will be supported where line managers are willing to, and capable of, undertaking HR roles. This will require an appropriate number of HR professionals to be retained to support line managers, ensure an appropriate balance of responsibilities, and avoid role overload (Mesner Andolsek & Stebe, 2005). Consistency will also be enhanced by effective coordination between HR professionals and line managers, to ensure that HR practices are implemented as designed (Khilji & Wang, 2006). In addition, we raise the question of who holds line

management roles in healthcare, given the importance of legitimacy in professional service contexts. In the ensuing sections, we will identify the key actors involved in delivering devolved HRM in nine professional service hospitals across three European countries, what they do, and how they coordinate their roles.

Research methods

Comparative, qualitative case study approach

This article is based on a comparison of international case study data from Ireland, the Netherlands and the UK. Case studies are a prevalent and robust methodology for health services research (Iles & Sutherland, 2001), appropriate for analyzing contextually embedded practices (Yin, 2009). Sampling identified hospitals reflecting variations in scale and complexity across each national context. Each study analyzed data from several sources including: (1) secondary data such as health policies, organizational strategies and archival data on the organizations' approach to the policy issue and to HRM; and (2) semi-structured interviews with managers and staff (128 in total, detailed in Table 1). Interviews are recognized as among the most important sources of case study information (Yin, 2009). In each study, interviewees were asked about their own roles, their expectations of others they were working with (HR, line managers and/or others), and collaboration between those involved in delivering HR. Following Langley (1999), interviewees were also asked to provide specific narrative examples of the practice of devolved HRM, using country-specific 'tracer' issues. Tracer issues were areas under pressure for change from mandated policy reform. The narratives provided in-depth information on the actual HR roles and processes implemented in each organization. Case-study research can provide strong within-case validity, but weaker external validity, limiting broader generalization. However, our investigation of the implementation of HR and of collaboration between HR, line managers

10

and senior professionals in different service and national contexts enhances confidence in our findings (c.f. Ferlie, Fitzgerald, Wood & Hawkins, 2005).

Insert Table 1 about here

Case overviews and data analysis

The Irish study comprised three hospitals, with 700, 1700 and 3,000+ employees. The tracer issue considered the implementation of human resource management in supporting day-to-day service delivery issues in cardiology. Interviews were conducted with 41 respondents supporting or directly involved in service-delivery, including the senior management team, HR professionals, and line managers in cardiology.

The Dutch study comprised three hospitals with 3500, 5500 and 9500 employees. This tracer issue considered the implementation of sickness management in hospital wards – a key front line manager role. Interviews were conducted in matched pairs of line and HR managers with 40 respondents (19 HR managers and 21 line managers) in 19 different wards.

The UK study comprised three hospitals, with 1,800, 1950 and 4,000 employees. The tracer issue considered the management of service change in cancer care, including the implementation of HR. Interviews were conducted with 47 respondents, including the senior management team, HR and middle managers, 17 line managers and 4 clinical-managerial 'hybrids'.

A common three-stage approach to data analysis was applied across the studies, illustrated in Table 2. This utilized inductive analysis (Thomas, 2006), before comparing findings with deductive themes from prior research (Miles & Huberman, 1994). First, individual field reports of cases were prepared in each study. Tracer issues were considered in each national context (day-to-day service delivery; addressing absence management as a

11

strategic priority and; delivering change) to illuminate the implementation of HR by line management and HR professionals, and the involvement of additional actors, where applicable. These tracer issues were utilized to develop case-by-case narrative accounts of people-management roles under devolution, and how these were practiced. The narratives were based on field reports and on the interrogation of the data using three standardized questions. These are set out in Table 2. The second step in analysis was comparison of findings within and across the national contexts, and then across all cases – illustrative quotes are provided in Table 3. In the third and final stage of our analysis, we compared our findings with those from prior research and extant theory on devolution.

Insert Table 2, Table 3 about here

Our three-stage analytic approach facilitated identification of those involved in delivering HR under devolution, and the factors influencing effective collaboration. Next we present a summary of empirical data and key findings from each national context, illustrating the viewpoints of our three key stakeholder groups - HR specialists, line managers and senior professionals (managers and specialists) with involvement in HR. Findings from each country are organized around our research questions, detailing who takes responsibility for HR and what they do, as well as coordination between HR roles in each national context. This is followed by cross-case comparison and theory building. Our contribution is premised on the identification of a novel, tripartite structure of devolved HRM in healthcare, and the explication of resulting coordination challenges within the professionalized health care context. Implications within and beyond health services are considered in our final discussion.

Devolved HRM in three Irish hospitals: the management of service delivery

12

Context

In Ireland, focusing on cardiology as a tracer issue enabled consideration of HR delivery to address day-to-day service delivery issues, as well as service improvements associated with a national cardiology strategy and consequent progress reports. Cardiology services are often provided on an emergency as well as routine basis, and can entail medical and surgical interventions. In Ireland, many HR policies and procedures are centrally determined by the national Health Service Executive (HSE), the national administrative body for the Irish Health Service. The national mandate strongly influenced the division of responsibility for HR in the Irish hospitals.

Who takes responsibility for HR in Irish hospitals, and what do they do?

Although the HR function devolved delivery of national and organisational HR policies to line managers, the relationship between HR and the line managers was often directive, to ensure compliance:

> *"I can offer a professional HR service to management and to line managers and I would see it very much as a kind of an advisory service but perhaps I think it goes beyond that in HSE in that the job has to have a stronger mandate in terms of actually complying with legislation and complying with the HSE terms and conditions. So it can be quite directive."* (HR manager)

The role undertaken by HR professionals encompassed ensuring compliance with HSE terms and conditions, acting as functional experts to support line managers, undertaking industrial relations and union engagement, as well as providing induction, oversight of mandatory training and responsibility for routine pensions and salary administration. Thus, HR professionals acted as functional and administrative experts - rather than adopting strategically oriented roles. The HR manager noted that, while they would like to move the

HR function towards a strategic partner role, this was not currently feasible, due to a strong focus on industrial relations. '*Is it a best practice HR model? Probably not...certainly we're not as proactive and positive as we could be.*' HR and managerial legitimacy was a common concern among HR staff, expressed in the assertion that:

> "*it's important I think to operate at this level in this environment [among professional clinical staff] to have some sort of an academic foundation or basis that basically says you know look, you know, I know what I'm talking about or just to give it validity in that sense you know*" (HR manager).

Line managers undertook a range of HR tasks including planning rosters; ensuring mandatory training was completed; career planning with staff; absence management; managing staffing levels and; addressing local people-related service issues. The line managers adopted their HR responsibilities willingly, often going beyond the formal requirements of their roles, to support service-delivery:

> '*I have taken accountability and initiative myself as a CNM (*clinical nurse manager) *in order to maintain a level of staff retention and awareness of the impact that sick leave is having on a unit.*' (Clinical nurse manager, cardiology unit)

However, a third group of stakeholders was evident in some aspects of HR delivery – senior professionals. These included those holding hybrid clinical management roles in the professional hierarchy (e.g. the clinical director, assistant director of nursing, physiotherapy manager), as well as senior specialists (e.g. consultants). Senior professionals both raised and helped to address people-related issues, resulting in their liaison with both HR and line managers. Liaison with line managers entailed the provision of advice, or acting as an advocate - making cases for staffing and escalating unit-level concerns. They also supported HR by providing judgment and advice on clinical practice issues and employees' fitness to practice:

"I am always saying, I'm not a clinician and I know the difficulties of you know, even if I'm talking to nurses and you're talking about a disciplinary issue and it has to do with some practice that's skewey or untoward - well look I won't make, I'll only make a comment on the process, I won't make a comment on the actual clinical issue." (HR manager)

Importantly, senior professionals' involvement enhanced the legitimacy of HR decision-making. In summary, there were three actors involved in HR delivery across the Irish hospitals – HR professionals, who designed and oversaw the delivery of HR practices and engaged in industrial relations and routine administration; line managers who dealt with operational HR; and; senior professionals (managers and specialists), who acted as advocates for line managers, and also supported HR professionals by providing expert knowledge to inform decision-making.

Coordination between line management and other HR roles in Irish hospitals

The tripartite model of HRM created three sets of relationships in HR delivery in Irish hospitals, rather than the one characteristic of bipartite models of devolution: line managers with HR; line managers with the professional hierarchy and; senior professionals (managers and specialists) with HR.

The HR-line manager relationship was perceived as problematic by both parties. Line managers felt insufficiently supported, describing HR managers' as uncooperative and removed from the reality of service-delivery. For example one clinical nurse manager noted that HR guidelines require a medical certificate for more than two full days of absence. However, on her unit staff work three 12 hour days per week, meaning that staff can miss a majority of their working week on uncertified absence. HR managers were similarly dissatisfied, perceiving line managers as ineffective in addressing routine people management issues:

"I find that a lot of issues that land on my door are basic line manager issues that could have been resolved, but they just don't do it. If they see a people problem or a potential grievance they automatically put an HR label on it and it's off their desk and onto mine. " (HR manager)

Line managers had more positive relationships with managers and specialists in their professional hierarchies (e.g. nurses reported to the assistant director of nursing; doctors to the clinical director; and allied health professionals to their most senior clinical service manager; clinicians often liaised with senior medical consultants also). Unresolved or complex issues were often referred to HR via this professional hierarchy:

"*So the physio manager would be the contact for physio and radiography and that kind of a structure.*" (HR manager)

"*HR and the Personnel Officer and ADON [Assistant Director of Nursing] I think that is kind of a circle there*" (Clinical nurse manager, cardiology)

However, line managers perceived that HR and professional managers did not have sufficient formal linkages, or work particularly well together. For example, a clinical nurse manager (CNM) noted that *'I would think that there is a certain amount of frustration that you know, that they don't work well together.'*

Summary: The practice of devolved HRM in Irish hospitals

The key feature of devolved HR in service-delivery was the relationship between the line managers and their more senior colleagues in the professional hierarchies. This introduced a third party to the typical line manager/HR relationship. However, while the quality of relationships between the line managers and their professional colleagues was good, the HR/line manager relationship was negatively affected by insufficient contact between HR and line managers/senior professionals, leading to misconceptions regarding the work undertaken

by each; lack of awareness of service realities among HR managers and; poor coordination in addressing service issues, due to the lack of formal reporting structures between the professional hierarchies and the HR function. Next we consider the Dutch experience.

Devolved HRM in Dutch hospitals: the management of long-term absence

Context

The three Dutch cases facilitate analysis of devolved HRM in the context of managing long-term sickness absence (more than six weeks). Significant changes to the national system of social insurance and benefits had made sickness absence an organizational policy priority in the Netherlands. National changes made employers financially responsible for the provision of two years of sick pay to employees during absence, with legal obligations for organizations to undertake problem analysis for each long-term absent employee; to develop a plan for their return to work and; to undertake regular follow-up evaluations and actions for long-term absent employees. The 2002 Gatekeeper Improvement Act introduced these procedures and also dictated that organizations appoint case managers for long-term absent employees. This role can be filled by a line manager or a HR representative, although most organizations allocate it to the employees' line manager – a situation evident in our three hospital cases.

Who takes responsibility for absence management in the Dutch hospitals, and what do they do?

In each of the three Dutch hospitals, HR and line managers agreed that the operational management of sickness absence should be devolved to line managers, while the HR function would monitor procedures and give advice. In two of the hospitals, HR specialists undertook this advisory role, while new and dedicated support role, titled the 're-integration officer', was established in the third. Line managers were also supported by an specialist occupational physician, who gave expert clinical advice regarding the physical and psychological

capabilities of each absent worker, and their ability to fulfill their job role. In some instances, the occupational physicians extended their role to incorporate HR advisory aspects – identifying issues affecting the absent employee such as team/ward communication problems and career development frustrations. Thus, although line managers were the designated organizational lead in managing long-term sickness absence, in practice HR responsibility was shared between line managers, HR practitioners (the HR manager or re-integration officer), and an occupational physician. Collaboration between the three parties was a prerequisite for successful absence management, although the actors tended to restrict their roles: HR practitioners' provided legal and procedural advice; line managers liaised with the employee regarding their illness and work role; and occupational physicians provided medical advice. Neither HR managers nor occupational physicians visited the ward, maintaining physical distance from the work environment.

Deficits and challenges in devolved HR in Dutch hospitals

Predominantly, issues in absence management didn't pertain to the implementation of formal organizational policies, but rather to how factors causing absence management were addressed. As case managers, line managers maintained contact with absent employees, consulted with HR, and received advice from the occupational physicians. However, line managers perceived their role as limited to implementing absence management procedures, rather than strategically and proactively addressing work-related influences on long-term absence. For them, this remained the remit of the HR function, in line with their strategic business partner and functional expert roles. For example, in dealing with ageing one line manager in declared: *"I notice that it is difficult to reintegrate some older nurses who cannot keep up with the many new developments in logistics and technology. So, I asked for ageing policies. Well, that has long been a focus of our HR manager in the past. But due to the whole*

reorganization, it is somewhere in a drawer, I believe". The perception that HR managers were underperforming in providing HR policies for the line managers to implement was shared across the majority of line managers.

Conversely, HR practitioners (and occupational physicians) reported that line managers did not prioritize addressing and preventing work-related issues (e.g. conflict, career development) contributing to sickness absence. In one hospital, HR practitioners noted that their physical distance from clinical areas impeded their capacity to address these issues. In a second, there was an illustrative case of a sick employee who made a successful move to another ward, after an intervention by an occupational physician. This intervention occurred a year into absence and after a number of years of work-related stress in the employee's previous role. In this instance, conflict with the line manager contributed to the employee's absence, implying that the line manager may not always be the most appropriate person to address absence issues. In summary, underpinning dissatisfaction among line managers, specialist professionals and HR practitioners was lack of discussion and reflection on the distribution of roles and responsibilities in the implementation of devolved HRM. As one re-integration executive noted: "*That alignment* [between HR and the line] *is very important.* [But] *It is predominantly not good. To give each other feedback and say what you think of the other and how they act therein, that is always a difficult issue."* While some operational aspects of sickness management were working well, broader strategic issues, including responsibility for proactively addressing issues contributing to sickness absence, remained unaddressed.

Coordination between line management and HR roles in the Dutch hospitals
Both line managers and HR were dissatisfied with the practice of HR roles in absence management. Line managers had anticipated greater expert support from the HR function, particularly in dealing with complex cases, developing new organizational policies,

and introducing new practices. Although line managers described adequate HR support in dealing with individual cases of absence management, they desired greater proactive support from HR to help them build local workforce capability (through training and development), to enhance workforce flexibility and enable staff to meet increasingly technical demands. One particular problem line managers' faced was encouraging employees to accept functional flexibility in their job roles. For example, one line manager described an initiative in a neonatal unit, that aimed to make every nurse capable of carrying out low, medium and, high-tech care. They described how, without HR support for training and communication, the transition toward functional flexibility caused feelings of insecurity and incapacity for some nurses, leading to absence and a lack of re-integration. Thus, coordination among those involved in the devolved management of sickness was effective in implementing clearly prescribed procedures, but ineffective in proactively addressing local issues related to absence management.

From the HR managers' perspective, line managers lacked independence and capability to deal with non-standard occurrences. Echoing themes from the Irish case, one HR manager asserted that line managers revert to HR when absence problems go beyond a simple flu or a broken leg. HR managers were unwilling to take responsibility for managing such non-routine issues: *"We do not take over the responsibilities of the line manager, who is the case manager and therefore has the case load."* However, this quote may reflect a defensive stance by HR managers. They recognized scope to undertake a greater specialist and advisory role, but were hampered by an abundance of managerial tasks: *"It is expected that we do more advisory work, such as in ageing, and it is expected that we have specialized knowledge in many areas. [...] I really would like to do the advisory work, but I cannot find time for it".* The HR managers felt that increasing work pressure, combined with uncertainty regarding their tenure (due to budget cuts and restructuring) hampered their capacity to

undertake a strategic and advisory HR role. In one hospital, the HR department had been physically moved to share space with another outsourced department, and told to become competitive relative to external HR providers. In a second, HR managers had to re-apply for their roles, as part of the reorganization of the HR department.

Summary: The practice of devolved HRM in Dutch hospitals

In the Dutch cases, line managers, HR officers, and specialist occupational doctors shared responsibility for HR tasks in managing absence – requiring collaboration between them. However, all parties identified areas of underperformance, predominantly pertaining to proactively addressing issues contributing to absence. HR and line managers held conversations about individual employees, and line managers received advice from occupational physicians, but they did not liaise to identify issues requiring the development of more strategic actions. In all three hospitals, devolution led to the diminution of HR responsibility for providing policies for ageing and career development. The HR function was physically and cognitively distanced from the work floor and HR staff rarely had direct contact with employees. Both line and HR managers were dissatisfied with their roles and the quality of collaborative working relationships under devolution. Next we turn to the UK experience.

Devolved HRM in UK hospitals: the management of service change in cancer care

Context

In the UK, hospitals were reconfiguring their cancer services to achieve partially mandated quality standards. Cancer care pathways were a high priority and the government had provided dedicated resources to support improvement in this regard. Thus the UK case explored devolved HRM in the context of service-improvement. Like Ireland, in the UK many

HR standards and procedures are centrally negotiated. National standards and guidance strongly influenced the practice of HR in hospitals.

Who takes responsibility for HR in the UK hospitals, and what do they do?

Acute hospitals in the UK have specialist human resource departments, provided as part of the central services of the hospital. Clinical departments are managed by a clinical director (CD), a professional-managerial hybrid, who holds a part-time clinical role and a significant management role, supported by a general manager. Formally, the general manager takes responsibility for HR for administrative and non-clinical staff within the department. However, the clinical professions - doctors, nurses, and allied health professionals are managed through a dual managerial/professional hierarchy. Thus, doctors report to the Medical Director, as one illustrated:

> *"When it comes to issues such as disciplinary matters, then I am 'it' from a medical point of view, so that's where all those issues come to. Also under governance, I am 'it' from a medical point of view, and I take responsibility for that…"*

These structures result in complex lines of responsibility and accountability for HR. HR practices are further influenced by strong non-professional unions and numerous professional bodies.

Our data illustrate that all the CDs undertook substantial HR responsibilities. One CD stated that the role was not strategic or change oriented, but focused on administration and dealing with human resource issues. CDs perceived HR tasks produced the most significant difficulties they faced and felt unsupported:

> *…personality clashes and that sort of thing – where I am not sure what I should do next, so I have to go and ask for advice and it would be nice to get a bit more feedback saying, "don't worry, we are behind you" because sometimes you feel a bit isolated.*

"The areas that I think are difficult are actually confronting difficult colleagues…"

In one hospital, there was more evidence of shared responsibilities for human resource functions, with both clinical staff and general managers describing their HR activities.   In each site, hospital strategy stated that improvements in cancer services were a high priority. Clinical managers led these complex sets of changes, involving alterations in individual roles and team working, engaging clinical and managerial staff to participate in planning and delivery.

Senior HR staff had variable influence in agreeing the HR strategy with the board in each hospital. Some HR departments were understaffed and focused on 'routine' aspects of HR, such as recruitment and selection, discipline and absence cover. Despite the priority of cancer care improvement, there was limited evidence of involvement from the HR function. HR staff did not attend meetings held to discuss the changes and the issues arising. Staff within cancer units noted that HR staff did not visit their clinical areas. This was exacerbated when hospitals had multiple sites. In the analysis, two significant deficiencies in HR provision were noted. First, clinical managers were offered management training. Second, in one hospital, HR failed to intervene in serious conflicts between clinical staff that were having detrimental effects on patient care.

Coordination between line management and HR roles in the UK hospitals

Across all the UK sites it was observed that clinicians predominantly engaged with other clinicians while managers engaged with other managers. One clinical consultant noted the "*disparity between the objectives of clinical staff and managerial staff.*" The clinical managers felt that the HR managers were unsupportive and did not hold them in high esteem. Alongside these common themes, co-ordination and relationships differed across the sites. In

one hospital, there was better co-ordination, with a mixture of clinical and managerial staff engaged in the improvement program. At times, HR practitioners were involved in the implementation of a change through membership of a temporary project team. And there was stronger evidence of a proactive approach to HRM at a strategic level with the Director of HR facilitating coordinated relationships:

"trying to spot the issues before almost the other managers do; keeping an eye on who's working with who; helping people work together with a degree of maturity; backstage stuff, like people getting on with each other, smoothing things over, trying to help senior staff with difficult individuals, people that they possibly can't cope with, don't know how to deal with, get in the way of the service…"

The picture observed in the second hospital was amicable with sound relationships. But the HR staff did not play any role in the service improvement program.

Relationships in the third hospital were poor. HR staff were distanced from the clinical and managerial staff on the wards and across the sites. This was widely acknowledged, and the CEO stated that for the last five years he had been *"trying to get the two places to talk to each other properly."* Both line managers and clinical managers described conflicts:

"It is very difficult. I mean they are totally paranoid down there …no, it is a very difficult relationship." (Line manager)

"I found within all the teams, urology were the most resistant in a way. There were a few who were very keen but would do no work to cooperate in order to produce protocols or guidelines that would have helped them greatly." (Clinical Manager)

Despite the impact on patient care, there was limited evidence of an active plan to resolve differences and the HR practitioners were reluctant to intervene in conflicts between doctors, as they perceived this as the responsibility of the Medical Director.

Summary: The practice of devolved HRM in UK hospitals

A mixture of line managers, senior professional-managers, general managers and HR specialists held responsibility for HR tasks. So, without good co-ordination, important tasks fell between the 'silos'. In two hospitals, devolution led to the abdication of HR responsibility for supporting change, through proactive or consultancy efforts and the result was slow, limited progress in improving cancer care. The HR function within these hospitals was distanced physically, and through differing agendas and priorities, from the clinical workface. HR staff rarely had regular contact with clinical managers. Further, there was evidence of a lack of functional expertise and ongoing management of basic HR practices. So in the majority of cases, HR adopted a functional and maintenance orientation, merely sustaining the system in place. However, in one site, the senior HR managers provided a framework of strategic human resource policies. Staff worked collaboratively and delivered many improvements in cancer services, indicating potential for HR to make a positive contribution to service-improvement.

Cross-case comparisons

Who takes responsibility for HR and what do they do?

In this section we answer two of three research questions, identifying who takes responsibility for HR in hospitals, and detailing their activities (see Figure 1). In the ensuing section we answer our third research question, considering factors supporting effective coordination and collaboration between those involved in implementing HR. As evident above, and

summarized in Table 3, a key finding common across the three national contexts and nine hospitals was that the typically theorized bipartite relationship between line and HR managers under devolution was supplemented by senior professionals (holding hybrid clinical-managerial, senior or specialized roles) contributing to HR. Thus we observed that devolution in professional service hospital organizations entailed senior professionals, as well as line managers, working to interpret and implement HR practices. As a result, devolution in hospitals requires the establishment of tripartite relationships instead of the traditional bipartite linkages between line and HR management. In the Irish and UK cases, line managers liaised with colleagues in their professional hierarchies to address HR issues. Unresolved or complex issues were then referred to the HR function. A triad of relationships (involving line managers, HR and the specialist occupational physician) was also evident in absence management in the Dutch hospitals. These key relationships are illustrated in Figure 1. This notes the role that each group aspired to, although as detailed in our findings section, the HR function lacked capacity to proactively and consistently provide a strategic framework and specialist expertise. Our findings also suggest particular coordination issues between line managers and HR, and between the professional hierarchy and HR.

A number of factors encouraged the involvement of the senior professionals. These included: (1) HR concerns regarding managerial legitimacy in addressing people-related service issues, due to their lack of clinical knowledge; (2) Line managers' limitations in addressing non-routine issues, due to deficits in training and advisory support. As previously reported (see Townsend et al. 2011; Hutchinson & Purcell, 2010), under-resourcing of training makes it difficult to equip line managers to confidently enact their devolved people-management responsibilities. In addition, deficits in institutional support from HR professionals in addressing complex or technical issues (c.f. Brewster & Larsen, 2000) further encourage professional involvement. Professional stakeholders extended the range of actors

and expertise involved in managing devolved HR in professional service hospital organizations, helping to address the legitimacy concerns of HR professionals, and the capacity concerns of front-line managers. However, it does appear that hospital HR faces de-professionalizing pressures under this model of devolution – with HR professionals too busy to proactively strategize, and line-managers ill-equipped to do so. Next we discuss how collaboration might be enhanced, present our concluding themes and summarize our contribution. We close by identifying practical strategies to support effective tripartite HR.

Concluding themes: A fragmented triad and how it might be addressed

This article makes a contextual, empirical and theoretical contribution to the literature. Contextually, we add to the growing but limited research on HRM in healthcare (Bartram and Dowling, 2013). Empirically, we explore devolution in a professional service context, providing a robust international base for our conclusions. We do so in a methodologically novel way, using tracer issues to examine those involved in HR delivery, in nine hospitals in three countries. In developing our theoretical contribution, in the form of the tripartite model of devolved HRM, we address an empirical deficit in research that draws on data from both within the HRM function *and* from the line managers to whom they provide a service. We respond to the challenge set out by Mossholder et al. (2011) and develop a *relational lens* on the interactions between HRM and line managers. We highlight four key findings that together demonstrate the interdependent, yet fragmented, character of the triad.

First, we find that in the hospital setting, the more complex, tripartite set of relationships between HR specialists, line managers, and the clinical professional hierarchy increases the challenge for collaboration. The tripartite model requires (and is lacking) a sophisticated system for the collaboration and alignment of the various perspectives and actions of actors with multidisciplinary backgrounds. The devolution of HR requires

adaptation by all these groups; their capacity to coordinate HR at different levels; and their willingness to share HR-knowledge and to invest in its development.

Second, all parties recognize the importance of HR providing an advisory and supporting role for service-improvement, policy-implementation and the delivery of change. However, in practice the HR function is overly distanced from the line to provide effective support. This is a particularly relevant issue for the core clinical workforce – where clinically trained line managers are integral to effective service-delivery. Although devolution is viewed as a positive development in giving line managers the lead for operational HR, this does not imply that specific knowledge and support of HR specialists is superfluous. On the contrary, our study shows that the underperformance of HRM, and particularly in strategic issues, is regretted by all parties in the triad.

Third, we emphasize that the involvement of professionals as third-parties in the tripartite model is not simply premised on adding 'another' group of people, but on the provision of professional knowledge, judgment and credibility. Each of the three groups therefore contributes important knowledge and skills.

Fourth, from our empirical analysis, we present the challenges facing the three parties in building mutually supportive relationships and practice. We have highlighted the issue of HR 'distance' from line managers and suggest that this encompasses both cognitive and physical distance. Cognitive distance refers to distance in the understanding of the contribution of HR, and concomitant understanding of roles and role boundaries. Gaps in understanding lead to divergence in priorities and a perceived lack of responsiveness from HR to the concerns of clinical staff. In our findings, the practice of HR specialists emphasised leadership of mandated policy changes, rather than service-related HR issues. Enhanced proactivity in this regard would help reduce distance in values. In particular, there is scope for HR practitioners to actively question: What are the local issues? How could we work with

professionals and others to make local improvements in the quality of care? Physical distance between HR and line managers limits HR specialists' knowledge of how professional services are organized, and the impact of common HR issues, such as absenteeism, on service provision. The historical, institutional arrangements in hospitals create barriers to productive devolution. In many instances, senior professional managers retain responsibility over individual professions, such as doctors or nurses and these 'silos' can lead to fragmented relationships between line managers, their superiors and the HR function. These historically established relationships also mean that certain aspects of organizational life, such as the conflicts between clinicians, are considered 'off limits' for the HR function. Here we argue that HRM has to respond to these challenges to play a strategic role in hospitals which are complex, professionalized contexts. At present, the strategic role of HR is getting lost in the gaps between the three groups involved in HR delivery. We identify three areas where there is particular scope for practical actions to enhance the efficacy of HR delivery.

First is creating greater opportunities for exchange between HR, line managers and the professional hierarchy. Our findings illustrate that HR, line managers and senior professionals had developed limited relationships, premised on addressing specific issues. These key actors reported few opportunities for interchange, creating physical and social barriers – and misunderstanding - regarding the extent of effort each cohort exerted to support HR. Improved opportunities for exchange could take the form of structured meetings, dedicated people-management 'clinics' or drop-in times, or the greater physical presence of HR staff within clinical areas.

Second, the centrality of professional managers and specialists to the implementation of devolved HRM necessitates the introduction of clear lines of liaison and reporting, as well as the clarification of the roles held by line, professional and HR managers. As Figure 1 illustrates, each of the three groups worked (if not always successfully), to make important

contributions to HRM. HR practitioners worked to provide a strategic framework; delineate strategic and operational HR activities and; allocate HR tasks. Line managers provided managerial knowledge and judgment and an interface between HR and clinical specialists. Professional actors provided clinical professional knowledge and judgment and generated credibility with professionals. However, the role of the professional hierarchy was not clearly prescribed in the Irish and UK cases, where professionals often became involved to fill informal 'gaps'.

Third, there is the need for greater expert input and support from the HR function. HR managers were not offering facilitation or analysis of common or complex issues, or supporting key service changes. In the Irish context, achieving greater HR input may require greater resourcing of industrial relations issues, to free up HR staff for other duties. HR could also enhance planning regarding medium to longer term skills development activities which might be anticipated in a human service organization.

Previous research has suggested that line managers' understanding of, belief in, and capacity for involvement in people-management supports effective devolved HR (Conway and Monks, 2010). Beyond the requirements of individuals', our findings emphasize the importance of relational dynamics and suggest a need to enhance collaboration between the stakeholders in the tripartite model - HR, the professional hierarchy and the line. In particular, our comparative analysis suggests that three factors may support enhanced collaboration and, in turn, greater consistency in HR delivery. Finally, beyond the hospital context, we emphasize the need for future research to consider HR's legitimacy in managing other forms of professional service work. In particular, research should consider the empirical and theoretical legitimacy of the tripartite model of devolution in other professional or knowledge work contexts.

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TABLE 1: Interviewees across the sites

Hospital	Ireland (Cardiology)	The Netherlands (Absenteeism)	United Kingdom (Cancer)
Hospital 1	11	12	16
Hospital 2	15	16	13
Hospital 3	15	12	18
Total	41	40	47

TABLE 2: Interrogative questions utilized in analysis

Research questions	1. Who is involved in the provision of devolved HRM in hospitals? 2. What do they do? 3. How do they coordinate their roles?
Stage of research	**How questions interrogated at each stage of analysis**
Stage 1: Within case analysis	Question addressed in writing up individual field reports, and subsequently used to interrogate data as part of development of a descriptive, narrative account for each hospital.
Stage 2: Cross-case analysis	Variations across cases and countries explored using paired comparisons and searches for disconfirming findings.
Stage 3: Theory building and testing	Emergent themes iteratively examined against literature and extant theory.

TABLE 3: Illustrative quotes for case analysis

Question	Ireland	Netherlands	UK
1. Who is involved in the provision of devolved HRM in hospital organizations?	I suppose the core contribution of my role is in the way that I can offer a professional HR service to management and to line managers and I would see it very much as a kind of an advisory service but perhaps I think it goes beyond that in HSE in that the job has to have a stronger mandate in terms of actually complying with legislation and complying with the HSE terms and conditions. So it can be quite directive. (HR manager, I H2) I am part of the hands-on patient care as well as my managerial role… (Clinical nurse manager, coronary care unit I H2)	The line manager is the initiator; everything stands or falls with that. As far as I can see, within care group C, the line managers are all very alert […]they are responsible and I am in a supporting role, if they need me (HR manager D H2) In the past, the hospital was not managed by figures. Sick leave, people had their thoughts about it but you were not held accountable for it [...]. This is changed now, so all line managers feel that they should focus more on control (HR manager D H2).	[Key priorities are] …implementing 'agenda for change'- it's about pay, competence, and training and education and skills; encourage people to develop competence and skills(Deputy Director of Nursing). My role is unpredictable and its like riding by the seat of the pants. she focused more on appraisal, troubleshooting and discipline – human resource issues rather than strategic direction…(Clinical Manager)
2. What do they do?	It's probably primarily industrial relations driven and employer relations driven. And the site is quite large obviously so you can just imagine there's a real diversity in terms of all grades of staff and employees with lots of vested interests and competing agendas. That I don't want to deal with. I suppose I should say from the outset, is that I don't really have any involvement with medical manpower (HR manager, I H2) I suppose my role as a manager is to ensure that all staff are up to standard with the in-service, mandatory in-service education, number one and that standards of care to patients are you know, gold standard in the coronary care unit setting. Procedures, policies and guidelines are adhered to, orientation of new staff... and the actual team approach to patient care, the multi-disciplinary approach to patient care. We don't have an appraisal system medically and it is something that we have been looking at. (Clinical nurse manager, coronary care unit I H2)	It is expected that we do more advisory work, such as in ageing, and it is expected that we have specialized knowledge in many areas. […] I really would like to do the advisory work, but I cannot find time for it (HR manager, D H1). There's been a HR project for ageing policies, but they received no answer in the organization so that project has come back on the shelf. Yes, and now we are already too late to start with it (HR manager, D H2) Basically, there is a fairly new protocol [for absence] in this organization that we use. [...] What are we doing to keep it low Uhmm ... I still think I make regular contact and good agreements. Discuss it in staff meetings, and point employees to their own responsibility (line manager D H2).	It is a long drawn out process of having the right paperwork, the right targets to actually do it, to actually try and performance manage them and then possibly either change their practice or get rid of them. It is very difficult… I talk to them, I write down everything I have said to them, and give them a copy of the letter, and we give target dates of when they should do x, y, and z and if they don't perform by then we come back to them and so on and so forth. It is a terrible process. (General manager, clinical unit).
3. How do they coordinate their roles?	You will rarely have a CNM 2, 3 you know, ringing me saying I have an IR issue. They do go through their nurse service manager which would be the ADON and it works basically and it is more streamlined (HR manager, I H2) Well, my direct accountability is to my – we will say Nurse Service Manager, who is my Assistant Director of Nursing… would have a good reporting relationship with her, she is very accessible to us as ADON's [Assistant Director of Nursing] go. I would have no problem lifting up and ringing her mobile at a moment's notice to ask advice on a situation if I was unsure about where I stand with maybe dealing with an issue. (Clinical nurse manager, coronary care unit I H2)	That alignment [between HR and the line] is very important. [But] It is does not work well. To give each other feedback and say what you think of the other and how they act therein, that is always a difficult issue. (Re-integration officer D H3) I noticed in my ward that we have problems with some older nurses who cannot keep up with the new logistics and technology. So, I asked for ageing policies. Well, that was a focus of our HR manager in the past, but due to the whole reorganization, it is somewhere in a drawer, I believe" (Line manager in D H1)	The actual cancer targets and the multidisciplinary work I don't tend to get involved with - it involves my general manager a lot more than it does me. I try and avoid it because there are too many other things to get on with. I would love cancer to be a different directorate. (Clinical Director). I can't influence…I am a simple man. I mean, it is impossible to influence... (Clinician). I do see myself very much as a sort of lynch pin – a connecting point between the clinical side and the sort of organizational side. (Clinical Director)

FIGURE 1: Tripartite model of devolved HRM

HR
Provides strategic framework; delineates
strategic & operational HR activities &
allocates roles. Provides HR specialist expertise.

Professional hierarchy
Provides clinical professional
knowledge & judgement; generates
credibility with professionals.

Line Managers
Provide managerial knowledge &
judgement; interfaces between clinical
professionals & HR specialists.