Social Partnership and Political Devolution in the National Health Service: Emergence, Operation and Outcomes

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Nicolas Bacon
Cass Business School, City University London, UK
Peter Samuel
Nottingham University, UK

Abstract

This article explores the emergence, operation and outcomes of social partnership in the National Health Service (NHS) in Scotland and Wales. Social partnership emerged in the NHS following political devolution in 1998 which transferred powers to left-wing governments in Scotland and Wales. These arrangements helped improve health services, modernise industrial relations and enhance staff terms and conditions. In NHS Scotland, union participation in strategic decisions produced extensive co-operation to dismantle the internal health market, improve services, and enhance staff terms and conditions. Union participation in NHS Wales was restricted to discussing workforce issues, and although co-operation increased when Welsh governments gained enhanced legislative powers and dismantled the internal health market, it delivered fewer improvements in service and pay levels. Differences in government political positioning (against public sector marketisation) and degree of independence (with devolved administrations granted different legislative powers) help explain the operation and outcomes of social partnership.

Keywords
partnership, trade unions, devolution, NHS, public sector, industrial relations, modernisation

Corresponding author:
Nicolas Bacon, Cass Business School, City University London, 106 Bunhill Row, London EC1Y 8TZ, UK. Email: nick.bacon.1@city.ac.uk

Introduction

The industrial relations institutions which provide a role for trade unions in the workplace and as legitimate social partners more broadly remain central to debates in the sociology of work (Heery, 2015; Terry, 2003). Commentators arguing from a pluralist perspective on industrial relations traditionally suggest unions may effectively represent the interests of workers through collective bargaining and joint consultation in the workplace. Neo-pluralists favour wider state corporatism between social partners and institutions for industrial democracy providing unions with a role in organisational decision making. Alternatively, commentators arguing from a radical and critical perspective dismiss such proposals in favour of workers' ownership and control of industry.

During the last decade these alternative perspectives informed assessments of the implications of labour-management partnership arrangements that emerged in liberal market economies including Britain, the USA and Ireland (Bacon and Samuel, 2009; Martínez Lucio and Stuart, 2005; Samuel and Bacon, 2010; Smith, 2006; Terry, 2003). Labour-management partnership involves commitments by unions and managers to co-operative workplace relations. Drawing on the pluralist perspective, advocates of labour-management partnership suggested that greater union participation in management decision making and increased co-operation may produce mutual gains for both employers and workers (Ackers and Payne, 1998; Kochan and Osterman, 1994). Case studies of partnership in Kaiser Permanente, Aer Rianta and Legal & General, for example, provided evidence of union participation in a wide range of organisational decisions, co-operation to improve organisational performance, and enhanced terms and conditions for workers (Kochan et al., 2009; Roche and Geary, 2006; Samuel, 2007). Critics of labour-management partnership drawing on the radical perspective dismiss these arguments (Kelly, 1996; 2004), highlighting cases of

partnership in aerospace, manufacturing plants and local authorities that did not provide for increased union participation in organisational decisions or labour gains (Danford et al., 2002; Jenkins, 2007; Roper et al., 2005).

Neo-pluralists occupied a more nuanced middle-ground between these positions suggesting mutual gains from labour-management partnership requires a broader institutional framework to support union participation in organisational decision making. Specifically, state support for unions may be required of the type provided in coordinated market economies. This may include a pro-labour state ideology, social dialogue with unions on economic and social policies, and legal backing for union participation in decision making (Ackers and Payne, 1998; Kochan and Osterman, 1994; Martínez Lucio and Stuart, 2004; Terry, 2003). Consistent with neo-pluralist theories of the state, however, unions rarely receive such state support in liberal market economies because employer interests predominate.

This article advances the neo-pluralist perspective on partnership by reporting a comparative analysis of social partnership in the National Health Service (NHS) in Scotland and Wales following political devolution in Britain. Although government-union dialogue to discuss public sector modernisation may be termed social partnership (Bach, 2002: 326) this article provides the first assessment of formal social partnership arrangements in Britain about which little is known. Britain's first, most extensive and significant examples of social partnership are studied, with the NHS in these countries accounting for over 40% of devolved government expenditure, and with 204,000 employees providing health services for 8 million people (2011-12 figures).

It extends studies of partnership in several further respects. A sharp conceptual distinction is drawn between labour-management partnership and social partnership. Social partnership is defined here as formal and continuous arrangements providing opportunities for consultation between government, public sector employers and unions in specific parts of the public sector (for example, health services or law courts). It operates at the higher sectoral level above labour-management partnership found at enterprise level. The findings show this higher level provides unions with privileged and institutionalised access to government ministers, civil servants and public sector employers who report to them, rather than access to employers or local managers provided by labour-management partnership. Social partnership thus facilitates union participation in a wide range of strategic decisions concerning the structure and governance of public services, in contrast to labour-management partnership's more restricted focus. Social partnership so defined is distinct from corporatism in coordinated market economies as private sector employers are not involved.

The findings also show that in liberal market economies, increased state support for union participation in organisational decisions may result in mutual gains. State support for union participation in NHS decision making increased as a result of political devolution with health services transferred to separate devolved governments. Comparing social partnership under two devolved governments also identifies two political issues - government political positioning (against public sector marketisation) and degree of independence (with devolved governments granted different legislative powers) - that influence the operation and outcomes of social partnership. The findings overall suggest social partnership has considerable potential to help improve public services, modernise industrial relations, and enhance staff terms and conditions.

Social Partnership: Emergence, Operation and Outcomes

Emergence

Given little is known about social partnership the article's first aim is to explain its emergence in NHS Scotland and Wales. Prior studies suggest labour-management partnership emerged in response to socio-economic transformation from the 1980s onwards. Globalisation and intensified competition appeared to require greater co-operation between employers and unions to improve organisational performance (Kochan and Osterman, 1994; Martínez Lucio and Stuart, 2004, 2005; Oxenbridge and Brown, 2004). In addition, the state played an important role (Roche and Geary, 2006; Stuart and Martínez Lucio, 2005b), with New Labour governments (1997-2010) in Britain promoting labour-management partnership as part of a broader Third Way approach to modernising industrial relations (Stuart and Martínez Lucio, 2005a; Terry, 2003).

This included specific attempts by New Labour to promote labour-management partnership in the public sector. Partnership was regarded as important to help overcome the opposition expressed by public sector unions to market oriented reforms. These reforms aimed to improve services by increasing competition in the NHS, Inland Revenue and Civil Service among others (Bach and Kessler, 2011; Cabinet Office, 2009; Work Foundation, 2004). Unions in the NHS had opposed market oriented reforms first introduced by Conservative governments (1979-1997), starting with competitive tendering and outsourcing ancillary services (such as catering, laundry and security) to private sector firms from the mid-1980s. Outsourcing created a two-tier NHS workforce by placing outsourced staff on contracts inferior to national agreements and pay awards. The subsequent *NHS and Community Care Act 1990* created an internal health market of separate purchasers (district health authorities and GP fundholders) acquiring services from competing providers (NHS Trusts). This increased competition that resulted exerted downward pressure on national agreements and pay awards. Unions also opposed the Private Finance Initiative (PFI) to help build NHS facilities involving high interest repayments and a lack of accountability (Pollock, 2004).

New Labour introduced further NHS marketisation by creating autonomous Foundation Trust hospitals, encouraging Independent Sector Treatment Centres run by private providers, and increased PFI use. In seeking to reduce union opposition to marketisation, labour-management partnership was encouraged in national-level Whitley Council arrangements for joint consultation. The NHS Staff Council, for example, worked in partnership to produce the NHS *Agenda for Change* (2004) pay modernisation agreement that harmonised pay scales and career progression arrangements. The NHS Social Partnership Forum also formed in 1998 to discuss a further range of workforce policies (Bach and Kessler, 2012: 141). At enterprise level in NHS Trusts, labour-management partnership developed on workforce issues to help implement *Agenda for Change* and improve training opportunities (Munro and Rainbird, 2004; Stuart and Martínez Lucio, 2002, 2005a; Tailby et al., 2004). Limiting partnership to workforce issues however restricted the discussion of wider strategic issues such as New Labour's market oriented reforms. This narrow focus resulted in less than 10% of NHS Trusts adopting labour-management partnership agreements despite government funding for partnership initiatives (Stuart and Martínez Lucio, 2005b). In the absence of broader agreements on the structure and governance of health services the diffusion of labour-management partnership arrangements remained limited.

This started to change when political devolution in Britain in 1998 created Scottish and Welsh governments as new industrial relations actors with a different approach to industrial relations than Westminster government. Both devolved governments made strong commitments to union participation in national and workplace decision making (Bacon and Samuel, 2009; Foster and Scott, 2007), indicated by establishing national level social partnership arrangements in devolved health services - the Scottish Partnership Forum and Welsh Partnership Forum. These arrangements reflect the pro-labour ideologies of the main political parties in Scotland and Wales and frequent interaction between regionally based representatives in tight knit policy making communities following devolution (Martínez Lucio and Stuart, 2004). Pro-labour state ideologies and union access to government and civil servants appeared a conducive environment for unions to participate in strategic decisions on health service structure and governance. In addition, partnership with unions also appeared more likely as the devolved governments and political parties in Scotland and Wales opposed public sector marketisation. Scottish and Welsh Labour parties positioned themselves to the left of Westminster politics on a left-right political axis (Keating, 2005), displaying an aversion to public sector marketisation and declaring 'clear red water' between themselves and New Labour (Davies and Williams, 2009). The respective nationalist parties - Plaid Cymru and the Scottish Nationalist Party (SNP) - also positioned themselves to the left of New Labour and opposed public services marketisation.

Although the shared characteristics of Scotland and Wales described above appear to support social partnership, Britain's devolution settlement was asymmetrical granting different responsibilities to each devolved government. The *Scotland Act 1998* vested powers to the Scottish Parliament to pass primary and secondary legislation on health matters. In contrast, the *Government of Wales Act 1998* vested powers to the National Assembly for Wales to pass secondary health legislation, with Westminster approval required for significant policy changes. This article explores the emergence of social partnership in NHS Scotland and Wales following political devolution, and assesses whether differences in legislative powers and government political positioning (against marketisation) result in contrasting types of social partnership.

Operation

The article's second aim is to analyse in detail how social partnership operates in NHS Scotland and Wales. Prior studies distinguish between two types of partnership - labour-parity and employer-dominant (Kelly, 2004; Oxenbridge and Brown, 2004). Labour-parity partnership is consistent with the pluralist perspective outlined earlier and broadens union participation to cover strategic decisions, encourages consensual decision making, and produces mutual gains. Employer-dominant partnership is more consistent with the radical and critical perspective as union participation in wider strategic decisions is constrained, unions comply with unilateral employer decision making, and few labour gains emerge. This suggests social partnership is appropriately assessed by the scope of issues in which unions participate, the style of decision making and substantive outcomes (see Kochan et al., 2009; Pass, 2008; Samuel and Bacon, 2010).

The main question regarding the scope of issues is whether partnership broadens union participation to strategic decisions such as those concerning organisational structure and governance, for example, or restricts the participation of unions to workforce issues covered in traditional joint consultation (Kochan and Osterman, 1994). Prior studies of labour-management partnership in the British public sector provided evidence of union participation restricted to workforce issues, and limited access to government and civil servants responsible for strategic decisions (Badigannavar and Kelly, 2004). Unions criticised the NHS Social Partnership Forum, for example, as not providing access to government ministers or senior civil servants, thereby preventing discussion of marketisation (Bach and Kessler, 2012: 141). Similar partnership arrangements collapsed in the Inland Revenue and Civil Service as they provided limited union access to government ministers and few opportunities to challenge New Labour's modernisation agenda (Beale, 2005; Martin, 2010). This article will assess the scope of union participation in strategic decisions in social partnership meetings in NHS Scotland and Wales, given pro-labour state ideologies and potential union access to government and civil servants, and consider differences between the cases relating to political positioning and legislative powers.

Assessing social partnership also requires considering the style of decision making in terms of the manner in which issues are dealt with, specifically the extent of joint working and consensual decision making. Joint working is considered essential for mutual gains as it helps generate a broad range of potential solutions to organisational problems (Kochan and Osterman, 1994; Walton and McKersie, 1965). Studies of labour-management partnership in the British public sector, however, report limited joint working and union frustration with unilateral government and employer decision making (Badigannavar and Kelly, 2004: 116; Beale, 2005: 150; Martin, 2010; Stuart and Martínez Lucio, 2000: 322; Tailby et al., 2004: 416). This article assesses the extent of joint working and consensual decision making in social partnership. It applies measures derived from Walton and McKersie's (1965) behavioural theory of labour negotiations (BTLN) as the predominant framework for classifying behaviours in labour negotiations as joint working and consensual or conflictual. The BTLN details a wide range of behaviours previous researchers have found useful in assessing the style of decision making. Levels of joint working in NHS Scotland and Wales are assessed in the context of pro-labour state ideologies and union access to government and civil servants, with potential differences between the cases due to political positioning and legislative powers.

Outcomes

The article's third aim is to assess the outcomes of social partnership in NHS Scotland and Wales. Prior studies suggest the imbalance in industrial relations power in the employer's favour will undermine labour gains from partnership (Danford et al., 2002; Kelly, 2004; Jenkins, 2007). This reflects socio-economic conditions since the 1970s that lessened union power and encouraged concessions to employer demands. Critics of partnership from the radical perspective conclude that unions should avoid partnership arrangements and co-operation with employers (Kelly, 1996). Social partnership following devolution may, however, help re-balance industrial relations power and produce mutual gains in NHS Scotland and Wales given pro-labour state ideologies and union access to government and civil servants, although differences in political positioning and legislative powers may also affect outcomes.

Gains for government and employers from social partnership in the NHS are measured by changes in service performance. Reductions in NHS marketisation (the internal health market, private sector involvement and outsourcing) and improvements to staff terms and conditions provide measures of labour gains.

Research Method

Comparative data are drawn from a variety of sources including interviews, participant observation and documentary analysis to address the article's three aims and provide a relatively comprehensive assessment of social partnership in NHS Scotland and Wales. Rather than triangulating data throughout the results section, semi-structured interviews with key stakeholders conducted between 2005 and 2013 explored social partnership's emergence with a representative sample of 29 senior civil servants and NHS chief executives, 10 NHS employers and 30 union representatives.

First-hand non-participant observations of Scottish Partnership Forum (SPF) and Welsh Partnership Forum (WPF) meetings are the main source of data used to measure the scope of issues discussed and style of decision making. This involved direct observations and audio recordings of 34 SPF meetings (lasting 334 hours) and 18 WPF meetings (lasting 72 hours) as timetables allowed. Transcripts of meetings produced from audio recordings and formal detailed minutes of unobserved meetings provided data on all SPF (1999-2013) and WPF meetings (2004-2013). Coding of meeting transcripts using NVivo9 software (see Bazeley and Jackson, 2013) assessed all contributions made in SPF and WPF meetings (2,152 and 1,975 contributions respectively). The word count for different issues organised into broad themes indicates the scope of issues discussed.

Coding meeting transcripts to assess the style of decision making drew on categories derived from a close reading of Walton and McKersie's (1965) BTLN as the predominant framework for classifying behaviours in labour negotiations as conflictual or joint working and consensual. A list of 20 negotiating behaviours were then grouped into integrative and joint working behaviours (proposing, building, including, solidifying, agreeing, openness, trusting), distributive and conflict behaviours (blocking, disagreeing, criticising, attacking, preconditions, shutting out, threats, apprehension) or neutral and information-exchange behaviours (providing information, seeking information, deferring, empathising, giving notice). This information was then cross tabulated in NVivo with individuals (cases) grouped as government and civil servant, employer or union. Word counts help calculate the overall proportion of these behaviours exhibited by each group to indicate the extent of consensual decision making.

The outcomes of social partnership are assessed using data from the substantive decisions taken on each agenda item in transcripts of partnership meetings, secondary documents and interviews to interpret the importance of different outcomes for stakeholders. Discussion of the initial findings in partnership meetings helped assess data reliability and develop explanations of similarities and differences between the two cases.

Results

The results are structured to answer the three research questions concerning the emergence, operation (scope and joint working) and outcomes of social partnership.

Emergence

The article's first aim is to explain the emergence of social partnership in NHS Scotland and Wales. Social partnership emerged as a direct result of political devolution in 1998 as legislative power over health services transferred to new governments for Scotland and Wales. The residual collectivism in British public sector industrial relations had left NHS unions well placed to re-engage with devolved governments given high membership density, voice at different levels of the NHS, and professional association expertise in healthcare delivery. Given these conditions, social partnership provided opportunities to address issues relating to state-union dialogue, marketisation and industrial relations as 'a reaction against eighteen years of Conservative governments in Westminster' (Unite-Scotland rep2).

Social partnership involved a process of institutionalising the increased state-union dialogue that developed from privileged union access to Scottish and Welsh Labour parties following devolution. NHS Scotland unions reported 'an inability to penetrate Westminster policy making circles' (Unite-Scotland rep1) prior to devolution. As devolution approached this was replaced by 'privileged access to the [Scottish] Labour politicians likely to form governments' (Unison-Scotland rep1), and more contact with locally based civil servants and employers. Civil servants explained the Scottish government's first Cabinet Secretary for Health (1999-2001), Susan Deacon, 'sought informal policy advice from unions' and seconded union representatives to join her advisory board and the Scottish Government Health Department (SGHD). This resulted in 'gradual [union] re-integration into decision making with 18 months of intensive talks to decide on health service organisation' (RCN-Scotland rep1). Unions reported 'immense involvement around strategic decisions, literally inside the Department writing some of the policy documents in the first few years' (Unite-Scotland rep1).

In NHS Wales, 'close relations between devolved governments and unions' (Welsh Civil Servant1) developed as unions reported 'sympathetic [Welsh] Labour politicians suddenly talking to unions in 1997' (Unite-Wales rep1), and 'good relationships with [subsequent] health ministers' (RCN-Wales rep1). Increased state-union dialogue reflected 'attempts by senior politicians to demonstrate accountability to people in Wales' (Welsh Civil Servant2), within a context of broader social dialogue between Welsh governments and Wales Trades Union Congress (TUC) (Bacon and Samuel, 2009: 238; Foster and Scott, 2007). However, state-union dialogue was not as strong in NHS Wales as NHS Scotland because social partnership was not considered essential to address marketisation in health services as described next.

Scottish government political positioning against marketisation encouraged social partnership and co-operation to reverse the reforms introduced by Conservative and New Labour Westminster governments. On the traditional left-right axis of party competition, Scottish voters are politically to the left of England in terms of opposition to neo-liberalism and support for the welfare state (Keating, 2005). They elected Labour-Liberal Democrat coalition (1999-2007) and SNP governments (2007 to date) opposed to marketisation of the NHS. Scotland's first Cabinet Secretary for Health, Susan Deacon, 'left everyone in no doubt that the market wasn't the future for health care in Scotland', with the SNP's stance against marketisation encouraging Scottish Labour further to the left. In contrast, Welsh governments faced less challenge from nationalists (Plaid Cymru) with the election of Labour-Liberal Democrat coalition (1999-2003), Labour governments (2003-7 and 2011 to date) and Labour-Plaid Cymru coalition (2007-2011). Social partnership in NHS Wales was not part of plans to reverse marketisation, with unions reporting 'the first two Welsh governments didn't have a dynamic or radical change agenda and did not seek to challenge NHS Trusts' (Unison-Wales rep1). As a result, social partnership was not as central to reforming NHS structure and governance in Wales compared to Scotland.

Government and employers in both countries inherited arm's-length arrangements for industrial relations that they regarded as inappropriate for the devolved context. Social partnership in each case provided opportunities for joint working to improve the industrial relations climate. The NHS Scottish Advisory Committee had become 'moribund and outdated' (Unite-Scotland rep1) prior to devolution and did not appear fit for purpose. Civil servants 'sought less adversarial relations with unions' (Scottish Civil Servant2) and desired a move away from the 'personal threats' received during the 1980-90s, threats that involved 'managers vilified both at the [negotiating] table and away from the table for implementing Westminster reforms' (Scottish Employer1). Employers described union participation in reform plans as 'the only politically feasible way forward given Scotland's political culture' (Scottish Employer4), with increased state-union dialogue making social partnership 'essential for engaging employees in initiatives to improve services' (Scottish Employer3). NHS Scotland's social partnership agreement in 1999 duly formalised increased union participation in decision making to develop healthcare reforms.

NHS Wales unions sought new arrangements to address their 'frustration with our outsider status' (Unite-Wales rep1), although devolution had a less pronounced impact on industrial relations. The All-Wales Joint Consultative Committee had 'ceased to function around 1990 because [NHS] Trusts didn't want to participate in all-Wales things, they only wanted local terms and conditions for staff' (Unison-Wales rep1). Trust employers reported 'a desire to improve industrial relations' (Welsh Employer2), but also 'valued their independence' (Welsh Employer1) and 'preferred to engage staff at Trust level rather than through national level negotiations with unions' (Welsh-Employer3). Welsh civil servants for their part continued to 'identify closely with the Department of Health

[in Westminster]' and the internal health market (Welsh Civil Servant1). As a result, unions felt 'devolution had little initial impact on NHS Trusts in Wales which continued to operate as local bargaining units' (Unite-Wales rep1), and employers 'resisted union calls for central negotiations to develop an all-Wales approach' (CSP-Wales rep1). The NHS Wales social partnership agreement eventually signed in 2001 was 'formalised almost by accident' (Welsh Civil Servant1). Differences in state support for social partnership and political positioning outlined above affected union participation in decision making as described next.

Operation

The article's second aim is to analyse in detail how social partnership operates in NHS Scotland and Wales. Social partnership involved large national level meetings. Forty-two representatives attended the SPF (14 each from the SGHD, NHS Scotland employers and unions) and 48 representatives attended the WPF (16 each for the Welsh government, NHS Wales employers and unions), meeting four times each year. These meetings notably differed in the scope of issues covered and the style of decision making.

The SPF provided unions with an influential role in NHS Scotland policy making and governance. The Minister wished to engage and involve as many staff as possible in the process of developing a Health Plan for Scotland. This was reflected in the SGHD's view that 'joint working with medical professionals and unions is an integral component in developing health plans to integrate and co-ordinate services' (Scottish Civil Servant1 - see Greer, 2008). In response, unions 'welcomed opportunities for early stage participation to help reform health services' and co-chaired the SPF with NHS Scotland's Chief Executive. They praised the SGHD's 'exceptional support' (Unite-Scotland rep1), described key employers as 'very faithful to partnership' (RCN-Scotland rep1), and commended 'key figures who faithfully attended partnership meetings over the years' (Unison-Scotland rep1). Representatives from the doctor (BMA) and nursing professions (RCN) attended throughout.

The principal evidence of union influence was 'an enormous consensus to dismantle the internal market in NHS Scotland' (Scotland-Unite rep1). The resulting *National Health Service Reform (Scotland) Act 2004* abolished Scotland's 26 NHS Trusts and discarded the purchaser-provider split (Greer 2008). Efficiencies were sought by re-organising into 14 Area NHS Boards responsible for planning and providing acute, primary and secondary care. Eight Special NHS Boards provided all-Scotland services (for example, the Scottish Ambulance Service). Statutory backing for social partnership unique in Britain accompanied these changes. Social partnership became a statutory requirement for NHS Scotland, with *NHS MEL(1999)(59)* and the *NHS (Reform) Scotland Act 2004* requiring each NHS Board to operate a local partnership forum at enterprise level, and the Health Minister appointing union nominated employee directors to NHS Boards. SPF union representatives accompanied the Minister and NHS Scotland Chief Executive in annual performance and accountability audits of NHS Boards. The SPF's role in health service governance strengthened to support service integration as it 'co-determined all-Scotland workforce policies' (Scotland-SOR rep1), levelling up standards in standing sub-committees (the Human Resource Forum (2003-4) and Scottish Workforce and Governance Committee (2004 to date)) as described in the outcomes section later.

Social partnership in contrast remained marginal to policy making and governance in NHS Wales following devolution. The first two Welsh governments (1999-2007) focussed on public health and localism (Greer, 2008: 125), maintaining the internal health market with Local Health Boards (LHBs) purchasing services from seven NHS Trusts in Wales. The WPF formed three years after devolution in 2001 because civil servants had not required union input into reform and restricted the WPF's role 'to encourage employer and union dialogue within a framework of the internal health market' (Welsh Civil Servant2). Consequently, the WPF was co-chaired by an NHS Employers' representative and full-time union officer. The Chief Executive NHS Wales did not attend and the BMA stopped attending after 'the restricted scope of discussions became apparent' in the first few meetings (Welsh Civil Servant3), although the RCN always attended. NHS Trusts were 'encouraged but not required to develop partnership' (Welsh Employer3) and 'continued to operate as local bargaining units, resisting union pressure to develop all-Wales policies' (Welsh Employer2).

Senior representatives in each country attributed these differences to the devolved government's contrasting legislative powers. Britain's devolution settlement was asymmetrical with differences in each government's devolved responsibilities in the *Scotland Act 1998* and *Government of Wales Act 1998* as described earlier. Civil servants explained 'the Scottish government's extensive legislative powers enabled unions to participate in a wide

range of decisions to reform health services' (Scottish Civil Servant5). NHS Scotland's Chief Executive agreed 'the legislative powers provided by devolution enabled Scotland to reorganise services and encourage co-operative industrial relations' (Scottish Civil Servant6). In contrast, Welsh governments 'maintained the internal market because we didn't have powers at that time to change the 1990 legislation' (Welsh Civil Servant5). Unions consistently argued for greater devolved powers to dismantle the internal market. These different constitutional arrangements reflected stronger desire for independence in Scotland than Wales, indicated by results in devolution and independence referenda and the SNP's electoral success. This had significant implications for the scope of social partnership and joint working.

Scope

Social partnership in NHS Scotland broadened union participation to strategic decisions such as those concerned with organisational structure and governance. According to interviewees, SPF meetings 'addressed the big ticket issues' (BMA-Scotland rep1) and 'influenced strategic decision making' (RCM-Scotland rep1). Analysis of SPF meeting transcripts show unions participated in an extensive range of issues. Three-quarters of debates covered 'big ticket' issues - health policy (21% of all debate), health service governance (20%), modernisation (21%) and finance (13%) - as measured by the word count for these issues as a proportion of meetings (Table 1). This included a broad range of health policies (28 issues including alcohol and tobacco, infections, pandemic flu and patient rights), governance (34 issues including accountability reviews, targets to improve health, efficiency and access to treatment), modernisation (38 issues including internal health markets, national planning, shared services, merging health and social care) and finance issues (specifically spending restrictions after 2009).

... Insert Table 1 about here ...

The restricted legislative powers vested to Wales constrained the range of issues discussed in the WPF. Civil servants and employers kept strategic issues off the social partnership agenda and limited discussions to workforce issues. Unions explained 'decisions appeared to bypass partnership arrangements' (RCN-Wales rep1), 'new health initiatives were introduced without reference to the partnership forum' (Unite-Wales rep2), and 'ideas which should be referred [to the forum] were instead produced as dictat' (CSP-Wales rep1). Less than one-third (32%) of WPF debates addressed health policy (2%), modernisation (25%, 12 issues including NHS reorganisation, HR strategy, shared services and mergers) and finance (5%) (Table 1). The WPF spent significant time debating workforce planning (3 issues - workforce statistics, staffing targets and education commissioning), pay and conditions (24 issues including contracts, *Agenda for Change* and sickness absence), and health and safety (7 issues including bullying, violence and aggression). The WPF's restricted focus mattered because the internal health market helped preserve NHS Trust autonomy and undermined union attempts to develop all-Wales workforce policies that averaged up standards. Civil servants explained 'health service organisation is outside the legitimate span of union influence', prevented the WPF from discussing issues over which Welsh governments lacked devolved powers, and 'restricted the range of issues discussed in the WPF to protect NHS Trust autonomy to decide key issues' (Welsh Civil Servant3). The SPF's focus on strategic decisions and the WPF's constrained focus had significant implications for joint working.

Joint working

SPF and WPF meetings displayed contrasting decision making styles after government policy leads introduced each agenda item. NHS Scotland developed consensual policy making to replace the adversarial industrial relations reported before devolution. The SPF's strategic focus and consensus to dismantle the internal health market encouraged joint working (which accounted for 48% of all contributions) rather than conflict (only 6% of contributions) (Table 2). More than two-thirds (69%) of union contributions in the SPF represented constructive contributions to joint working (Table 2). The SPF engaged in more joint working than the WPF on both 'big ticket' and workforce issues. This reflected the SGHD 'sharing early stage thinking on big ticket issues at the development

stage to encourage consensus' (Scottish Civil Servant6). NHS Scotland's Chief Executive explained, 'the way I have approached work with the SPF is to encourage as early involvement as possible, to encourage a discussion before any groups have been established, we need to be thinking what it is we're going to do, and unions need to be involved in that developmental work'. Unions responded positively to early stage consultation, expressed support for 'the values underpinning the general direction of travel', and nominated representatives to joint working groups taking the policies forward. Policies returned to the SPF several times for further comment to increase engagement. Consensual policy making illustrates the remarkable transformation of industrial relations in NHS Scotland under devolution.

... Insert Table 2 about here ...

In NHS Wales, the WPF's restricted focus and disagreements over the internal health market generated conflict. Only one-fifth (21%) of contributions involved joint working and one-third (33%) of contributions involved adversarial behaviour. On 364 occasions unions complained about their exclusion from policy development as 'Welsh governments presented policies to the WPF at late stages of development' (Unison-Wales rep2), and made unions 'just observers of policy making' (Unite-Wales rep1). Civil servants explained that Welsh governments 'did not engage in early stage consultation because health service policy is a ministerial preserve and outside the purpose of the partnership forum which is to concentrate on workforce issues' (Welsh Civil Servant3). The Welsh government's limited secondary legislative powers and the internal health market restricted the scope for consensual policy making under social partnership.

Subsequent changes in Wales further highlight the importance of these factors. As Plaid Cymru's electoral support increased, the Welsh government applied for enhanced legislative powers in the *National Health Service (Wales) Act 2006* and *Government of Wales Act 2006* to pass quasi-primary legislation from May 2007, under catch up devolution arrangements. The *One Wales* agreement of the Labour-Plaid Cymru coalition government (2007-2011) included a commitment to end the internal health market and private sector involvement in health services (One Wales, 2007: 9-10). Seven NHS Trusts in Wales were subsequently dissolved in October 2009 and replaced by seven unified LHBs responsible for commissioning and providing care. Three NHS Trusts provided all-Wales services (ambulance, cancer care and public health) (Welsh Assembly Government, 2009).

Welsh government political repositioning resulted in the WPF becoming less adversarial after the new Health Secretary (and former Head of Wales TUC), Edwina Hart, directed employers to develop all-Wales policies. In subsequent WPF meetings (November 2007-2013), compared to before the *One Wales* agreement (2004-2007), joint working increased from 18% to 27% of contributions and conflict declined from 38% to 25% of contributions. As the WPF continued to concentrate on workforce issues rather than health service structure and governance, the climate remained more adversarial than the SPF by end 2013.

As the 2008 financial crisis impacted NHS finances in 2010-11, responses in the two countries illustrated this continued difference between social partnership arrangements. NHS Scotland's Health Secretary, Nicola Sturgeon, chaired a National Scrutiny Group (NSG) of SPF representatives to review NHS Board workforce plans and manage risks to patient care, check plans had been developed in partnership locally, and ensure employment security with no detriment to earnings in line with the *Organisational Change Policy* (described in the outcomes section below). In contrast, NHS Wales employers repeatedly attempted to discuss the implications of the financial crisis in the WPF, with unions responding by 'drawing lines in the sand' on service change and national terms and conditions. Consensual policy making appeared stronger in NHS Scotland than NHS Wales in both times of service expansion and contraction.

Outcomes

Under social partnership in NHS Scotland and Wales unions realised their aims of dismantling the internal health market, abolishing NHS Trusts, and excluding private sector firms from providing public health services. Outsourced ancillary services were taken back into NHS Scotland. This involved re-nationalising both the private HCI Hospital in 2002 and Scotland's only independent sector treatment centre at Stracathro in 2010. NHS Wales returned 250

ancillary staff to the NHS at Neath Port Talbot Hospital in 2009 reversing the impact of a former Welsh Office (Westminster) PFI project. Staff transferred onto NHS contracts with higher pay (including *Agenda for Change* increases), more annual leave and improved sick pay. Both devolved governments rejected competitive tendering, the use of the private sector and PFI in the NHS. These developments represent the most notable reversal of public sector marketisation in Britain to date.

Dismantling the internal health market enabled unions to centralise and co-determine staff terms and conditions. This involved identifying current best practice and levelling up standards. In NHS Scotland, it became a statutory requirement for Health Board's to 'meet or exceed' ten national employment policies, including *Organisational Change* containing a 'no compulsory redundancies' clause and 'no detriment lifetime earnings protection' if redeployed. Unions explained 'national personnel policies and abolishing the internal health market were the main gains from social partnership' (Scotland-SOR rep1). Before catch up devolution, NHS Wales developed a single all-Wales policy (*Preventing and Dealing with Bullying and Harassment*) and from 2009 onwards co-determined six all-Wales employment policies including *Organisational Change*. Welsh unions overcame initial employer concerns regarding the costs of levelling up standards.

Pay-setting in the NHS is not devolved to Scotland and Wales with awards based on recommendations to Westminster from the UK-wide NHS Pay Review Body (NHSPRB). The Scottish government nevertheless exercised discretion in honouring the NHSPRB recommended 2.5% pay award in 2007, in contrast to the staged award in NHS Wales and England that reduced its value over a full year to 1.9%. The Scottish government also granted NHS Scotland staff the NHSPRB's recommended 1% increase in April 2014 denied to NHS Wales and England staff. This resulted in the typical NHS nurse earning £460 extra in Scotland than in Wales and England. NHS Scotland also included a flat rate £300 increase for staff earning under £21,000, in comparison with a non-consolidated £160 for all NHS Wales employees. Introducing the Scottish Living Wage across NHS Scotland in 2013 resulted in abolishing *Agenda for Change* pay band 1, with NHS Wales following suit in 2014.

Bevan et al.'s (2014) authoritative comparison of health service indicators for the UK's four health systems from the 1990s to 2011/12 (Scotland, England, Wales and Northern Ireland) provides some indication of the cumulative impact of changes on service performance since devolution. NHS Scotland narrowed the gap in performance indicators with NHS England inherited on devolution, with average waiting times in Scotland matching those in England by 2011/12 for all seven common elective procedures on which comparative data exists (ibid.:7-9). NHS Wales' comparatively longer waiting times increased as it reduced NHS spending in real terms by 1% (Scotland increased spending by 1%). Whereas NHS England charges patients for a range of services, both Scottish and Welsh governments reintroduced free prescriptions and abolished hospital car parking charges for patients and staff. NHS Scotland also reintroduced free eye tests, free dental check-ups (only available if under 25 or over 60 years of age in Wales) and free personal care for over-65s.

Conclusions

This article provided the first assessment of social partnership arrangements in Britain by exploring the emergence, operation and outcomes of social partnership in NHS Scotland and Wales. Social partnership emerged as a result of political devolution with the transfer of power to devolved governments opposed to the marketisation of public services. In NHS Scotland, extensive co-operation developed to dismantle the internal health market, improve services and enhance staff terms and conditions. The internal market was also dismantled in NHS Wales under catch up devolution, although restricting social partnership to workforce decisions limited the extent of co-operation, with modest improvements to services and pay levels.

The findings advance the neo-pluralist perspective on partnership in drawing a sharp distinction between social partnership at the higher sectoral level and labour-management partnership at enterprise level. Social partnership delivered mutual gains that appeared elusive in prior studies of labour-management partnership in the British public sector (Badigannavar and Kelly, 2004; Beale, 2005; Martin, 2010). The positive outcomes from social partnership are attributed to the privileged and institutionalised access that unions gained to government ministers, civil servants and employers who report to them. This facilitated union participation in a wide range of strategic decisions concerning the structure and governance of public services, in contrast to labour-management partnership's

more restricted focus. Social dialogue was sustained by the pro-labour ideology of devolved governments and co-determination of workforce policies. The Scottish government also provided legal backing for partnership in NHS decision making and appointed employee directors on health boards (Ackers and Payne, 1998; Kochan and Osterman, 1994; Martínez Lucio and Stuart, 2004; Terry, 2003). The level of state support provided and the positive outcomes reported suggest that social partnership in NHS Scotland and Wales may be regarded as Britain's leading experiments to modernise public sector industrial relations. The subsequent improvements in health services further suggest that social partnership is a viable alternative to the introduction of markets when governments seek to improve public services.

The findings challenge the claims made by the radical perspective on partnership. Critics argue that partnership does not increase union participation in organisational decisions or provide labour gains, and should be avoided by unions (Kelly, 1996; 2004). These arguments appear to over-generalise the findings from studies of labour-management partnership under New Labour Westminster governments. The findings presented here suggest social partnership offers opportunities for unions to work with left-wing governments to develop alternatives to public service marketisation, reduce the downward pressure of competition on employees' terms and conditions, and improve public services. The cases presented demonstrate the positive contribution unions can make in the public sector.

Government support for unions of the type described is rare in liberal market economies, however, and critics may argue the social partnership arrangements outlined here are exceptional. The emergence of social partnership in the NHS reflects the broadly social democratic approach to industrial relations adopted by the Scottish and Welsh devolved governments. Devolved governments are providing more support for unions and it appears that devolution is an important source of divergence in Britain's system of industrial relations. The analysis identified two issues that appear to shape this process - government political positioning against marketisation and degree of independence. Future studies may further explore the impact of devolution on industrial relations as these factors change, specifically the implications of the SNP's election success and forthcoming legislation to increase devolved powers. The implications of political devolution for industrial relations systems in other countries may also be considered, as nationalist and regionalist movements pursue greater independence.

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References

Ackers P and Payne J (1998) British trade unions and social partnership: rhetoric, reality and strategy. *International Journal of Human Resource Management* 9(3): 529-50.

Bach S (2002) Public-sector employment relations reform under Labour. *British Journal of Industrial Relations* 40(2): 319-39.

Bach S and Kessler I (2012) *The Modernisation of the Public Services and Employee Relations*. Basingstoke: Palgrave Macmillan.

Bacon N and Samuel P (2009) Partnership agreement adoption and survival in the British private and public sectors. *Work, Employment and Society* 23(2): 231-248.

Badigannavar VI and Kelly J (2004) *Labour-management partnership in the UK public sector*. In: J Kelly and P Willman (eds) *Union Organization and Activity*. London: Routledge, 110-28.

Bazeley P and Jackson K (eds) (2013) *Qualitative Data Analysis With NVivo*. London: Sage.

Beale D (2005) The promotion and prospects of partnership at Inland Revenue. In: Stuart M, Martínez Lucio M (eds) *Partnership and Modernisation in Employment Relations.* London: Routledge, 137-53.

Cabinet Office (2009) *Public Services Forum: The First Five Years*. London: Cabinet Office.

Danford A, Richardson M and Upchurch M (2002) Trade union strategy and renewal: the restructuring of work and work relations in the UK Aerospace Industry. *Work, Employment and Society* 16(2): 305-327.

Davies N and Williams D (2009) *Clear Red Water: Welsh Devolution and Socialist Politics*. London: Francis Boutle.

Foster D and Scott P (2007) Trade unions and regional government working in partnership? Emergent lessons from Wales. *Economic and Industrial Democracy* 28(3): 349-373.

Greer S (2008) Options and the lack of options: healthcare politics and policy. *Political Quarterly* 79(Supplement 1): 117-32.

Heery E (2015) Frames of reference and worker participation. In: Johnstone S, Ackers P (eds) *Finding a Voice at Work?* Oxford: Oxford University Press, 21-43.

Jenkins J (2007) Gambling partners? The risky outcomes of workplace partnerships. *Work, Employment and Society* 21(4): 635-652.

Keating M (2005) Policy convergence and divergence in Scotland under devolution. *Regional Studies* 39(4): 453-63.

Kelly J (1996) Union militancy and social partnership. In: Ackers P, Smith C, Smith P (eds) *The New Workplace and Trade Unionism*. London: Routledge, 77-109.

Kelly J (2004) Social partnership agreements in Britain: labor co-operation and compliance. *Industrial Relations* 43(1): 267–92.

Kochan TA and Osterman P (1994) *The Mutual Gains Enterprise*. Boston, MA: Harvard Business School Press.

Kochan TA, Eaton AE, McKersie, RB and Adler, PS (2009) *Healing Together: The Labor-Management Partnership at Kaiser Permanente*. Ithaca, NY: Cornell University Press.

Martin D (2010) The removal of workplace partnership in the UK Civil Service. *Industrial Relations Journal* 41(3): 218-32.

Martínez Lucio M and Stuart M (2004) Swimming against the tide: social partnership, mutual gains and the revival of 'tired' HRM. *International Journal of Human Resource Management* 15(2): 410-424.

Martínez Lucio M and Stuart M (2005) 'Partnership' and new industrial relations in a risk society: an age of shotgun weddings and marriages of convenience? *Work, Employment & Society* 19(4): 797-817.

Munro A and Rainbird H (2004) Opening doors as well as banging on tables: an assessment of UNISON/employer partnerships on learning in the UK public sector. *Industrial Relations Journal* 35(5): 419-433.

One Wales (2007) *One Wales: A Progressive Agenda for the Government of Wales*.

Oxenbridge S and Brown W (2004) Achieving a new equilibrium: the stability of cooperative employer-union relationships. *Industrial Relations Journal* 35(5): 388-402.

Pass S (2008) *Working in Partnership: What does academic research tell us?* Leeds: Department of Health.

Pollock A (2004) *NHS Plc: The Privatisation of Our Healthcare*. London: Verso.

Roper I, James P and Higgins P (2005) Workplace partnership and public service provision: the case of the 'best value' performance regime in British local government. *Work, Employment and Society* 19(3): 639-49.

Samuel P (2007) Partnership consultation and employer domination in two British life and pensions firms. *Work, Employment and Society* 21(3): 459-477.

Samuel P and Bacon N (2010) The contents of partnership agreements in Britain, 1990-2007. *Work, Employment and Society* 24(3): 1-19.

Smith A (2006) 'Partnership' at work? *Work, Employment and Society* 20(4): 811-817.

Stuart M and Martínez Lucio M (2000) Renewing the model employer: changing employment relations and 'partnership' in the health and private sectors. *Journal of Management in Medicine* 14(5/6): 310-26.

Stuart M and Martínez Lucio M (2002) Social partnership and the mutual gains organization: remaking involvement and trust in the British workplace. *Economic and Industrial Democracy* 23(2): 177-200.

Stuart M and Martínez Lucio M (2005a) (eds) *Partnership and Modernisation in Employment Relations.* London: Routledge.

Stuart M and Martínez Lucio M (2005b) *ACAS in the NHS: Helping improve employment relations in response to Agenda for Change.* London: ACAS Research Paper Ref: 06/05.

Tailby S, Richardson M, Stewart P, Danford A and Upchurch M (2004) Partnership at work and worker participation: an NHS case study. *Industrial Relations Journal* 35(5): 403-18.

Terry M (2003) Can 'partnership' reverse the decline of British trade unions? *Work, Employment and Society* 17(3): 459-472.

Walton RE and McKersie RB (1965) *A Behavioral Theory of Labor Negotiations.* Ithaca, NY: ILR Press.

Welsh Assembly Government (2009) *NHS in Wales: Why we are changing the structure*. Cardiff: Welsh Assembly Government.

Work Foundation (2004) *Trade union and employee involvement in public service reform*. London: Office of Public Services Reform.

Author biographies

Nicolas Bacon is Professor in Human Resource Management at Cass Business School. His research explores the impact of human resource management practices on organisational performance and employees in a wide variety of settings including manufacturing firms, unionised workplaces, small and medium-sized enterprises, private equity-owned firms and the public sector. He edited the *Industrial Relations Journal* 2004-2008, serves on the editorial board of several journals and co-edited both *The Sage Handbook of Industrial Relations* and *The Sage Handbook of Human Resource Management*.

Peter Samuel was Lecturer in Employment Relations at Nottingham University Business School and sadly passed away in 2013. Specializing in studying labour-management partnership he published articles in *Work, Employment and Society* and the *Industrial Relations Journal*. His PhD at Cardiff Business School was published as the book *Financial Services Partnerships: Labor-Management Dynamics* in 2014 by Routledge.

Table 1: Scope of Collective Regulation in the Scottish Partnership Forum and Welsh Partnership Forum

Issue	**Scottish Partnership Forum**	**Welsh Partnership Forum**
Health Policy	21	2
Modernisation	21	25
Health Service Governance	20	0
Finance	13	5
Partnership	10	13
Workforce Planning	7	22
Pay and Conditions	4	15
Training and Equality	3	5
Staff Survey	2	2
Health and Safety	1	11

Notes:
Column percentages for each forum based on word counts of minutes and transcribed recordings. Totals do not sum to 100% due to rounding.

Table 2: Behaviours by Issue and Actor (percentages) in the Scottish Partnership Forum and Welsh Partnership Forum

	Scottish Partnership Forum			**Welsh Partnership Forum**		
	Co-operation	Neutral Information Exchange	Conflict	Co-operation	Neutral Information Exchange	Conflict
ISSUE						
Health Policy	50	46	4	27	51	22
Modernisation	44	49	8	21	46	33
Health Service Governance	49	43	8	0	0	0
Finance	39	51	10	18	39	43
Partnership	75	18	7	25	36	39
Workforce Planning	45	43	12	15	43	41
Pay and Conditions	72	15	12	20	47	33
Training and Equality	46	49	5	30	42	28
Staff Survey	42	58	0	33	54	13
Health and Safety	65	33	2	24	49	27
ACTORS						
Trade unions and professional associations	69	14	17	17	26	57
NHS Employers	60	36	5	36	40	24
Government (SGHD or Welsh government)	31	68	1	18	66	17
OVERALL TOTALS	47	48	6	21	46	33

Notes:
Row percentages for each forum based on word counts of minutes and transcribed recordings. Totals do not sum to 100% due to rounding. All behaviour categories developed from Walton and McKersie (1965) as described in the methods section.