

NHS MUTUAL

ENGAGING STAFF AND ALIGNING INCENTIVES TO
ACHIEVE HIGHER LEVELS OF PERFORMANCE

Jo Ellins and Chris Ham



NHS MUTUAL

ENGAGING STAFF AND ALIGNING INCENTIVES TO
ACHIEVE HIGHER LEVELS OF PERFORMANCE

Jo Ellins and Chris Ham



The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

ABOUT THE NUFFIELD TRUST

The Nuffield Trust is a charitable trust carrying out research and policy analysis on health services. Its focus is on the reform of health services to increase the efficiency, effectiveness, equality and responsiveness of care.

Published by
The Nuffield Trust
59 New Cavendish Street
London W1G 7LP

Telephone: 020 7631 8450
Facsimile: 020 7631 8451

Email: info@nuffieldtrust.org.uk
Website: www.nuffieldtrust.org.uk

Charity number 209201
© The Nuffield Trust 2009
ISBN-13: 978-1-905030-39-2

Designed by Mike Roberts at Susan Rentoul Design
www.susanrentouldesign.co.uk

Printed by Modern Colour Solutions
www.moderncoloursolutions.co.uk

CONTENTS

ACKNOWLEDGEMENTS	5
ABOUT THE AUTHORS	6
FOREWORD	7
GLOSSARY	8
EXECUTIVE SUMMARY	9
1. INTRODUCTION	13
2. PROMOTING STAFF ENGAGEMENT IN THE NHS	16
2.1 <i>'Working Together' and the NHS Taskforce on Staff Involvement</i>	16
2.2 <i>More staff, working differently</i>	18
2.3 <i>The NHS Next Stage Review</i>	19
2.4 <i>A renewed emphasis on staff involvement</i>	20
2.5 <i>The NHS Constitution</i>	21
2.6 <i>Summary</i>	22
3. THE EXPERIENCES OF STAFF WORKING IN THE NHS	23
3.1 <i>Factors that drive engagement of NHS staff</i>	23
3.2 <i>Findings of the NHS Staff Survey</i>	24
3.3 <i>Further research into the NHS staff experience</i>	26
3.4 <i>Summary</i>	27
4. WHAT IS EMPLOYEE OWNERSHIP?	28
4.1 <i>Defining employee ownership</i>	28
4.2 <i>Organisational forms</i>	29
4.3 <i>Social enterprises</i>	31
4.4 <i>NHS foundation trusts</i>	32
4.5 <i>Summary</i>	33

5. THE EMPLOYEE-OWNED SECTOR	34
5.1 <i>The international perspective</i>	34
5.2 <i>Employee ownership in the UK</i>	35
5.3 <i>Employee ownership of public services</i>	36
5.4 <i>New opportunities for employee-owned public services</i>	38
5.5 <i>Summary</i>	39
6. THE EVIDENCE FOR EMPLOYEE OWNERSHIP	40
6.1 <i>The theory behind employee ownership</i>	40
6.2 <i>Outcomes of employee ownership</i>	43
6.3 <i>The combination effect of employee ownership and participation</i>	51
6.4 <i>Workplace participation without employee ownership</i>	54
6.5 <i>Summary</i>	57
7. EMPLOYEE OWNERSHIP CASE STUDIES	58
7.1 <i>John Lewis Partnership</i>	58
7.2 <i>Kaiser Permanente</i>	60
7.3 <i>Circle</i>	63
7.4 <i>Central Surrey Health</i>	64
8. CHALLENGES TO DEVELOPING EMPLOYEE OWNERSHIP OF HEALTH SERVICES	66
<i>Summary</i>	70
9. CONCLUSIONS	72
<i>Summary</i>	75
REFERENCES	76

ACKNOWLEDGEMENTS

The authors acknowledge the support of the Nuffield Trust in funding this work, and hosting a series of events to explore the issue and examples of employee ownership. We are indebted to Ken Temple (John Lewis Partnership), Nick Seddon, Massoud Fouladi and Jonathan Pearson (Circle), Sharon Levine (Kaiser Permanente) and Tricia McGregor and Jo Pritchard (Central Surrey Health) for contributing their experiences to the project. A number of people shared their insights and evidence with us. In particular, we would like to thank Jonathan Michie, Patrick Burns, Peter Hunt, Andrew Foster and all those who joined us in a seminar to discuss our findings and their implications for the NHS. They have contributed greatly to our thinking on this subject. We are also grateful to two anonymous reviewers and to Jamie Samuel, Becky Farren and Phillip Smith at the Department of Health for their helpful comments on an earlier draft. While indebted to many, the authors are responsible for the views expressed and the content of this monograph.

ABOUT THE AUTHORS

Jo Ellins

Jo Ellins is a research fellow at the Health Services Management Centre, University of Birmingham. Prior to joining HSMC in 2007, Jo managed a national organisational development programme at the NHS Centre for Involvement and was a research associate at the Picker Institute. Her main research interests are in the area of patient and public involvement, including patient choice, self-management of long-term conditions and public participation in health service development and commissioning.

Chris Ham

Chris Ham has been Professor of Health Policy and Management at the University of Birmingham, England, since 1992. From 2000 to 2004 he was seconded to the Department of Health where he was Director of the Strategy Unit, working with ministers on a number of NHS reform initiatives. Chris is the author of 19 books and numerous articles about health policy and management. His work focuses on the use of research evidence to inform policy and management decisions in areas such as health care reform, chronic care, primary care, integrated care, performance improvement and leadership. Chris has advised the World Health Organisation (WHO) and the World Bank, and has served as a consultant to governments in a number of countries. In 2004 he was awarded a CBE for his services to the National Health Service.

FOREWORD

Increasing staff involvement and motivation has long been understood to be vital to the NHS. As NHS organisations begin to feel the financial squeeze, they will need to find more creative ways to maintain and improve patient care on tighter budgets.

This timely report examines how the NHS can best engage and incentivise its staff, taking a wider view of the productivity gains achieved through employee engagement in other sectors.

The authors, Jo Ellins and Chris Ham from the University of Birmingham's Health Services Management Centre, highlight the need for reform, drawing on national and international lessons from within and beyond health care. They describe a series of alternative social ownership models for the NHS, which I believe will serve as a very useful basis for discussion among all those with an interest in this area.

The Nuffield Trust has a growing programme of research and policy analysis that addresses critical questions about health service reform. To keep in touch with our developing programme, please visit our website where you can sign up for regular updates.

Dr Jennifer Dixon
Director, The Nuffield Trust

GLOSSARY

Term	Definition	Source
Employee ownership	Organisations where employees own a controlling stake in the business, i.e. more than 51 per cent. Shares can either be personally held by individual employees (direct ownership) or collectively held on behalf of employees, normally through an employee benefit trust (indirect ownership).	Employee Ownership Association (EOA, 2007)
Co-ownership	Organisations where employees own a substantial but minority stake in the business (generally more than 25 per cent).	Employee Ownership Association (EOA, 2007)
Employee share ownership	Organisations where employees own a share in the equity, but where the proportion of shares held by employees is likely to be a very small proportion of the total.	Employee Ownership Association (EOA, 2007)
Employee engagement	Employee engagement is exemplified by a positive attitude held by the employee towards the organisation and its values. An engaged employee is aware of business context, and works with colleagues to improve performance within the job for the benefit of the organisation. Requires a two-way relationship between employer and employee.	Institute for Employment Studies (Robinson, 2007)
Employee involvement	Employee involvement comprises four key elements: sharing information about the performance of the organisation; rewards based on the performance of the organisation; knowledge that enables employees to understand and contribute to organisational performance; and power to make decisions that influence organisational performance and direction.	(Lawler, 1988)
Employee benefit trust	An employee benefit trust (EBT) acquires and holds equity collectively on behalf of employees. In the United States, the main vehicle for employee ownership is a form of EBT called an employee stock ownership plan (ESOP).	(Pendleton, 2001)

EXECUTIVE SUMMARY

Staff engagement and staff surveys in the NHS

- Many policy initiatives have been launched since 1998 to increase staff involvement and foster partnership working at a national and local level. These include the NHS Taskforce on Staff Involvement, the NHS Social Partnership Forum and the first comprehensive human resources strategy for the NHS.
- These initiatives have identified engaging and motivating staff as critical to the delivery of the NHS reform programme, and to achieving the goals of high-quality, responsive and efficient patient care.
- The NHS Next Stage Review (The ‘Darzi Review’; Secretary of State for Health, 2008) reiterated the need for NHS reforms to be locally led and clinically driven, and for there to be greater freedoms for front-line staff. The NHS Constitution (Department of Health, 2009) pledged that staff will be engaged in decisions that affect them and empowered to put forward ways of delivering better and safer services.
- Notwithstanding the emphasis placed on staff engagement, experience in the NHS is variable and policy aspirations have yet to be translated into practice on a consistent basis. This suggests that more than exhortation and guidance are needed to convert policy into practice.
- The strongest driver of staff engagement in the NHS is a sense of being valued and involved. Annual surveys show that NHS staff are highly satisfied with the support they receive from colleagues, the amount of responsibility they are given and the opportunity they have to use their skills.
- However, relatively few staff report that they are involved in important decisions, consulted about changes that affect them, encouraged to suggest ideas for improving services or feel that their organisation values their work.
- NHS staff are motivated by the opportunity to deliver high-quality services that make a difference to patients. But they feel that their ability to do this is being threatened by the adoption of a more business-oriented approach within the health service.
- Awareness among NHS staff of involvement initiatives is much higher than actual levels of participation. Staff involvement is associated with a wide range of performance benefits including lower levels of sickness absence, patient mortality and complaints, and higher levels of innovation, job satisfaction and cooperation with co-workers.
- Comparisons of the findings from recent NHS surveys have found that there is a correlation between staff and patient experience. Patients are more satisfied with their care when this is provided by organisations that have satisfied staff.

The employee-owned sector

- Employee financial participation occurs along a continuum from full employee ownership, through employee share ownership, to incentive schemes in which employees do not have a long-term financial stake, such as profit-related pay.
- Employees can personally have a financial stake in their organisation (direct ownership), or this can be held on their behalf in an employee benefit trust (indirect ownership). Employee ownership can take many different organisational forms including cooperatives, mutuals and partnership arrangements.
- Within the health sector, the government is promoting new forms of ownership through the establishment of social enterprises and NHS foundation trusts.
- Evidence suggests that more needs to be done to promote the development of social enterprises and help them enter the market. Social enterprises may face particular barriers in competing for public sector contracts.
- In the United States, an estimated one fifth of the workforce is engaged in some form of financial participation. The employee-owned sector in the United Kingdom has grown steadily since the 1990s, and is estimated to have an annual turnover of £20–25 billion.
- There are currently only a handful of employee-owned organisations delivering public services. These include Central Surrey Health, which provides community nursing and therapy services and is owned by its 780 staff.
- Employee ownership of public services may be expected to grow as the government challenges monopoly provision and encourages greater plurality of service provision. While there is political sensitivity around an increased role

for commercial companies in public service provision, employee-owned organisations may be seen as a more acceptable alternative.

- Within the NHS, primary care trusts (PCTs) are being asked to develop plans for the future of their directly provided services and establish themselves as commissioning organisations. A number of options for provider services have been proposed, including the social enterprise model.

Evidence of impact

- On average, companies experience a productivity boost of four to five per cent when employee ownership is introduced, which is sustained over subsequent years. There is also evidence that employee ownership can lead to lower levels of staff turnover and absenteeism, and to higher levels of innovation.
- Research has also shown that staff in employee-owned companies are more likely to confront a non-performing colleague. This finding is especially important in health care, given the importance of peer pressure as a driver of performance and the difficulty facing non-clinicians in challenging under-performance.
- Few studies have assessed the impact of employee ownership on customer/service user outcomes. The best evidence is for mutuals, whose accountability to their customers (rather than external shareholders) has resulted in higher levels of customer trust and loyalty.
- Research consistently demonstrates that employee ownership only produces (or only sustains) benefits when two further factors are present: human resource management practices that foster staff participation; and a culture of ownership that is associated with staff having a collective voice in the organisation.

- This raises questions about whether staff participation and collective voice (in the absence of employee ownership) would achieve similar outcomes. Research shows that initiatives to increase staff participation in the workplace can improve financial performance, employee turnover and satisfaction. But these schemes are generally only effective when they grant staff higher levels of influence and autonomy, are introduced in bundles rather than as one-off initiatives and are actively supported by managers.
- Neither employee ownership nor staff participation schemes by themselves produce the same level and sustainability of impact as they do in combination. The evidence reviewed here suggests that employee ownership underpins and enhances the positive effect of staff participation schemes and increases employees' faith that such schemes are genuine and long-term.

Case studies of employee ownership

- Four case studies of employee-owned organisations are described: John Lewis Partnership, Kaiser Permanente, Circle and Central Surrey Health.
- These four organisations have developed different organisational models for employee ownership: Circle and Kaiser are professional partnerships, while Central Surrey Health is a limited liability company in which each staff member has a 1p share.
- A characteristic common to all is the strong emphasis that is placed on communicating with employees and involving them in decision-making. At the John Lewis Partnership, managers can be held to account by staff through democratic mechanisms at every level of the organisation.

- The case study examples provide further evidence of the impact of employee ownership on performance. These organisations are among the most innovative and successful in their sectors.

Challenges for the NHS

- There are a number of challenges in developing employee ownership in the NHS. These include whether there is sufficient political will, and practical and financial support, available to make this happen. The establishment of any new type of organisation within the NHS also requires support from leaders at a regional and local level, including strategic health authorities who will have a major role to play in approving local plans and business cases.
- Trade unions are concerned about moves to introduce new types of provider organisation and create a mixed economy in health. However, employee-owned organisations may be seen as more closely aligned to core NHS values, and an acceptable alternative to commercial providers.
- Employee-owned organisations in the NHS will be operating in an increasingly competitive market environment. While this poses a risk in terms of their long-term sustainability, choice and competition may prevent employee ownership leading to 'provider capture'.
- Access to NHS pensions remains a major barrier to PCT provider arms becoming social enterprises. Unless the rules on new staff employed by social enterprises not being entitled to join the NHS pension scheme are changed, then the number of provider arms choosing to go down this route is likely to be extremely limited.
- Clarity about the migration path to employee ownership is also needed before this is seen as a viable option. Organisations will need to access

business and legal support and other practical advice on organisational options, the transfer of staff and related issues.

Options for the future

- Employee ownership may help the NHS to further empower staff and unlock their potential to drive service improvements. There are at least five ways in which employee ownership in the NHS might be fostered.
- **Option 1: Greater voice and participation.** At a minimum, local NHS organisations can increase the extent and ways in which staff can play a role in shaping the services they deliver. This should be informed by the evidence about the factors that promote effective staff participation, in particular the importance of leadership styles and managerial commitment.
- **Option 2: Employee-owned community health services.** New models for community health services are being sought and appraised, and could include employee-owned social enterprise. Given the opportunity, participation structures could be built into the governance framework of an employee-owned social enterprise from the outset.
- **Option 3: Multi-professional partnerships in general practice.** Employee ownership is well established in general practice and the new primary care contract made multi-professional partnerships possible for the first time. Ownership of general practitioner (GP) services could be extended to other primary care professionals, non-clinical staff such as practice managers and medical specialists, whose work is increasingly community-oriented.
- **Option 4: A social enterprise model for primary care and community health services.** A further possibility is for primary care and community health services to combine elements of options 2 and 3 above. General practices would continue to be run as partnerships but would collaborate with a wider range of community and stakeholder interests through a social enterprise approach.
- **Option 5: Multi-professional chambers within NHS foundation trusts.** In NHS foundation trusts, a multi-professional ‘chambers’-type arrangement, in which clinical staff within the same directorate or service unit take greater ownership, would be possible. This is consistent with the development of service line management in these organisations.
- These options are not mutually exclusive and the time is now right for government to support the testing out of different approaches, to support the engagement of staff and to achieve a better alignment of incentives.

1. INTRODUCTION

The NHS in England has been on a rollercoaster ride of reform in the last decade. The journey started with the Government promulgating a large number of targets and standards for improving performance. Implementation of these targets and standards was managed through hierarchical controls. In parallel, new systems for inspection and regulation were introduced, based on annual assessments of the performance of NHS organisations linked to publication of the results in the form of performance ratings. From around 2002, the Government also emphasised the need to increase the choices available to patients and for health care providers to compete for patients and the resources they brought with them. In this way, a quasi-market in health care was overlaid on targets and regulation.

The evidence indicates that the performance of the NHS in England has improved significantly in the last decade, particularly in areas of high priority like reducing waiting times for treatment, and improving cancer and cardiac services. These improvements have resulted mainly from the use of hierarchical controls linked to a massive increase in NHS spending. In the process the weaknesses of hierarchical controls have also become apparent. These weaknesses include the risk that front-line staff will be demotivated through micro-management of their work, innovation will be stifled, and managers and clinicians will ‘game’ the system to achieve targets set by Government.

In recognition of these risks, ministers have talked of the need to turn the NHS into a ‘self-improving system’ (Hewitt, 2005) in which the drivers for improvement come from within rather than being imposed from outside. This argument was at the heart of the NHS Next Stage Review led by Lord Darzi. The final report of the review, *High Quality Care for All* (Secretary of State for Health, 2008), explicitly stated that the Government was seeking to ensure that further reform was locally led with the full engagement of NHS staff, especially clinicians. The corollary was that less emphasis was to be placed on targets in future. Indeed, *High Quality Care for All* was at pains to note that no new national targets were included in its recommendations.

Underpinning these policies is awareness that the sheer size of the NHS and the range and complexity of the services it delivers means that it will always be difficult to achieve continuous improvements in performance from its headquarters in Whitehall. This has been recognised in recent years with the policies set out in *Shifting the Balance of Power* (Department of Health, 2001), which started the process of partial devolution of responsibility to NHS organisations. The best example of devolution has been the establishment of NHS foundation trusts as public benefit corporations, no longer in a line management relationship with the Secretary of State for Health, and overseen by the independent regulator, Monitor. An assessment carried out by the Healthcare Commission shows that the

performance of NHS foundation trusts is superior to that of NHS trusts that have not achieved foundation trust status.

Assuming that ministers are serious in the aim of moving from a system driven from the top to one that is led from the bottom, a key challenge is how to ensure effective local leadership and staff engagement throughout the NHS, building on the experience of NHS foundation trusts and extending it to other organisations. At the heart of this challenge is moving beyond discussion of new organisational forms, which in themselves are only the start of the journey to improvement 'from within', to consideration of the relationship between staff and the organisations they work for. The critical question here is how to refashion this relationship to achieve a better alignment between staff, their organisations and the aims of the NHS as a whole, in order to bring about further improvements in patient care.

The importance of alignment is illustrated by the position of clinical staff working in hospitals. Bruce Keogh, NHS Medical Director in the Department of Health, has described the nature of the allegiances of these staff as 'first of all it is to their profession, their second allegiance is to their specialty...thirdly it is to the department in which they work, fourth it is to their hospital and fifth to their trust. The NHS is the magic dust that joins it all together' (quoted in Mooney, 2009). Achieving a much closer linkage between these different allegiances is likely to be critical to the next stage of NHS reform and the desire to engage front-line staff in bringing about further improvements in performance. Among other things, this means questioning whether the model established in 1948, in which most NHS staff are employees in public sector organisations, is still fit for purpose. It also means looking outside the NHS at the experience of employee-owned organisations and asking whether their experience holds lessons for the future.

The relevance of so doing is demonstrated by the approach to public service reform set out by the government in recent reports from the Cabinet Office Strategy Unit (2008 and 2009). These reports emphasise the role of citizen empowerment, a new professionalism in public services and strategic leadership. As the Prime Minister noted in the most recent of these reports, 'we will grasp the opportunity to put teachers, doctors, nurses and the police back at the heart of our public service mission, by providing them with new opportunities to run services in return for the greater accountability and responsiveness that we seek' (Cabinet Office Strategy Unit, 2009: p 4). To turn this rhetoric into reality means giving serious attention to the ideas set out here and exploring how in practice employee ownership can help in the urgent task of revitalising and renewing public services. At a time when all political parties are reviewing the role of government in relation to civil society, there is a strong case for mutual approaches to be at the heart of future thinking on public services.

In the wider political and economic context, the ideas set out here find resonance in moves to give workers a stake in companies that have found themselves in difficulty in the current economic recession. In Germany this is expressed in the idea of *Mitarbeiterbeteiligung*, in which workers and their trade unions are negotiating to participate in either the capital or profits of their company as part of restructuring arrangements. These arrangements often involve workers agreeing to take cuts in pay and working hours in return for a share of the business. Part of the rationale is to achieve closer alignment between workers and companies and in the process to harness the energies of staff in reviving the fortunes of struggling companies (Bryant, 2009). British Airways has recently proposed a similar arrangement for some of its staff.

This project

To study these issues, the authors were commissioned by The Nuffield Trust to study the relevance and applicability of employee ownership and staff partnership models to the NHS. The work we have undertaken involved:

- summarising the literature on employee ownership and staff partnership models in other sectors
- identifying and describing examples of employee ownership and partnership models outside the NHS, for example in the independent sector and in other countries
- organising a number of high-level seminars to discuss the literature review and to understand current examples of successful employee ownership, like the John Lewis Partnership
- bringing together the results of this work and indicating how the NHS might adapt the learning from employee ownership and staff partnership models.

While an important focus of the project was employee ownership, other aspects were also examined, including the use of participative mechanisms to ensure a productive dialogue between staff and managers, and the means used to give staff a collective voice in their organisation.

This monograph sets out the findings from our study and identifies a number of options for the future. It is intended as a contribution to the debate about how to make a reality of the aspiration to engage staff more effectively in the NHS, and how to align incentives to achieve higher levels of performance.

2. PROMOTING STAFF ENGAGEMENT IN THE NHS

Summary points

- Many policy initiatives have been launched since 1998 to increase staff involvement and foster partnership working at a national and local level. These include the NHS Taskforce on Staff Involvement, the NHS Social Partnership Forum and the first comprehensive human resources strategy for the NHS.
- These initiatives have identified engaging and motivating staff as critical to the delivery of the NHS reform programme and to achieving the goals of high-quality, responsive and efficient patient care.
- The NHS Next Stage ('Darzi') Review published in 2008 reiterated the need for NHS reforms to be locally led and clinically driven, and for there to be greater freedoms for front-line staff. The NHS Constitution pledged that staff will be engaged in decisions that affect them and empowered to put forward ways of delivering better and safer services.
- Notwithstanding the emphasis placed on staff engagement, experience in the NHS is variable and policy aspirations have yet to be translated into practice on a consistent basis. This suggests that more than exhortation and guidance are needed to convert policy into practice.

2.1 'Working Together' and the NHS Taskforce on Staff Involvement

When the New Labour Government came to power in 1997 skills shortages and significant recruitment and retention difficulties in the NHS had pushed staff morale to a worrying low (Finlayson, 2002). Not only were these problems affecting the quality and level of services that could be provided but, critically, they threatened to derail the Government's far-reaching reform agenda for the health service.

It is in this context that a series of workforce and pay reforms have been introduced into the NHS, with a strong focus on staff involvement and partnership working (Farnham et al, 2003). The Government initially set out its programme

for workforce development in *Working Together: Securing a high quality workforce for the NHS* (Department of Health, 1998). This made an explicit link between improved staff conditions and better services, and proposed a series of human resource (HR) targets for local NHS organisations. By April 2000 they were expected to have:

- developed and reviewed their mechanisms for involving staff in planning and delivering care, and published a local policy on staff involvement
- reviewed their induction arrangements and agreed specific improvements with local staff
- undertaken an annual staff survey to act as a benchmark against which improvements in the quality of working life could be measured.

Working Together was soon followed by the establishment of a taskforce to explore how front-line staff could be more involved in improving services. Led by the Director of Human Resources at the NHS Executive, the Taskforce on Staff Involvement spent ten months visiting workplaces and reviewing research evidence before publishing its findings.

In its final report, the Taskforce described staff involvement as:

...making sure that staff are involved in all decisions that affect them: from big change programmes, to the day-to-day decisions on how services are delivered. It is about effective partnership working, good communications and, above all, real team-work.

(Department of Health, 1999: p 3)

It argued that front-line staff are best placed to make decisions about patient care and set out the benefits of involvement in terms of improved quality of working lives, staff retention and morale, and delivery of services (Department of Health, 1999). The report also outlined the benefits of collective representation, and advocated both stronger partnerships between managers and trade unions and joint problem-solving.

The NHS Social Partnership Forum – composed of employers, unions and the NHS Executive – developed an action plan to implement the Taskforce's 11 recommendations (Box 1). At a national level, the action plan specified investment in developing leaders; self-assessment tools for NHS organisations to audit their progress in involving staff; the development of staff involvement principles and a framework of rights and responsibilities; and the involvement of staff in designing and implementing national initiatives. Locally, it called for staff involvement events; improved communications; personal development plans; trade union recognition; and

for trusts to develop their own action policies and plans (Department of Health, 2000).

The NHS Plan (Secretary of State for Health, 2000) introduced an 'Improving Working Lives' standard, which made it clear that all NHS staff are entitled to work in an organisation committed to more flexible working conditions that give staff greater control over their time. A kite-marking system for NHS organisations to be accredited against the standard was developed with three levels reflecting different degrees of implementation: Pledge, Practice and Practice-Plus. All NHS organisations were required to be accredited against the standard by April 2003 and to have achieved Practice-Plus status by 2006.

Box 1. Recommendations of the NHS Taskforce on Staff Involvement

1. Encourage good leadership
2. Promote good industrial relations
3. Develop and use a self-assessment tool
4. Develop a local statement of rights
5. Provide support and advice
6. Promote good practice on intelligence networks
7. Improve communication
8. Invest in personal development
9. Monitor performance and progress
10. Include questions about staff involvement in attitude surveys
11. Commission regular independent research

Source: Department of Health, 1999

2.2 More staff, working differently

The Government's policy document on NHS reform, *Shifting the Balance of Power*, reaffirmed that the key to delivering service improvement and modernisation was the empowerment of front-line staff (Department of Health, 2001). In so doing, it returned to one of the themes in the *Working Together* HR framework: that of an 'involving culture':

A real shift in the balance of power will not occur unless staff are empowered to make the necessary change. The cultural shift needed will in many ways be more crucial to the success of the project than new management structures. Staff need to be involved in decisions which effect [sic] service delivery. Empowerment comes when staff own the policies and are able to bring about real change.

(Department of Health, 2001: p 24)

In 2002, two years after the publication of the NHS Plan, the Government launched the first comprehensive human resource strategy for the NHS, *HR in the NHS Plan*. The strategy described four pillars on which the goal of 'more staff, working differently' would be built:

- making the NHS a model employer by embracing best policies, practices and facilities
- ensuring the NHS provides a model career through the concept of the Skills Escalator, with an expectation of lifelong learning and development
- improving staff morale
- building people management skills, by developing the capacity and skills of the human resources function.

To support these pillars, the strategy also promised modernisation of the pay structure, learning and professional development, professional regulation and workforce planning.

Further guidance on staff involvement was published in October 2003 when the Department of Health launched a resource pack to help NHS organisations 'turn the rhetoric of staff involvement into a reality' (Department of Health, 2003). While the need for locally developed approaches was recognised, the pack offered a sample partnership framework, staff charter and evidence to support organisations in making a business case for workplace participation. What the pack demonstrated, through a series of case studies, was the progress that many NHS organisations had already made in implementing new ways of communicating with and involving staff. Common examples included involvement policies, staff forums or involvement groups, briefing systems, staff representation on committees, surveys and other methods for gathering feedback, partnership events and staff intranet sites.

The issue of staff engagement was returned to in 2005, with the publication of a national framework to support local workforce development. This talked of the need for NHS organisations to 'enable staff to deliver high-quality services...through progressive employment practices and acting as 'model employers'' (Department of Health, 2005a: p 1). The framework proposed ten changes in human resource practices which evidence indicated would have the greatest benefit to delivering organisational goals, one of which was 'Staff involvement, participation and good employee relations' (Box 2). It also put forward a number of model employment practices including flexible working, effective appraisal systems, staff involvement policies and partnership working with staff-side organisations. This framework was soon followed by guidance on developing a workforce scorecard, a tool to help local NHS employers align their human resource strategies with broader organisational goals (Department of Health, 2006).

Box 2. NHS Ten High Impact HR Changes

1. Support and lead effective change management
2. Effective recruitment, good induction and supportive management
3. Develop shared service models and effective use of IT
4. Manage temporary staffing costs as a major source of efficiency
5. Promote staff health and manage sickness absence
6. Promote job and service re-design
7. Develop and implement staff appraisal
8. Involve staff and work in partnership to develop good employee relations
9. Champion good people management practices
10. Provide effective training and development

Source: Department of Health, 2005a

In 2007, the Health Select Committee published a far-reaching review of NHS workforce planning (House of Commons Health Committee, 2007). This documented the substantial increase in staff numbers and pay over of the period 1999–2005. It also noted the various means by which new ways of working had been introduced into the service, including new clinical roles and reform of medical education and training. But the Committee also found clear evidence of a ‘boom and bust’ approach, with job reductions, sweeping training cuts and severe pay restrictions imposed from 2006 onwards as financial deficits in the health service emerged. It concluded that there had been a ‘disastrous failure’ of workforce planning, which had too often been a series of isolated decisions and initiatives rather an integrated process. A number of recommendations were made to foster a more integrated approach, including greater clinical involvement and engagement in all areas of workforce planning and development.

2.3 The NHS Next Stage Review

The final report of Lord Darzi’s NHS Next Stage Review of the NHS set out a series of recommendations to create a ‘locally-led, patient-centred and *clinically driven* service’ (Secretary of State for Health, 2008: p 17; authors’

italics). It promised to give greater freedoms to front-line staff and pointed to the importance of both ‘empowering’ organisational forms – such as social enterprises – and of staff and leadership development. Moreover, it proposed that PCTs should be obliged to consider and support proposals from staff to form social enterprises and also removed a major barrier to their development by giving an assurance that NHS staff transferring to this new type of organisation would be able to remain in the NHS pension scheme (see section 4.3 on page 31 for further details on the social enterprise model and its development within the NHS).

An accompanying document considered the workforce implications of the Darzi proposals (Department of Health, 2008a). This set out improvements to workforce planning, training and education to ensure that the health system is ‘fit to deliver’. A stronger professional voice in the development and scrutiny of all workforce activities was promised, through the establishment of professional advisory groups at a local and national level. A new Centre of Excellence was proposed to support local NHS organisations by gathering workforce data, establishing the evidence base for workforce strategy and developing local capability with tools and resources.

2.4 A renewed emphasis on staff involvement

Spurred by the publication of the NHS Next Stage Review, 2008 saw a renewed emphasis on staff involvement. The Department of Health published *What Matters to Staff in the NHS*, reporting on a study it had commissioned to explore the key drivers to staff motivation and engagement and the extent to which the NHS was delivering on these (Ipsos MORI, 2008). This identified senior management support and opportunities for staff development as areas most in need of improvement (for a detailed summary of the findings see section 3.2 on page 24).

Staff engagement was also identified as a major priority by Clare Chapman, NHS Director General of Workforce, who called for ‘another leap forward in the improvement of workplaces’. Chapman emphasised the need for a step change in NHS leadership practices to deliver a more engaged workforce:

Building genuine staff engagement requires a 180 degree turn from those leaders who believe that their staff are there to serve them, not the other way around. Leaders create shared direction on priorities and then to coach [sic] and support their people to succeed.

(Chapman, 2008)

This was reiterated in the NHS Operating Framework for 2009/10, which set a challenge for all NHS organisations ‘to sustain and build upon existing levels of staff engagement and empowerment’ (Department of Health, 2008b: p 18). Progress against this will be measured using a new NHS ‘Vital Sign’ indicator based on job satisfaction data collected through the annual staff survey.

At around the same time, the Department of Health established a national policy group on staff engagement and involvement, including

representatives from NHS Employers, Unison and the Healthcare Commission. Among the group’s responsibilities will be commissioning research to explore how management practices can foster positive employee experience and deliver benefits in terms of organisational performance and patient care. In parallel, NHS Employers launched a briefing paper presenting evidence on the benefits of staff engagement and good practice examples of employer-led initiatives (NHS Employers, 2008). One of these examples was the Listening into Action approach developed by Sandwell and West Birmingham Hospitals, which is described in Box 3.

The year 2008 also saw the publication of the Involvement and Participation Association’s review of the NHS Social Partnership Forum. This reported that there had been a growing gap between the rhetoric and reality of partnership working following the establishment of the Forum, particularly at a national level in terms of relationship between the Department of Health and the unions. This culminated in the publication in July 2005 of *Commissioning a Patient Led NHS* without prior staff or union consultation:

...it appeared the national system had broken down. Unions believed that reform appeared to be something being done to rather than with staff; one consequence was a perception that staff were reluctant to act as advocates for the changing service, despite the substantial sums of money all sides acknowledged were being invested in the service.

(Involvement and Participation Association, 2008: pp 1–2)

A revitalised partnership agreement was published in 2007 which – the review found – had fostered constructive working relations and provided a clearer framework for partnership working both locally and nationally. Alongside publication of the review, and in response to its

recommendations, the Government announced a £500,000 NHS Partnership Fund to support projects that ‘encourage and develop partnership working at local employer level within the NHS’.

The goal of improving employee engagement has also been pursued outside the NHS. In September 2008, the Department for Business, Enterprise and Regulatory Reform announced a review to explore how employee motivation and commitment can be fostered to enhance organisational performance. The review set out to ‘define effective employee engagement, examine the barriers which are preventing businesses engaging with their employees and consider non-regulatory solutions that can be offered to help business overcome such obstacles’. It will report its findings later in 2009.

2.5 The NHS Constitution

Many of the above policy themes were picked up in the NHS Constitution, published in draft form in June 2008 and in its final version in January 2009 (Department of Health, 2009). In addition to their legal rights as employees, the NHS pledged to ensure a high-quality working environment for its staff by providing them with:

- clear roles and responsibilities, and rewarding jobs
- personal development, access to appropriate training and line management support
- support and opportunities to maintain their health, well-being and safety.

A final pledge to staff related directly to involvement, with the NHS committing to ‘engage

Box 3. Listening into Action at Sandwell and West Birmingham Hospitals NHS Trust

In March 2008, Sandwell and West Birmingham Hospitals Trust launched a new approach to engaging with staff called ‘Listening into Action’ (LiA). The programme aims to turn feedback from staff into positive action to deliver better outcomes. Over the first two months, five ‘staff conversations’ were hosted by the trust’s chief executive. Staff members from across the organisation were randomly selected and invited to attend. The events drew strong attendance, and in one case turnout was greater than the number of staff invited. At the events, staff were asked to explore a number of questions including:

- what gets in the way of us working as well as you would like to?
- what would make us feel really proud?
- what should we prioritise changing together?

The LiA approach encourages organisations to quickly mobilise staff to translate feedback into action. From the issues raised at the staff conversations, a number of ‘quick wins’ were implemented including a re-vamped team brief, regular walkabouts and long-service awards. In addition, a number of early adopter projects were selected to support staff in addressing challenges in clinical areas. The sustainability of the LiA approach has been promoted through a trust-wide campaign to raise awareness, profile stories from early work, share progress and encourage wider participation.

By October 2008, 1,500 staff had become directly involved in LiA. The approach is also being used to engage patients. Stroke patients and carers were invited to an LiA event to share their experiences and inform future services.

staff in decisions that affect them and the services they provide...all staff will be empowered to put forward ways to deliver better and safer services for patients and their families'. These pledges will form the core of the Department of Health's approach to devolving greater control to front-line staff, as promised in the Next Stage Review.

2.6 Summary

It is clear from this brief review that engaging staff in the NHS has been an explicit priority in government for over a decade. Despite this, experience in the NHS is variable and policy aspirations have yet to be translated into practice on a consistent basis. There have also been difficulties in making a reality of partnership working at a national level, as a review of the experience of the NHS Social Partnership Forum published in 2008 clearly demonstrated. The fact that the initiatives taken by the Department of Health to promote staff engagement in the last 12 to 18 months contain strong echoes of policy documents published in the late 1990s suggests that more than exhortation and guidance are needed to convert policy into practice.

3. THE EXPERIENCES OF STAFF WORKING IN THE NHS

Summary points

- The strongest driver of staff engagement in the NHS is a sense of being valued and involved. Annual surveys show that NHS staff are highly satisfied with the support they receive from colleagues, the amount of responsibility they are given and the opportunity they have to use their skills.
- However, relatively few staff report that they are involved in important decisions, consulted about changes that affect them, encouraged to suggest ideas for improving services or feel that their organisation values their work.
- NHS staff are motivated by the opportunity to deliver high-quality services that make a difference to patients. But they feel that their ability to do this is being threatened by the adoption of a more business-oriented approach within the service.
- Awareness among NHS staff of involvement initiatives is much higher than actual levels of participation. Staff involvement is associated with a wide range of performance benefits including lower levels of sickness absence, patient mortality and complaints, and higher levels of innovation, job satisfaction and cooperation with co-workers.
- Comparisons of the findings from recent NHS surveys have found that there is a correlation between staff and patient experience. Patients are more satisfied with their care when this is provided by organisations that have satisfied staff.

As the previous chapter demonstrated, improving staff engagement has long been a goal for the NHS. At the same time that policy and practice initiatives have been introduced to achieve this goal, research has provided greater insight into what ‘being engaged’ means to NHS staff, and the factors that drive this. This shows that the culture of the NHS workforce is shaped by strong values relating to the delivery of high-quality patient care, which both encourage people to join the NHS and motivate them in their work. The opportunity for staff to influence and improve the services that they deliver in order to fulfil these values is therefore critical.

3.1 Factors that drive engagement of NHS staff

There are numerous definitions of the concept of employee engagement. Many focus on affective dimensions, emphasising the influence of engagement on employees’ attitudes and behaviours. In this sense, engagement is often understood in terms of an emotional connection or psychological bond or ‘contract’ between the individual and their employing organisation, resulting in a higher level of commitment and willingness to go beyond the requirements of the job. The drivers and practices that foster

engagement are also sometimes highlighted, and overlap with related concepts such as ‘participation’ and ‘involvement’ can arise. The definition offered by the Institute of Employment Studies (IES) makes reference to both of these aspects; they propose that employee engagement is:

A positive attitude held by the employee towards the organisation and its values. An engaged employee is aware of business context, and works with colleagues to improve performance within the job for the benefit of the organisation. The organisation must work to develop and nurture engagement, which requires a two-way relationship between employer and employee.

(Robinson, 2007)

A common feature of most definitions of engagement – including the IES one given above – is that it is characterised as a two-way relationship between employer and employee. A relational process occurs whereby employers work to engage their workforce and employees choose the level of engagement they are willing to reciprocate.

A number of studies have explored the issue of staff engagement in the NHS. For example, research by Finlayson (2002) identified three broad factors that affect NHS staff motivation and morale: feeling valued, working environment, and resources and pay. Of these, it was the perception of feeling valued that emerged as the most significant driving force; this was described in terms of perceived worth, levels of support, being listened to, and recognition and good treatment. Comments made by one specialist registrar participating in the research exemplified the negative effect of a ‘command and control’ style of decision-making in the health service:

We are expected to steer by directions from the Department of Health – that’s been a big problem. They talk about local decisions for local situations but then they say you must do a, b, c, d, e. They

allocate you money and they tell you how to spend it. You’re not allowed to be creative to suit your local population, and that’s a big demotivator.

(quoted in Finlayson, 2002: p 6)

These findings are confirmed by extensive research carried out by the IES, who have looked at the results of attitude surveys completed by more than 10,000 employees in 14 NHS organisations. This showed that the strongest driver of staff engagement in the NHS is ‘a sense of feeling valued and involved’, which has four principal elements (Robinson, 2007):

- involvement in decision-making
- the extent to which employees feel able to voice their ideas, and managers listen to these views and value employees’ contribution
- the opportunities employees have to develop their jobs
- the extent to which the organisation is concerned for employees’ health and well-being.

Furthermore, IES research has demonstrated the strong influence of organisational culture and managerial style, concluding that managers in the NHS have ‘a very important role in fostering employees’ sense of involvement and value’ (Robinson, 2007: p 3).

3.2 Findings of the NHS Staff Survey

How does this research compare to the experience of staff currently working in the NHS? The 2008 NHS Staff Survey found that the majority of employees were satisfied with the support they got from colleagues (77 per cent), the amount of responsibility they were given (71 per cent) and the opportunities they had to use their skills (67 per cent). However, the survey pointed to many areas where staff experience is largely negative, in particular with regard to relationships with

senior management. Less than one third of those surveyed (29 per cent) agreed that senior managers tried to involve staff in important decisions, and only 36 per cent felt that senior managers encouraged staff to suggest ideas for improving services. Communication, both between senior managers and front-line staff and across different parts of organisations, was another problem area. Just over half of respondents reported that they had been involved or consulted about changes that would affect their work area, team or department (see Table 1).

Table 1. NHS Staff Survey questions on communication and involvement

Survey question	% agree or strongly agree
Senior managers here try to involve staff in important decisions	29%
Communication between senior managers and staff is effective	27%
Senior managers encourage staff to suggest new ideas for improving services	36%
On the whole, the different parts of the trust communicate effectively with each other	20%
I am involved in deciding on the changes introduced that affect my work area/team/department	50%
I am consulted about the changes that affect my work area/team/department	52%

Source: Healthcare Commission, 2009

The survey also showed that the NHS needs to do more in terms of reward and recognition. Well under half of those who took part in the survey reported that they were satisfied with their level of pay, received recognition for good work or felt valued by their employer. The implications in terms of staff retention were spelt out, with 30 per cent of staff indicating that they regularly considered leaving their job and 15 per cent prepared to leave the trust they were working for as soon as they found alternative employment.

Table 2. NHS Staff Survey questions on reward and recognition

Survey question	% satisfied or very satisfied
The recognition I get for good work	44%
The extent to which my trust values my work	33%
My level of pay	36%

Source: Healthcare Commission, 2009

A recent study commissioned by the Department of Health provides further insight into NHS staff experience (Ipsos MORI, 2008). The research involved staff across clinical, managerial and administrative positions in NHS organisations and independent sector treatment centres. Their perspectives and experiences were explored through a combination of qualitative and quantitative methods, including a written survey. While over 9,000 staff participated in the study, only 29 per cent of those polled responded to the survey and the number of people providing detailed responses through focus groups and in-depth interviews numbered just over 200.

The report, *What Matters to Staff in the NHS*, found that there was a dissonance between the

strong emphasis placed by NHS staff on values such as empathy and collaboration, and the adoption of a more business-oriented approach within the health service that focused on financial considerations and national targets. Some staff reported that this was leading to a feeling of alienation from their work.

The study also identified ten factors that contributed to staff engagement and motivation to provide high-quality patient care. Staff rated the NHS highly in terms of delivering some of these factors, above all the sense of having a worthwhile job that made a difference to patients. But other areas were rated less positively and the research team concluded that the NHS should focus on the following three in order to enhance current levels of staff engagement:

- I understand my role and where it fits in
- Senior managers are involved with our work
- I have the opportunity to develop my potential.

3.3 Further research into the NHS staff experience

A major study conducted by a research team at Aston University – where the NHS Staff Survey is coordinated – explored the extent and impact of staff involvement in the NHS (West et al, 2005). Between 2000 and 2003, information was gathered from more than 10,000 staff working in the NHS across primary and secondary care. This was subsequently compared with performance data from the 66 organisations at which those staff were employed.

The study found that awareness of involvement initiatives among staff was far higher (40 to 50 per cent) than actual levels of participation (six to 38 per cent). Opportunities for staff involvement through meetings with managers and reviews (for example of performance) were far more common than direct participation in projects,

decision-making or focus groups. Differences of opinion about the motives for staff involvement initiatives emerged. While managers were most likely to see involvement in terms of improving the quality of care, medical staff gave the need to increase efficiency and reduce costs as the key drivers.

Impact across a range of outcomes was also demonstrated. The study showed that when staff were included in involvement initiatives, they were more likely to feel that the work they did was meaningful and important. Regular meetings with immediate managers led staff to feel more supported and clearer about their role and responsibilities. This, in turn, meant that staff felt they had higher levels of autonomy, more influence over decision-making and greater confidence in their abilities.

The degree of involvement, and the extent to which it was supported by the organisation, were particularly influential. When both these factors were present, staff involvement was significantly associated with lower levels of sickness absence, patient waiting times, complaints and mortality, and higher levels of innovation, job satisfaction and cooperation with co-workers. These findings were summed up by the authors as, ‘the stronger the commitment from the organisation towards involving staff, the stronger the commitment of staff towards the organisation. The results suggest that a staff involvement culture may lead to employees feeling a sense of pride and belonging both to their professions and to the trusts they work in’ (West et al, 2005: p viii).

Evidence linking NHS staff and patient experience is also emerging. In 2008 the Healthcare Commission reported the initial findings of a study comparing data from the 2006 adult inpatients survey and of staff surveys carried out in the same organisations (Raleigh, 2008). The Healthcare Commission’s analyses found that patient experience was positively correlated with

higher levels of managerial support, and was negatively correlated with longer working hours and work-related stress. This research suggests that efforts to improve staff satisfaction could play a critical role in delivering the customer focus that NHS organisations are seeking as they compete to attract patients in a more market-driven environment.

3.4 Summary

As staff surveys and other research shows, the NHS still has a long way to go in terms of demonstrating that it values its staff and engages successfully with them. Above all, poor communication and a lack of involvement in decision-making appear to leave many staff feeling disempowered and demoralised. This raises questions about whether the current approach to staff engagement, important as this is, is sufficient to deliver the Government's stated goal of a 'self-improving' NHS. Rather, a rethinking of the relationship between the NHS and its staff may now be necessary. One option, to which we now turn, would be to explore the potential of employee ownership models and how these might be adapted within the NHS.

4. WHAT IS EMPLOYEE OWNERSHIP?

Summary points

- Employee financial participation occurs along a continuum from full employee ownership, through employee share ownership, to incentive schemes in which employees do not have a long-term financial stake, such as profit-related pay.
- Employees can personally have a financial stake in their organisation (direct ownership), or this can be held on their behalf in an employee benefit trust (indirect ownership). Employee ownership can take many different organisational forms including cooperatives, mutuals and partnership arrangements.
- Within the health sector, the government is promoting new forms of ownership through the establishment of social enterprises and NHS foundation trusts.
- Evidence suggests that more needs to be done to promote the development of social enterprises and help them enter the market. Social enterprises may face particular barriers in competing for public sector contracts.

4.1 Defining employee ownership

There are a number of challenges in defining the concept of employee ownership. Much of the language that is used is imprecise and many of the key terms overlap with each other. This problem is compounded by the fact that many different types of organisation may be described as 'employee-owned'. Nonetheless, it is possible to outline the main facets of employee-owned organisations and also differentiate these from traditional public ownership models.

At its broadest, the term employee ownership can refer to any form of employee financial participation. However, given that the nature

and level of this financial participation can vary substantially in practice, the Employee Ownership Association suggests the need for definitional clarity and proposes three key distinctions: between employee ownership, co-ownership and employee share ownership (see Box 4). As these definitions indicate, employee financial participation falls along a continuum from full company ownership to a small equity stake. Beyond this continuum are incentive schemes in which employees do not have a long-term financial stake, such as profit-related pay, profit-sharing and bonuses linked to performance.

Box 4. Key definitions from the Employee Ownership Association

- ‘Employee ownership’ and ‘employee-owned company’ – companies where employees own a controlling stake in the business, i.e. more than 51 per cent. An employee-owned company may involve employees owning shares, but may instead or as well involve ownership via one or more trusts – for example, no employees own shares in the UK’s largest employee-owned company: the John Lewis Partnership.
- ‘Co-ownership’ and ‘co-owned company’ – a wider definition which includes employee-owned companies but also companies where employees own a substantial but minority stake in the business, say more than 25 per cent. Here again, the employee ownership element may be based on direct share ownership by staff, or indirect ownership via one or more trusts, or a combination of both shares and trust(s).
- ‘Employee share ownership’ (ESO) – a narrower definition, referring to companies where although many employees may own a share in the equity, their combined holding is a very small proportion of the total. Naturally, the term ESO can also simply be a factual description of the act of employees owning any share(s) at all.

Source: Employee Ownership Association, 2007

As the above definitions indicate, a further distinction can be made between direct and indirect forms of employee ownership. Where employees personally own shares, which can be freely bought and sold, then employee ownership is direct. Individual share owners are entitled to receive dividends, vote at company meetings and receive profits from the sale of shares.

The alternative is for employees’ shares to be owned or held collectively by a trust and for the benefit of employees; this is known as indirect ownership. In this case, it is the trustees of the employee benefit trust (EBT) who principally exercise shareholding rights and who decide how any benefits of share ownership will be used (Postlethwaite et al, 2005). EBTs carry the advantage of providing a permanent employee stake in a company and a degree of long-term stability in terms of the ownership structure. In fact, they may be the only viable route to employee ownership in most circumstances:

Without an employee trust, it’s unlikely that most companies will ever become employee-owned. This is because in the majority of companies, employees can’t finance the purchase of a controlling interest. They might be able to buy some shares, and may be willing to take out a personal loan to contribute to the purchase price, but they can rarely raise all the money.

(Postlethwaite et al, 2005: p 21)

The best known British example of employee ownership through an EBT is the retail chain John Lewis Partnership. In the United States, the majority of employee-owned companies are controlled by a type of EBT known as employee stock ownership plans (Blasi et al, 2003a). In practice, some companies combine direct and indirect forms of ownership by having both an EBT and opportunities for individual shareholding.

4.2 Organisational forms

As well as being direct or indirect, employee ownership can operate in many different organisational forms. These forms vary in terms of the proportion of employees who participate in ownership; the percentage of ownership held by employees; the equality of ownership among employee owners; and the rights conferred on

employees by virtue of ownership (Kruse, 2002). For example, worker cooperatives are owned and controlled by their employees and operate according to the seven principles of cooperation (Box 5). They are democratically controlled through a one-member one-vote rule.

Like cooperatives, mutuals also do not have external shareholders. Instead they are owned by, and for the benefit of, their membership which may include customers, employees and wider stakeholders. When membership is broadly defined, the outcome is a multi-stakeholder governance structure. With regard to mutuals, Cook and colleagues (2003) note that two aspects of ownership are particularly important. These are the right to call management to account and the right to share in the surplus generated by the organisation.

Employee ownership can also operate through a partnership model, which can have varying characteristics. For example, all permanent employees of the John Lewis Partnership are considered 'partners' and have a stake in the company profits. By contrast, the partnership structure in many professional services firms (e.g. law, accountancy) tends to restrict ownership to a relatively small number of individuals, who share the profits and are jointly liable for the company's debts and obligations.

Partnership arrangements of this type are already well established in the NHS within general practice. Historically, admission into the partnership has been restricted to general practitioners, with partners owning their premises, employing staff, managing practice finances and taking a share of any profits made. However, new primary care contracts have encouraged multi-professional partnerships which include practice nurses and managers, as well as GPs.

Against this, these contracts have also led to GP partners employing more GPs on a salaried basis to enable the partners to benefit from the higher profits generated rather than to share these more widely. Changes in the primary care workforce involving the appointment of more female GPs and doctors who prefer part time contracts have also been important factors. The greater use of salaried GPs in primary care has in this way eroded the well established partnership model, making it more difficult to envisage how employee ownership can be extended in primary care in current circumstances.

A recent discussion paper from the Royal College of General Practitioners (Gerada, 2009) has described the risks involved in the move away from the partnership model, including the likelihood that it will undermine some of the traditional strengths of general practice. As the paper noted:

Salaried doctors... are fearful that they have lost the chance of ever being able to shape general practice and have lost the opportunity, maybe forever, to become masters of their own destiny; some talk about the 'ladder being pulled up'. A collective helplessness and confusion is pervading the profession, with those in the lucky position of being partners being set against the ever-growing workforce of salaried doctors.

(Gerada, 2009: p 15)

The sense of bereavement conveyed by this quote is testimony to the perceived value of the partnership model in general practice.

Box 5. The seven principles of cooperation

1. Voluntary and open membership:

cooperatives are voluntary organisations, open to all persons able to use their services and willing to accept the responsibilities of membership, without gender, social, racial, political or religious discrimination

2. Democratic member control: cooperatives are democratic organisations controlled by their members, who actively participate in setting their policies and making decisions

3. Member economic participation: members contribute equitably to, and democratically control, the capital of their cooperative

4. Autonomy and independence: cooperatives are autonomous, self-help organisations controlled by their members

5. Training and information: cooperatives provide education and training for their members, elected representatives, managers and employees so they can contribute effectively to the development of their cooperatives

6. Cooperation among cooperatives: cooperatives serve their members most effectively and strengthen the cooperative movement by working together through local, national, regional and international structures

7. Concern for the community: cooperatives work for the sustainable development of their communities through policies approved by their members

Source: International Co-operative Alliance (www.ica.coop)

4.3 Social enterprises

There is a strong resonance between the principles of employee ownership and the social enterprise model. As social enterprises, companies trade

for primarily social objectives and surpluses are reinvested in the business or used for community benefit. Most of the employee-owned companies providing public services in the UK describe themselves as social enterprises.

Social enterprise is not a legal entity in itself and therefore social enterprises can take a number of different forms. Two prominent examples of employee-owned social enterprises within the public sector are Central Surrey Health and Greenwich Leisure Limited, discussed further below. The first is a company limited by shares, and the latter is an industrial and provident society. Different variants of social enterprise are being developed within the health service, particularly in primary and community care where alliances between NHS and non-NHS organisations are being forged. For example, in Stoke-on-Trent general practice services are being delivered by Willow Bank Community Interest Company – a social enterprise partnership between primary care professionals, a local charity (Gingerbread) providing hostel accommodation to single-parent families and a local management consultancy, Change Through Partnership.

Recently, the government has promoted social enterprises as a new model for public service delivery, establishing both a Social Enterprise Unit within the Department of Health and an Office for the Third Sector in the Cabinet Office with overall responsibility for promoting voluntary and community organisations. In October 2006, the Department of Health announced £1 million of funding to develop 26 social enterprise ‘pathfinder’ organisations in health and social care. An evaluation of the pathfinder projects has been carried out and is due to publish its findings in summer 2009. Further financial support was pledged the following year when it created a £100 million Social Enterprise Fund to help with set-up costs and access to business support.

Some of the barriers to social enterprises within the health care system are also being removed. The NHS Next Stage Review introduced a right for primary and community care staff to request to set up a social enterprise and pledged that social enterprises set up under the ‘right to request’ would be guaranteed an uncontested contract for up to five years. It also announced that staff transferring into social enterprises could remain in the NHS pension scheme if they continued to deliver NHS care. However, this is unlikely to have fully resolved concerns about pension rights given that staff in social enterprises delivering non-NHS care would be required to leave the NHS scheme and newly recruited staff would not be eligible to join the scheme.

A key question is whether the government is doing enough to support the development of social enterprises and to help them enter the market. A King’s Fund report on social enterprises in health care concluded that, ‘If too much time passes before staff-led and patient-led organisations take shape, when they finally do enter the marketplace there may be little left for them’ (Lewis et al, 2006: p 21). Furthermore, an inquiry by the Public Administration Select Committee reported that third sector organisations, including social enterprises, faced particular barriers in competing for public service contracts (House of Commons Public Administration Select Committee, 2008).

The Committee found that many organisations lacked the resources necessary to compete in public procurements, which were typically labour intensive and required fast turnarounds. Often the scale of contracts was too large for third sector organisations to bid for (except as consortia), or else funding was only short-term which posed a risk in terms of financial sustainability. The Committee recommended a re-design of the commissioning process to create a more level playing field between different types of organisations.

4.4 NHS foundation trusts

Moves to decentralise power to a local level within the NHS to date have focused on the establishment of NHS foundation trusts (FTs). As membership organisations with devolved governance arrangements, FTs provide a larger role for stakeholder groups in the running of local services. Along with the local public and partner organisations, employees are represented by elected governors on the trust’s membership council – which is intended to have a key role in shaping the strategic direction of the organisation (Department of Health, 2005b). Increased opportunities for the workforce to play a fuller part in the design and delivery of their services might be expected given this emphasis on staff involvement.

Initial uncertainty about the role of FT governors and their relationship to trust management teams is reflected in early research which found that membership councils had relatively little power to influence trust decisions (Day and Klein, 2005; Lewis, 2005). Nonetheless a more recent study, which looked at the experiences of five established FTs, indicates that membership governance has become increasingly effective (Ham and Hunt, 2008). This study found that, as governors have gained greater clarity about their respective role and built up knowledge and skills, they have been able to more fully participate in the work of their organisation. However, the findings for staff engagement were less positive. Across the case studies, the role of staff governors had been relatively under-developed such that they were often an ‘under-used resource’. The study’s authors concluded that FTs should pay more attention to realising the potential of staff governors, for example by linking their role to the organisation’s human resource strategies.

As yet, the benefits of FTs as a means of empowering NHS staff are largely unproven, although individual positive examples are

emerging (such as the payment of bonuses to staff based on performance). There are also isolated examples of NHS foundation trusts that have departed from national terms and conditions for their staff (Moore, 2009). Despite these examples, there is little evidence that FTs have used their freedoms to develop innovative approaches to employee engagement. This reinforces the view that more radical alternatives, drawing on employee ownership principles, may be needed to achieve closer alignment between staff and their organisations.

4.5 Summary

Employee ownership takes various forms and there is increasing interest in government in encouraging new kinds of organisations to become involved in the provision of public services. Current examples include social enterprises such as Greenwich Leisure Limited and Central Surrey Health, and NHS foundation trusts. A key question is whether there is sufficient support available to enable more social enterprises to become established and to overcome the barriers identified by the Public Administration Select Committee.

5. THE EMPLOYEE-OWNED SECTOR

Summary points

- In the United States, an estimated one fifth of the workforce is engaged in some form of financial participation. The employee-owned sector in the United Kingdom has grown steadily since the 1990s, and is estimated to have an annual turnover of £20–25 billion.
- There are currently only a handful of employee-owned organisations delivering public services. These include Central Surrey Health, which provides community nursing and therapy services and is owned by its 780 staff.
- Employee ownership of public services may be expected to grow as the government challenges monopoly provision and encourages greater plurality of service provision. While there is political sensitivity around an increased role for commercial companies in public service provision, employee-owned organisations may be seen as a more acceptable alternative.
- Within the NHS, PCTs are being asked to develop plans for the future of their directly provided services and establish themselves as commissioning organisations. A number of options for provider services have been proposed, including the social enterprise model.

5.1 The international perspective

Much of the published literature on employee ownership focuses on the United States where it is estimated that more than one fifth of the workforce is engaged in some form of financial participation (Blasi et al, 2003b). The popularity of employee ownership in the United States can be largely explained by favourable tax measures introduced in the early 1970s that exempt company owners from paying capital gains if they sell more than 30 per cent of the business to their employees. The main vehicle for employee ownership is the employee stock ownership plan (ESOP): a type of employee benefit trust which can be funded by corporate contributions and/or loan-funded share purchase. Shares are allocated, typically on the basis of salary or length of service, to individual accounts and employees can build

up substantial equity stakes over a number of years. Accounts are usually cashed in either when the individual leaves the company or retires. Between 17 and 20 million Americans own company stock through ESOPs (Kruse, 2002).

While the extent of employee financial participation has historically been far smaller in Europe, recent research suggests that employee ownership is on the increase (Mathieu, 2008). Currently, it is estimated that around 8.2 million employees in Europe partially or fully own the companies that they work for, holding a total of €260 billion in assets. The pattern of employee ownership varies substantially across the continent with significantly higher levels in France and the UK than in any other European country. However, nearly one third of all companies where employees have the controlling

stake (51 per cent or more) are cooperatives based in Italy. The Mondragon Cooperative Corporation – constituted of over 150 retail and financial operations throughout Spain – is the largest fully employee-owned company with over 103,000 employees and assets totalling almost €33 billion. The second largest is the British-based John Lewis Partnership (see section 7.1 on page 58 for case study).

5.2 Employee ownership in the UK

There is a longstanding history of employee ownership in the UK, beginning with the formation of worker cooperatives in the mid-19th century. The sector has grown steadily since the 1990s, and is presently estimated to have a combined annual turnover of £20–25 billion (Postlethwaite et al, 2005). In part, this growth has been driven by legislation – dating from the late 1970s – that has created a favourable tax regime for employee financial participation (Poutsma et al, 1999). In particular, employee share ownership has been promoted through three tax-advantaged schemes: Share Incentive Plans (SIPs); Savings Related Share Option Schemes (SAYEs) and Enterprise Management Incentives (EMIs). The most important of these – the Share Incentive Plan – allows employers to give employees up to £3,000 of shares each year, which are subject to neither income tax nor National Insurance Contributions. Employees can purchase additional shares up to the value of £1,500 each year from their pre-tax earnings. Across the UK, around three and a half million employees participate in 5,000 tax-advantaged share schemes.

However, at the same time that government policy has promoted individual employee shareholding, tax rules governing the use of EBTs may have restricted the wider outcome of employee ownership (Postlethwaite et al, 2005). Specifically, concerns about the potential abuse of EBTs for the

purpose of tax avoidance led the government in 2003 to remove the ability of companies to donate into EBTs before corporation tax. This has made the use of benefit trusts to facilitate employee ownership a less attractive and viable option. In effect, a key vehicle for employee buyouts has been removed. On this issue, the All Party Parliamentary Group on Employee Ownership recently commented that:

We are concerned that the 2003 changes in tax provisions affecting the co-owned sector are proving to be a significant impediment to its growth and future stability.

(2008: p 26)

The Group called for the Treasury to review the relevant tax rules, suggesting the need to distinguish between legitimate EBTs and trusts set up for the purpose of avoiding tax obligations.

While employee ownership of public services is now beginning to emerge (see below), the sector is more established in areas such as manufacturing, professional services and retail (see Table 3).

Table 3. Examples of employee-owned companies in the UK (not public services)

Company	Activity
Arup Group	Engineering and design consultancy, with headquarters in England and offices in 37 countries
The Baxi Partnership	Financing for employee buyouts
Circle	Private health care provider and hospital developer
Childbase	Nursery provider
Loch Fyne Oysters	Seafood producers and wholesalers
Make	Architecture and design company
Savant	Specialist software developer for the health care sector
Scott Bader	Polymer manufacturer operating in nine countries including the UK
St Lukes	Advertising and communications agency
Tullis Russell	Paper manufacturer

enterprise to run community nursing and therapy services formerly provided by East Elmbridge and Mid Surrey PCT. Central Surrey Health is entirely owned by its 780 employees. Other prominent examples include (see Boxes 6 and 7):

- Sunderland Home Care: provides personal care services to people in the Sunderland area
- eaga: provides energy efficiency and fuel poverty services for central government and local authorities
- Greenwich Leisure Limited: manages municipal leisure centres in the Greater London area.

5.3 Employee ownership of public services

At present, only a handful of public service providers have been established with, or transferred into, employee ownership. In health care, Central Surrey Health was the first – and remains the only – employee-owned organisation (see section 7.4 on page 64 for case study). It was established in 2006 as a not-for-profit social

Box 6. Sunderland Home Care

In 1993, Sunderland Social Services advertised for expressions of interest to provide home care services. In response, they received a business case for a home care cooperative from Margaret Elliot, a local resident with a long history of running cooperative businesses in the area. The council provided £10,000 of funding to develop the company, and Sunderland Home Care (SHC) started trading in 1994 with 20 staff members and a small contract to provide 450 hours of care per week.

In 1998, the decision was taken to transfer SHC from a worker cooperative into an employee-owned company limited by guarantee. Two trusts were set up to facilitate the transfer of company shares to employees: an employee benefit trust (EBT) which holds the majority of the shareholding in SHC, and a profit share trust which can allocate profits to employees. While employees must sell their shares back when they

leave SHC, they are not required to do so until they are free of tax liabilities.

The EBT consists of one member of management and eight trustees: five elected employees and three external non-executives. Managers undertake the day-to-day management of the company, but are responsible to the EBT as the major shareholder. There are various mechanisms in place which ensure that employees play a major role in the running of the organisation. The company's Articles of Association stipulate 21 areas where the management board must get the agreement of the EBT – including capital expenditure and issuing new shares. In addition, at least three of the employee trustees must support any resolution before it is passed by the EBT. SHC now employs over 220 staff and has an annual turnover of around £2 million. The business model has also been developed in other cities in the North of England through an umbrella company, Care and Share Associates.

Box 7. Greenwich Leisure Limited

In 1993, following a 30 per cent cut in the funding of local leisure centres, Greenwich Council proposed that a not-for-profit company be established to manage leisure services in the borough. Consequently, management of the council's seven remaining leisure centres was transferred to a new company: Greenwich Leisure Limited (GLL). Structured as an Industrial and Provident Society for the benefit of the community, GLL is owned by its contracted staff who become society members by purchasing a single (£25) share. There is a multi-stakeholder governance structure, with customer, local authority and trade union representatives sitting on the board. As elected employees constitute the majority on the board, GLL describes itself as 'worker controlled'.

Since taking over management of leisure services in Greenwich, GLL has won a series of tenders from other local authorities and now manages more than 70 leisure centres within the M25 area. Wherever possible, existing staff are transferred to GLL when a contract is taken over. It employs community development officers to tailor the sport and leisure programmes to local needs, and operates a concessionary pricing scheme to ensure that entry price is never a barrier to access. Through GLL's leisure centre advisory committees, local staff and community members can contribute to the design and delivery of services. GLL now employs over 3,000 staff and has an annual turnover of around £45 million.

The deregulation of the municipal bus service in the early 1990s led to a wave of employee buyouts and, by 1993, 30 per cent of the service was under employee control. However, employee ownership ultimately proved unsustainable as the service went through a period of intense competition resulting in multiple mergers and takeovers. Now only a fraction of the original employee stake remains (Spear, 1999). This raises questions about the sustainability of employee-owned public services, particularly in a more pluralist and marketised system.

There are clear parallels between the municipal bus service example and the current situation in the NHS, where an increasingly competitive provider environment is emerging. The barriers facing third sector organisations in winning public sector contracts are increasingly recognised and the need for a level playing field between different types of provider has been emphasised (House of Commons Public Administration Select Committee, 2008). If employee ownership models are developed in health care, then lessons from the experience of the bus service will be important in terms of fostering long-term success. We will return to this issue in Chapter 8, when considering the challenges to employee ownership of health services.

5.4 New opportunities for employee-owned public services

There are many reasons to think that employee ownership of public services – and health care in particular – may be set to increase. Above all, the government's promotion of choice and contestability is opening up a market in health care. As monopoly provision is challenged, so more contracts are being awarded to different types of provider. Experience has already demonstrated the political sensitivity around an increased role for commercial companies in health care. Employee-owned organisations may

be both a viable alternative to traditional forms of public ownership and a more publicly acceptable alternative to commercial providers.

This latter point is made by the Employee Ownership Association, which identifies a possible alignment between the principles of employee ownership and the ethos of public sector provision:

It is likely that public service users may trust the motives and commitment of an employee owned business more than they trust those of a private provider owned entirely by external shareholders. In particular, co-owned companies may be perceived as more responsible, more committed to the community, more ethical than the average private provider. This perception would tend to be reinforced by co-owned companies' longer term investment horizons, and radically different approaches to profit distribution.

(Employee Ownership Association, 2007)

Employee ownership also fits particularly well with the current trend towards decentralisation in the NHS which emphasises devolved decision-making, stronger local accountability and clinical leadership. Arguably a service which is run by its employees is better placed to understand and respond to local needs than one which is under central government control. As Leadbeater and Christie have argued:

By involving their members, mutuals should be able to unlock ideas among individuals and whole communities, which investor-owned companies and public sector bureaucracies cannot reach. This is a central component of the case for employee ownership, especially in knowledge-based businesses, where the know-how of employees is critical to the competitiveness of the business.

(Leadbeater and Christie, 1999: p 20)

The current drive for PCTs to divest themselves of their provider functions, and establish themselves as commissioning organisations, offers a realistic

opportunity for employee ownership to develop in the health service. The *Transforming Community Services* guidance (Department of Health, 2009) sets out a requirement for all PCTs to have developed plans for their directly provided services by October 2009. This also identified a number of possible options for the future of PCT provider functions, including direct provision with separate governance arrangements, setting up a community foundation trust, establishing a social enterprise and integration with either local authorities or other NHS providers. The ‘right to request’ made available to PCT staff may increase the interest in social enterprises as PCTs consider these options.

A review of social work practices, on behalf of the Department for Education and Skills, put forward employee ownership as the solution to many of the problems in the profession. The working group convened for the review reported that the sector had come to be dominated by a managerialism that has left social workers ‘de-motivated, overwhelmed by bureaucracy and deprived of autonomy’ (Le Grand, 2008: p 5). Having considered a number of different options, the group recommended that social work practices be organised according to an employee-owned professional partnership model. This, it was proposed, would best serve the interests of both service deliverers and users in the long term.

5.5. Summary

Employee ownership is much less common in the public services than in the private sector. However, it could become more significant in the light of government policies to increase plurality of provision and encourage new kinds of organisations to enter the market, like social enterprises. In the NHS, there are clear opportunities in relation to PCT provider services.

6. THE EVIDENCE FOR EMPLOYEE OWNERSHIP

Summary points

- On average, companies experience a productivity boost of four to five per cent when employee ownership is introduced, which is sustained over subsequent years. There is also evidence that employee ownership can lead to lower levels of staff turnover and absenteeism, and higher levels of innovation.
- Research has also shown that staff in employee-owned companies are more likely to confront a non-performing colleague. This finding is especially important in health care, given the importance of peer pressure as a driver of performance and the difficulty facing non-clinicians in challenging under-performance.
- Few studies have assessed the impact of employee ownership on customer/service user outcomes. The best evidence is for mutuals, whose accountability to their customers (rather than external shareholders) has resulted in higher levels of customer trust and loyalty.
- Research consistently demonstrates that employee ownership only produces (or only sustains) benefits when two further factors are present: human resource management practices that foster staff participation; and a culture of ownership that is associated with staff having a collective voice in the organisation.
- This raises questions about whether staff participation and collective voice (in the absence of employee ownership) would achieve similar outcomes. Research shows that initiatives to increase staff participation in the workplace can improve financial performance, employee turnover and satisfaction. But these schemes are generally only effective when they grant staff higher levels of influence and autonomy, are introduced in bundles rather than as one-off initiatives and are actively supported by managers.
- Neither employee ownership nor staff participation schemes by themselves produce the same level and sustainability of impact as they do in combination. The evidence reviewed here suggests that employee ownership underpins and enhances the positive effect of staff participation schemes, and increases employees' faith that such schemes are genuine and long-term.

6.1 The theory behind employee ownership

Most of the literature on employee ownership is concerned with demonstrating its impact on organisational outcomes. Of particular interest

is the potential for employee ownership to align the interests of an organisation with its staff, and the effects that this might have on productivity and financial performance. As we show below, studies are increasingly exploring the benefits for employees themselves and for those who are the

customers or users of services. Nevertheless, what has interested most researchers (and companies) to date is whether employee ownership makes good business sense from an employer point of view.

So how might employee ownership be expected to improve productivity? According to Michie and colleagues (2002), the answer lies in the likely impact that employee ownership can have on employee attitudes and behaviour:

As productivity is fundamentally about how productive people are at work, their skills, motivation and commitment are key.

(Michie et al, 2002: p 6)

What this suggests is that employees can become the vehicle for business improvement only insofar as they are incentivised to act in the company's best interests, for example by working hard and innovating. The imperative to incentivise staff in this way has led some companies to develop 'high-commitment work systems' through a range of progressive human resource management (HRM) practices.

Aimed at enhancing employee performance, such practices include functional flexibility, appraisal schemes, problem-solving groups, direct and representative participation, workforce briefings and employee attitude surveys (Guest and Peccei, 2001; Goddard, 2004). A key characteristic of high-commitment workplaces is that they foster collective effort and group reward through the promotion of teamworking and team autonomy. An enhanced role for employees in decision-making is often achieved through team-based work systems that are intended to flatten management hierarchies and encourage self-direction. In some cases, companies have introduced flexible remuneration schemes such as profit-related pay, performance bonuses and efficiency wages to further encourage employee commitment and promote loyalty to the organisation.

These progressive HRM practices can be contrasted with traditional forms of work organisation which are characterised by hierarchical relations, rigid role demarcations, retention of decision-making authority by managers and top-down communications. The interest shown in these HRM practices, and in employee ownership, stems from extensive research and evidence drawn from different sectors. This evidence is important in making the case for new ways of working within organisations in terms of the benefits for employees as well as leaders and owners (as examples see de Geus, 1997, and Ulrich et al, 2002, among many others).

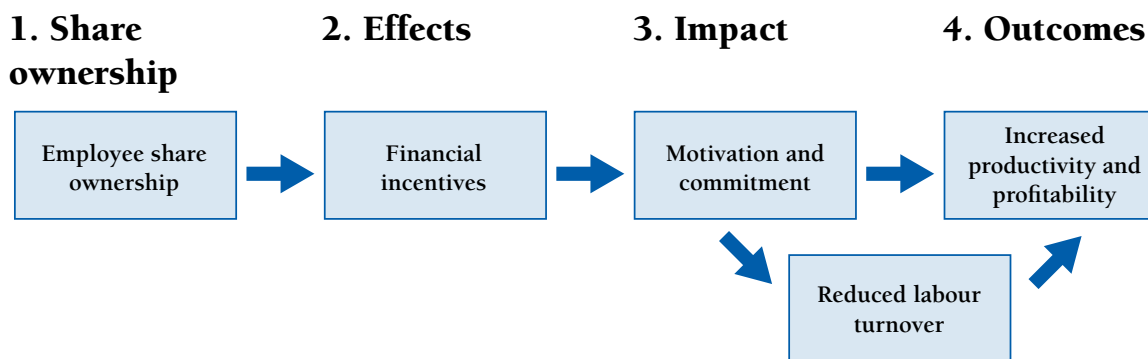
Employee ownership potentially goes beyond creating a 'high-commitment' work environment, because the distinction between the roles of owner and employee are blurred. Employees stand to directly benefit from the financial success of the business which, it is proposed, encourages participation and commitment. The effect is an alignment of interests and incentives across all levels of the organisation, which can be summarised as follows:

The theory is that owning shares will provide employees with financial incentives that will make them more committed to the organisation and more motivated at work. If the company is more profitable, employees will gain financially through dividend payments and an increased share price. Greater motivation will have a direct effect in improving productivity through greater effort and possibly innovation.

(Michie et al, 2002: p 6)

It might also be expected that, as employee commitment increases, so levels of staff turnover will fall. Consequently cost savings might be achieved because there would be less need for recruitment and training, and also insofar as the valuable organisational knowledge that employees build up over time would be retained. Therefore,

Box 8. Linkages from employee ownership to organisational effects



Source: Michie et al, 2002

the benefits of employee ownership are likely to occur both directly by increasing productivity, and indirectly by encouraging staff retention. These putative causal links between employee ownership and positive organisational outcomes are represented in the diagram above (Box 8).

Another body of research concludes that one of the most powerful determinants of job satisfaction is the amount of control that employees have over their work tasks and environment. For example, Nguyen and colleagues (2003) examined the determinants of job satisfaction, using data from the US National Educational Longitudinal Study, which followed a cohort of young people through the education system into the workplace over a 12-year period. The perceived autonomy that employees had in the way they carried out their job had a positive and highly significant influence on levels of satisfaction.

This relationship held even after controlling for various demographic and job-related factors, such as average hours worked. A further study, which surveyed 1,251 US public sector workers, found that employee participation in organisational decision-making was a strong predictor of

job satisfaction (Witt et al, 2000). Moreover, participation also mitigated the negative effects of organisational politics, defined as self-serving behaviour on the part of individual staff members or groups of employees.

The implication of this research is that employee ownership is most likely to produce positive effects when it is combined with forms of workplace participation. In terms of where this additional component might fit into the diagram in Box 8, there are two possibilities. One is that opportunities for employees to influence their working conditions and organisations are more likely to be introduced as a *result* of employee ownership. In this argument, participation is an effect of employee ownership in the same way that financial incentives are (Michie et al, 2002).

Alternatively, participation may not so much be caused by employee ownership, but rather be a necessary condition for its development (Kaarsemaker, 2006). So, for example, organisations which have strong values around involving staff members may be more likely to transfer into employee ownership than those which do not. Whichever of these is correct – and

of course it is possible that the causality works in both directions – one would expect that employee ownership is most successful in companies where employees also have opportunities to participate in important decisions. These are what Reeves (2007) describes as ‘CoCo’ companies – bringing together co-ownership and co-creation.

6.2 Outcomes of employee ownership

Evidence on the outcomes of employee ownership was gathered from a number of sources. We conducted a structured search of various electronic databases covering business, management and health care publications to identify relevant studies published between 1990 and 2008. Reference lists of major articles and reports, and the websites of key organisations, were scanned for further material. Additionally, a number of experts in the field were contacted for additional and unpublished literature and, in some cases, to review our draft findings.

As noted above, much of the literature on employee ownership is specifically concerned with its impact on organisational outcomes and corporate performance. Fewer studies have explored its potential effects on factors that are valued by employees. There is now emerging (although still very tentative) evidence on the difference it makes to customers/service users. Broadly, then, the literature on effects can be categorised according to three sets of outcomes:

- **organisational:** including performance, productivity, absenteeism, innovation, recruitment and retention, quality of labour output
- **employee:** including motivation, job satisfaction, wages, job security, training and development, work environment

- **customer/service user:** including responsiveness, innovation, quality of service or product.

Studies have also explored whether there are any negative effects arising from employee ownership. In particular, these have focused on factors such as costs, competitiveness, risk-taking and decision-making processes.

Before summarising the outcomes of employee ownership, it is worth commenting on the state of the evidence base. The vast majority of the published literature relates to the experience of employee ownership in the United States, and usually in the commercial rather than the public sector. Much of this literature focuses on the impact of share ownership plans such as ESOPs, rather than full employee ownership. However, on this point, Michie (2007) argues that the incentive effects of employee financial participation would be expected to increase in proportion to degree of ownership. Therefore, if anything, full employee ownership is likely to achieve better results than those which are commonly reported for employee shareholding.

There is relatively little data specifically relating to employee ownership in Britain. As the All Party Parliamentary Group on Employee Ownership recently concluded:

Given that the sector is now larger than the agricultural sector and is making a major economic and social contribution to the UK economy – it would appear perverse that we currently know more about pig farming than we do about employee ownership and its impact in co-owned companies.

(All Party Parliamentary Group on Employee Ownership, 2008: p 4)

Much of what is known about employee-owned companies in Britain is anecdotal evidence, and even basic information about the size and characteristics of the sector is lacking.

A final issue concerning the evidence base is the difficulty of establishing causality. Reviewing the published literature on employee participation and company performance, Summers and Hyman (2005) found that causal links between these variables are frequently assumed rather than empirically demonstrated. The possibility that other workplace or broader economic factors are responsible for any observed productivity improvements is often left unexplored. The authors also caution against the generalisation of data, noting that:

A further assumption, which is rarely contested, is the generalisability of participation schemes between different workplaces, industrial sectors and sizes of enterprise. Finally, of concern for the social outcomes of participation is the assumption that participation affects all employees identically, regardless of gender, age, race and contract status.

(Summers and Hyman, 2005: pp 15–16)

These methodological shortcomings are compounded by the fact that much of the research in this area takes the form of cross-sectional surveys, which only give a snapshot picture of employee participation. Longitudinal studies, designed to measure changes over time, would provide for a more robust assessment of both the nature and direction of causality but are rarely used.

6.2.1 Organisational outcomes

Over 30 empirical studies have examined the effects of employee ownership on company performance in the United States. These have shown either neutral or positive results, with no evidence that employee ownership has a negative effect on productivity. The largest study to date compared financial data for 343 ESOP companies with the same number of non-ESOP companies, matched for size, industry and location (Blasi et al, 2003a). Sales and employment growth was 2.3 to 2.4 per cent higher where there was employee share ownership and these companies were also

significantly more likely to still be in business when followed up a number of years later. On average, companies experience a four to five per cent productivity boost when employee financial participation is introduced, which is sustained over subsequent years (Kruse, 2002).

In view of this evidence, the US National Center for Employee Ownership has concluded that:

Researchers now agree that ‘the case is closed’ on employee ownership and corporate performance. Findings this consistent are very unusual. We can say with certainty that when ownership and participative management are combined, substantial gains result. Ownership and participation alone, however, have, at best, spotty or short-lived results.

(cited in All Party Parliamentary Group on Employee Ownership, 2008: p 8)

As the above quote indicates, and the research consistently shows, employee ownership only achieves (or at best only sustains) positive outcomes when combined with opportunities for workplace participation. This is most clearly demonstrated by a major study of employee ownership carried out by the US General Accounting Office in the mid-1980s (General Accounting Office, 1987). The productivity and profitability of 110 companies was compared before and after they set up an ESOP. While employee shareholding alone did not have any impact on profits, companies that also scored highly on participative management measures increased their productivity growth rate by 52 per cent per year. There is also evidence to suggest that it is employee participation in work decisions, rather than representation on governance boards, that accounts for the productivity effects. As Pendleton (2001) suggests, this finding is consistent with the notion that task-related participation is beneficial insofar as it acts as a forum for employees to share information about the production process.

Further support for the organisational impact of employee ownership is provided by Pfeffer (1998), who explored the common features of US companies that were most successful (as measured by shareholder value) during the 1980s and 1990s. From his research, Pfeffer identified seven characteristics of organisational success, many of which are typically associated with employee-owned companies:

1. Employment security
2. Selective hiring of new personnel
3. Self-managed teams and the decentralisation of decision-making as the basic principles of organisational design
4. Comparatively high compensation contingent on organisational performance
5. Extensive training
6. Reduced status distinctions and barriers
7. Extensive sharing of financial and performance information throughout the organisation.

In the UK, HM Revenue and Customs recently carried out research into the extent and impact of two employee shareholding schemes: *Save As You Earn* and the *Share Incentive Plan* (Kerr and Tait, 2008). Over 600 companies offering one or both of these schemes participated in a survey, and just over half reported positive effects in terms of increased or improved organisational performance. Other benefits were also found. For example, of the companies offering *Save as You Earn*, 87 per cent reported that it had improved employer–employee relations, 79 per cent that it had improved employee motivation and 78 per cent that it had improved employee commitment.

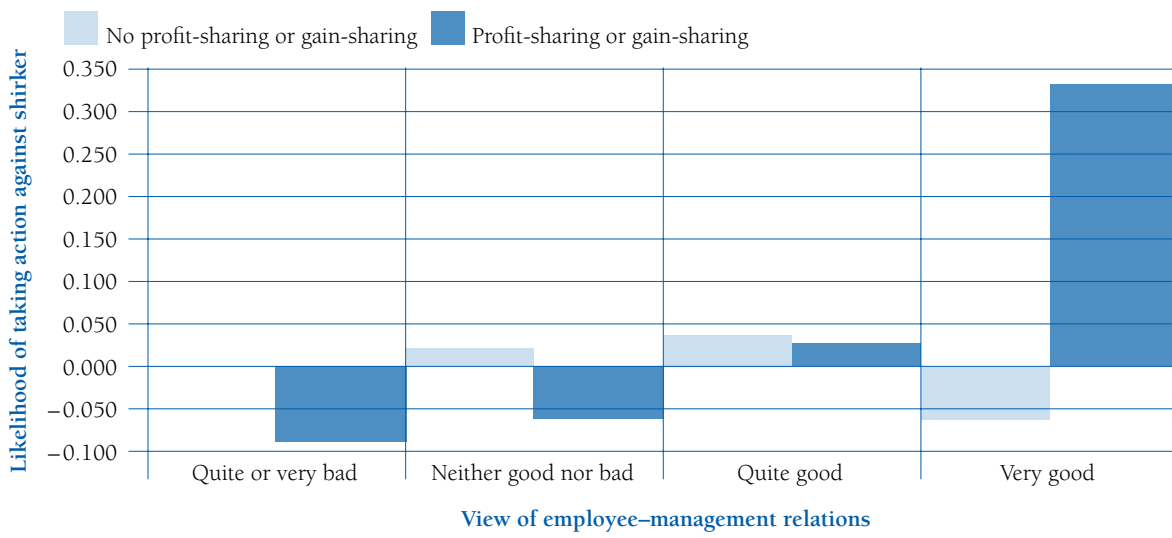
In addition to its impact on performance and productivity, employee ownership has been shown to improve other organisational outcomes. Reviewing the published literature on employee financial participation, Festing and colleagues

(1999) report on several empirical studies which have found reduced levels of staff absenteeism and/or turnover. There is some evidence to suggest that this outcome is affected by the type of employee financial participation. An analysis of data from 127 French companies over the period 1981–91 showed that worker absences were reduced by 14 per cent where there was employee share ownership, but only by seven per cent where profit-sharing schemes were in operation (Brown et al, 1999).

Support for this relationship is also provided by employee-owned companies themselves. All of the employee-owned companies providing public services in Britain report far lower levels of staff turnover compared to their sectoral averages (All Party Parliamentary Group on Employee Ownership, 2008). For example, staff turnover at Sunderland Home Care is three to five per cent, compared to a national average of 20 per cent among care workers. According to Sunderland Home Care, a strong commitment to staff training and development is a key factor in accounting for their higher levels of staff retention.

Employee ownership is also associated with higher levels of collective responsibility and peer pressure. Freeman and colleagues (2004) analysed the responses to two questions in the 2002 US General Social Survey, which asked employees about detecting and reporting ‘shirking’ behaviour among co-workers. Employees in share ownership plans were significantly more likely to confront a non-performing colleague and report their behaviour to management, compared to employees who did not have those incentives. Furthermore, employees were most likely to take action against shirking behaviour in companies where employee–manager relations were described as good than where they were described as quite or very bad, and when employees trusted management than when they did not trust management (Box 9). It was only when financial

Box 9. Effect of profit/gain-sharing and employee–management relations on peer pressure



Source: Freeman et al, 2004

participation was combined with good workplace relations that effects were seen; neither variable by itself was associated with employees taking action against a colleague felt to be shirking their responsibilities.

These findings are especially important in health care in view of the importance of peer pressure as a driver of performance and the difficulty facing non-clinicians in challenging under-performance. They also take on particular significance in the light of recent events at Mid Staffordshire NHS Foundation Trust, where serious lapses in the care provided by the trust’s accident and emergency department had been occurring for a number of years before they came to light. By giving staff a stronger voice within their organisation and encouraging them to raise concerns about under-performance, employee ownership could have a positive impact in terms of patient safety within the NHS.

A further area of interest is the potential link between employee ownership and innovation. It might be expected that giving employees a stake in company outcomes will encourage innovation, particularly where staff are encouraged to share ideas and information. Moreover, it is possible that employee ownership removes a strong barrier for employees to initiate innovation: namely the fear that if they make suggestions for improving efficiency then they could lose their own job as a result. According to Michie (2007), this perceived risk is significantly reduced because of the higher degree of job security afforded by virtue of being a co-owner.

Employee-owned companies have long reported higher levels of innovation, but there has been relatively little empirical research to test these claims. One of the few studies to specifically explore this issue surveyed more than 25,000 employees in over 200 worksites of a large US multinational organisation (Blasi et al, 2008).

Analysis was conducted to explore the impact of different types of employee financial participation: profit/gain-sharing, employee ownership and stock options. While employee ownership was associated with greater employee willingness and ability to contribute innovative ideas to the organisation, no impact was found for profit/gain-sharing. The authors conclude that profit/gain-sharing focuses employees towards immediate gains and, therefore, is insufficient to encourage engagement in innovation as this only usually reaps rewards over the longer term.

6.2.2 Employee outcomes

In comparison to the large volume of research on performance and productivity effects, few studies have explicitly examined the impact of employee ownership on outcomes of importance to employees themselves. Most studies that have looked at how employees are affected by ownership have focused on changes in work attitudes, rather than improvements in the working experience (which might be measured by variables such as job satisfaction, wages and job stability). One of the outcomes that researchers have been most interested in is organisational commitment, which can be defined as loyalty to and identification with the employing organisation (Meyer and Allen, 1991). Organisational commitment is particularly important insofar as the literature demonstrates that this is positively associated with job satisfaction and performance.

A US study by Culpepper and colleagues (2004) explored the impact of ESOPs on employee commitment attitudes in the airline industry. Analysis of surveys from 321 pilots, working in one of three US airlines, showed that share ownership significantly increased organisational commitment, but only when employees perceived that shareholding had increased their influence within the company. According to the authors:

The more strongly an ESOP fosters a sense of empowerment, the more positive are employees' work experiences, thus leading to stronger emotional bonds to the organization.

(Culpepper et al, 2004: p 157)

Research by Kuvaas (2003) provides further insight into this relationship. His questionnaire-based study of 108 Norwegian employees found that organisational commitment was greater among employees engaged in share ownership than those benefiting from cash-based profit-sharing. It was also greater when the share ownership plan, and resulting allocation of rewards, was perceived by employees to be fair. These findings suggest that employee attitudes are most positively affected where there is a longer-term interest rather than immediate financial gain, and where there is a shared perception of procedural justice.

So what of outcomes valued by employees themselves? Kruse reviewed the evidence from 31 studies which reported on a range of employee-related outcomes, including job satisfaction. The majority of these studies made cross-sectional comparisons between employee owners and non-owners, either within the same company or across different companies. His main conclusion was that:

Most studies find higher organizational commitment and identification under employee ownership, while studies are mixed between favourable and neutral findings on job satisfaction, motivation and other behavioural measures.

(Kruse, 2002: p 68)

Aside from one example – involving a company that had lost a bitter strike the year before – none of the 31 studies demonstrated that employee outcomes had worsened as a result of employee ownership. The mixed findings for outcomes such as job satisfaction suggest that other factors might also need to be in place before employee-related benefits are seen.

This issue was explored by Pendleton and colleagues (1998), using attitudinal data collected in the early 1990s from employees working in four UK bus companies that had adopted ESOPs. Only around one third of employees reported positive effects including improved motivation and satisfaction; the remainder felt that little if anything had changed as a result of the ESOP. What set apart those employees with positive assessments is that they had relatively higher levels of share ownership and felt that they were able to participate in organisational decision-making. These factors produced what the authors termed a ‘feeling of ownership’ among employees, which acted as a powerful intervening variable between ownership and attitudinal and behavioural change.

Employees also stand to benefit if higher levels of trust and good industrial relations arise from shared ownership. Research into high commitment work systems offers some insight here. This points to the importance played by the degree and level of employee influence. Participation schemes which allow for only a low degree of influence can leave employees feeling frustrated, disappointed and dissatisfied (Summers and Hyman, 2005). It is the extent to which employee participation can be seen to influence key strategic decisions and is reflected in the management approach that counts. Coming back to the issue of employee satisfaction, the implication of this research is that positive employee outcomes will typically only occur when participation – be it financial or workplace – actually changes the underlying structure of the employment relationship.

Claims made by some commentators that employees gain shares at the expense of competitive pay and benefits are not borne out by the literature. Data on more than 5,000 public companies in the US – including 562 with ‘significant’ employee ownership (defined

as employee stock totalling five per cent or more of the company value) – were analysed by Blasi and colleagues (1996). Wages were eight per cent higher in companies with employee share ownership. The same percentage difference was found in a study comparing wages in ESOP and matched non-ESOP companies in Washington State in the US (Kardas et al, 1998). However, this study also provided evidence that share ownership selectively benefits higher earners, thereby increasing wage differentials between employees. Specifically, the highest ten per cent of earners in ESOP companies enjoyed 18 per cent better wages than their equivalents in non-ESOP companies, while there was only a four per cent improvement in wages for those who were least well-paid.

A related body of literature suggests that employee ownership, insofar as it enhances employee participation, may have a beneficial impact on health outcomes. The demand–control–support model of workplace health provides a theoretical basis for this area of research (Karasek and Theorell, 1990). The model originally proposed that employee health is negatively associated with job demands and positively associated with employees’ degree of control. On this basis, workplaces that are characterised by high volumes of work and time pressures, and low levels of employee decision-making authority and skill utilisation, increase work-related stress. In a later version of the model it was suggested that social support from co-workers and supervisors acts as a mediating factor between job demands, employee control and workplace stress.

Empirical research has broadly confirmed the demand–control–support model. For example, a systematic review of organisational interventions designed to increase employees’ control over their work and their degree of autonomy found that these produced significant health effects (Egan et al, 2007). The greatest improvement

was seen in terms of employees' mental health, as measured by self-reported anxiety and depression. A common feature of successful interventions is a participative approach that seeks to increase employee involvement in workplace decision-making and foster collaborative working between employees and managers (see for example Bourbonnais et al, 2006; Semmer, 2008). Given the documented link between employee well-being and productivity (Brun, 2008), these findings may – at least in part – account for the organisational outcomes of employee ownership summarised above.

6.2.3 Customer/service user outcomes

Very little is currently known about the impact of employee ownership on customer/service user outcomes. On the basis of the evidence already presented, positive effects might be anticipated for this group. For example, it is possible that employee-owned companies are better positioned to meet customer needs because of their greater ability to innovate. Certainly, the small number of companies providing public services in Britain have collectively shown a capacity for rapid and substantial service improvement (All Party Parliamentary Group on Employee Ownership, 2008).

Most of the evidence in this area is provided anecdotally by employee-owned companies, who often report that customers are more satisfied with their products/services and more loyal to them as a result. For example, 78 per cent of companies responding to a survey conducted by the Employee Ownership Association felt that their customers liked the fact that they were employee-owned (Burns, 2006). While these claims are not insignificant, more research is needed to verify whether and how employee ownership might contribute to increased customer/user responsiveness and satisfaction.

The matter of whether third sector organisations, such as social enterprises, are particularly suited to the provision of public services was considered by the House of Commons Public Administration Select Committee (2008). Specifically, the Committee gathered evidence to assess five claims made about the third sector, namely that it has:

- a strong focus on the needs of service users
- specialist knowledge and expertise to meet complex personal needs and tackle difficult issues
- a more joined-up approach to service delivery
- the capacity to build users' trust
- the experience and independence to innovate effectively.

While numerous case study examples were submitted in support of the above claims, there was a lack of comparative evidence to show that these were distinctive characteristics of the sector as a whole. Rather it was suggested that factors such as a joined up approach to service delivery are largely dependent on local commissioning practices, and are not particular to any type of organisation. Moreover, the Committee found some evidence which appeared to contradict the notion that the third sector is particularly user-focused; for example, a 2006 Charity Commission survey reported that 40 per cent of charitable organisations providing public services lacked a complaints procedure.

Some of the best evidence to date of greater customer responsiveness is for the mutual sector. Cook and colleagues (2003) surveyed customers and members of two large mutual organisations: The Yorkshire Building Society and the Oxford, Swindon and Gloucester Co-operative Society. Survey respondents reported high levels of trust in their organisations, which translated into strong customer loyalty. On further analysis, the authors found that this feeling of trust largely resulted

from the absence of external stakeholders, which had enabled the mutuals concerned to prioritise member and customer interests. In practice, this had meant substantial investment in product development, community involvement and employee training and empowerment.

6.2.4 Disadvantages of employee ownership

As with customer outcomes, the literature does not contain a great deal of information about the disadvantages of employee ownership. The two negative outcomes that are most commonly reported are a slowing down of decision-making processes and an aversion to risk-taking, both arising from a more inclusive governance process. However, the evidence for both of these problems is mixed.

For example, Pencavel (2001) noted that worker cooperatives tend to attract more financially risk-tolerant workers, while those who are more risk-averse seek more traditional business cultures. Moreover, while decision-making may take longer if it is carried out collectively rather than unilaterally, involving employees in the process has been shown to improve implementation of decisions (Summers and Hyman, 2005). It is possible that any increase in the time taken to make decisions is subsequently cancelled out by a smoother implementation phase, although this has not been specifically tested.

A British survey found that slower decision-making was the most common problem among employee-owned companies, reported by 65 per cent of respondents (Burns 2006). Around half of all respondents indicated that their company had experienced a tendency to avoid unpopular decisions (53 per cent); slower implementation (46 per cent); and found it harder to generate investment (43 per cent). The full range of responses are shown in Box 10.

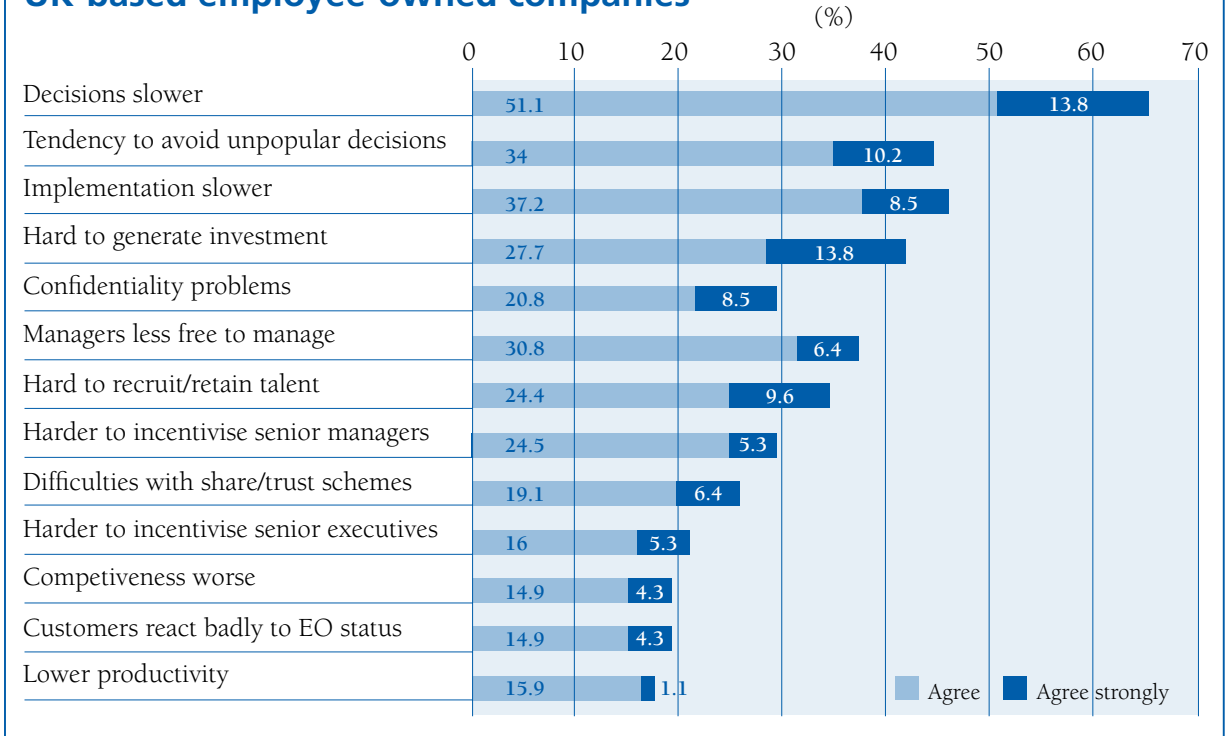
Another potential disadvantage is that employee-owned organisations can become inward looking and may lack the capacity to innovate. As Leadbeater and Christie argue:

Membership involvement in a mutual does not automatically confer upon the organisation the innovative capacity their advocates claim. Much depends on how mutuals are managed to make the most of their strengths.

(1999: p 23)

This is a theme to which we now turn.

Box 10. Disadvantages of employee ownership, reported by UK-based employee-owned companies



Source: Burns, 2006

6.3 The combination effect of employee ownership and participation

The most consistent finding in the literature is that positive outcomes do not automatically flow from employee ownership. Rather, two additional factors need to be present (Postlethwaite et al, 2005). The first of these is *human resource management practices that foster employee participation* in the company, which might include ‘employee involvement in decision making processes, methods of sharing information with employees and other policies that encourage dialogue between different parts of an organisation’ (Postlethwaite et al, 2005: p 14).

The second factor is a *culture of ownership* that is associated with employees having a collective voice in the organisation. Essentially, this means that employees are provided with the opportunities and incentives to think and act *as owners*. What this can achieve is an alignment of employees’ interests and goals with those of the broader organisation.

The importance of collective voice provides support for indirect employee ownership models through EBTs, because benefit trusts are bodies with formal responsibilities for articulating and acting on employee interests. A mechanism such as an EBT provides employee shareholders with a significant lever to influence the governance of an organisation (Postlethwaite et al, 2005). Conversely, where employee ownership is

individualised and the equity stake is small, employees tend only to have minimal influence over the company and decisions made (Estrin and Shlomowitz, 2007). It is unlikely that a culture of ownership would develop under such conditions. Therefore, the current tax restrictions on EBTs may not only be limiting the growth of the sector but also be preventing the development of an effective model of employee ownership.

The combination effect evidenced in empirical studies is also supported by an extensive psychological literature which explores the factors that motivate employees. Three different theoretical models have been proposed to explain the incentivising effects of employee ownership (Buchko, 1992):

- **intrinsic satisfaction:** it is the very fact of ownership – the status of being an ‘owner’ and the pride associated with this – which positively affects employee attitudes and behaviours
- **instrumental satisfaction:** employee ownership positively influences employees insofar as it increases their involvement in decision-making activities and control over their work
- **extrinsic satisfaction:** the benefits of employee ownership occur when this results in financial or other material rewards.

Numerous studies have tested these models, using data gathered from employee owners either through surveys or using qualitative methods. Their results have repeatedly provided greatest support for the instrumental satisfaction model, as well as showing an important secondary role for extrinsic satisfaction (for example Gamble et al, 2002; Kuvaas, 2003). In other words, employees are motivated by both financial and non-financial incentives, and may be more strongly influenced by the latter. A financial stake by itself, therefore, is unlikely to be sufficient to deliver superior outcomes.

The question, then, is whether a participatory culture emerges alongside employee ownership. Certainly, research has shown that there is no direct or simple causal relationship between these factors. Logue and Yates (1999) found that, of companies with ESOPs in the United States, a quarter had not developed employee participation and governance, half had made a modest effort and the final quarter had significant levels of employee involvement. Less than one fifth of companies had non-managerial representatives on the board of directors, although 42 per cent had passed on full voting rights to employees.

However, a clear pattern emerges when employee and traditionally owned companies are compared. Conyon and Freeman (2001) analysed various UK datasets including the 1998 Workplace Employment Relations Survey (WERS) and the 1990–98 longitudinal WERS panel survey of nearly 900 workplaces. Companies with shared compensation schemes – such as profit-related pay, profit-sharing or employee share ownership – were more likely to have formal communication and consultation mechanisms than those without such schemes. The most extensive employee involvement, including decentralised decision-making processes, were found in companies with more substantive forms of financial participation such as employee shareholding.

The same relationship between financial participation and other forms of employee participation – both direct and representative – was reported by another UK-wide study of ESOPs (Pendleton, 2001). The author identified four broad factors that affect the composition and extent of participation in employee-owned companies (see Box 11). Reflecting on this evidence, Michie and Oughton suggest that:

It may be that the key effect of employee share ownership on performance is through making it more likely that firms introduce [progressive human resource management] practices – of

communication, involvement and participation. In addition, where such practices are pursued, the existence of employee share ownership may underpin and enhance the positive effect that

these have on commitment and motivation, by increasing employees' faith that such involvement and participation is genuine and long-term.

(2003: p 13)

Box 11. Factors affecting participation and governance in employee-owned companies

1. Owners. Owners' perspectives on, and desire to shape, employee participation vary considerably. Their motivation for transferring ownership rights to employees is particularly influential. Private companies usually pass on some of their ownership stake to employees for corporate control or paternalistic reasons. When these objectives are combined with a strong personal sense of ownership, which is characteristic of majority owners of small and medium-sized enterprises, this can lead to hostility towards the creation of institutions that facilitate employee participation in strategic decisions. By contrast, public authorities generally attach greater value to employee participation and governance in the services that they transfer to employee ownership.

2. Managers. Managerial philosophies strongly influence the character of employee participation in employee-owned companies. Managers may favour employee participation because it promotes information sharing, upward problem-solving and employee commitment. But studies show that they may hold a number of concerns too; for example that participation will detract from managerial control, will make discipline more difficult to enforce, will open up decision-making to those who are not well qualified for it, or will create divisions within the workforce. Managerial involvement in the design of employee participation will be particularly high when managers have had a lead or major role in the transfer to employee ownership.

3. Employees. Employee aspirations and expectations of participation will also vary. A key issue is whether employees have played an active role in the transference of ownership, or are the passive recipients of shares. Where the risks for employees are higher – for example where they have subscribed to shares to part fund the transfer – then they are likely to attach considerable importance to shareholder participation. Employees need a means for representation during the ownership transfer by which they can articulate, coordinate and express their objectives for participation. This role may be fulfilled by union representatives where these are present, but the role of unions is often complex. While unions are usually in favour of extending employee rights, they may be opposed to new participation and governance arrangements where these are seen to be in conflict with traditional union-based forms of representation.

4. Financiers. Those providing finance to employee-owned companies will be influential, particularly in determining governance arrangements. In general, investors are often wary of employee involvement in corporate governance, due to concerns about its effectiveness and the risk that employees will put their own interests before successful financial performance. They may insist on limitations to the degree and scope of employee involvement in governance as a condition of granting loans. The extent to which an employee-owned company is dependent on external investment is critical. Indeed, in some cases financiers may have the majority share of ownership and control.

6.4 Workplace participation without employee ownership

While employee participation is a catalyst for successful employee ownership, what does the literature say about the impact it can achieve by itself? There is a substantial body of research reporting on the outcomes of employee participation, much of which focuses on the introduction of high-commitment HRM practices which were described above. One of the challenges in interpreting this research is that it often addresses employee participation as a general category, rather than reporting on the outcomes of different types of strategy. Moreover, as with the literature on employee ownership, the majority of studies have been conducted in commercial enterprises and the transferability of findings to the public sector may not be straightforward. Nonetheless, some important results have emerged from the research to date.

A review of evidence for the relationship between governance, incentives and outcomes in health care organisations explored the impact of human resource management policies (Davies et al, 2005). It identified several studies which found that such policies positively influenced a range of outcomes including financial performance, employee turnover and satisfaction. This included a study by West and colleagues (2005), who surveyed 61 chief executives and HR directors in acute hospitals in England and reported a significant association between the management of employees and levels of patient mortality.

The incentivising effect of performance-related pay was also considered. The evidence gathered indicated that performance-related pay can increase productivity, but that it does so by giving rise to a renegotiation of performance norms rather than by directly motivating staff. Therefore, it is more likely to deliver benefits when combined with goal setting and appraisal by line managers.

However, many other studies have failed to provide support for participatory HRM, and some have even suggested that employees can be disadvantaged by these practices. Cappelli and Neumark's (2001) analysis of longitudinal data from US National Employer Surveys reported that high commitment practices increased labour costs, produced only weak productivity effects and had no association with workforce efficiency. Research by Goddard (2004) found that devolution of responsibility to team level was associated with work overload, role stress and after-work fatigue among employees. Summarising the evidence base on employee participation and company performance, Summers and Hyman suggested that 'while there are some signs that [high commitment work practices] can be linked to positive performance indicators, the evidence is not conclusive' (2005: p 23).

What has also been demonstrated is that most organisations have only partially or selectively adopted workplace participation practices. The 1998 British Workplace Employment Relations Study, which collected data from over 30,000 questionnaires and 3,000 interviews, demonstrated the variability in adoption of 'new' management practices and employee involvement schemes. While over two thirds of those surveyed had introduced teamworking, only 28 per cent had a consultative committee that brought together managers and employees to discuss workplace issues (Table 4).

Similarly, Guest and Peccei's (2001) major UK study suggests that companies may be selectively adopting employee involvement practices. In their sample of 54 organisations (drawn from the membership of the Involvement and Participation Association) there was generally a low level of direct employee participation in work decisions and of representative participation in organisational decisions. By contrast, there had been far greater adoption of HRM practices

emphasising flexible job design, focus on quality and performance management. Goddard (2004) also notes that the literature provides some evidence that high-commitment HRM systems are fragile and that they are often scaled back or discontinued over time.

Various factors have been identified as affecting the outcomes of employee participation, which may in part account for the variability seen in the literature on effectiveness. The degree of influence afforded by participation schemes has a major impact, with benefits rarely seen in organisations where changes in the work situation are only superficial and there is little employee autonomy (Summers and Hyman, 2005). Guest and Peccei point out that 'It is only when employees are engaged, in terms of attitudes and behaviour, that performance gains are apparent' (2001: p 232). In their study, only two practices were associated with positive employee attitudes and behaviour: job design and direct employee participation in workplace decisions.

Several studies support the notion of an additive effect insofar as participatory HRM practices achieve greater results when they are implemented in bundles and the introduction of additional practices may further enhance any benefits (for example Ichniowski et al, 1996). By contrast, individual initiatives in isolation are unlikely to achieve positive results. The literature also points to the importance of employee perceptions and managerial culture. Specifically, as Summers and Hyman remark, 'The propensity for employees to participate is partly a result of management's commitment to the programme and their ability to make employees think that they are taking the scheme seriously' (2005: p 46). Lack of sustained managerial support is one of the most commonly cited obstacles to the implementation of employee participation initiatives (Semmer, 2008).

Table 4. Use of 'new' management practices and employee involvement schemes in UK workplaces

Practice	% of workplaces
Most employees work in formally designated teams	65
Workplace operates a system of team briefing for groups of employees	61
Most non-managerial employees have performance formally appraised	56
Staff attitude survey conducted in the last five years	45
Problem-solving groups (e.g. quality circles)	42
'Single status' between managers and non-managerial employees	41
Regular meetings of entire workforce	37
Profit-sharing scheme operated for non-managerial employees	30
Workplace operates a just-in-time system of inventory control	29
Workplace level joint consultative committee	28
Most supervisors trained in employee relations skills	27
Attitudinal test used before making appointments	22
Employee share ownership scheme for non-managerial employees	15
Guaranteed job security or no compulsory redundancies policy	14
Most employees receive minimum of five days training per year	12
Individual performance-related pay scheme for non-managerial employees	11

Source: Cully et al, 1999

The importance of leadership styles has also been demonstrated. A study by Alimo-Metcalf and colleagues (2007) examined the relationship between the quality of leadership within 116 mental health crisis resolution teams and a range of employee and organisational outcomes. Three elements of leadership were identified and their effects explored: leadership competency, visionary leadership, and engaging with others. The findings indicated that leadership behaviours that were primarily focused on engaging with others had the greatest impact on staff attitudes to work and their well-being at work.

This engaging style of leadership comprised a number of different elements including empowering staff by trusting them to take decisions; being active in supporting staff through coaching and mentoring; and using face-to-face communication. The study also found that 'engaging with others' (but not visionary leadership or leadership capability) had a significant impact on the productivity of teams. The implication of this research is that it is the extent to which managers engage their staff – rather than their visionary potential or particular skill-set – which will produce the greatest benefits for employees and organisations.

6.5 Summary

The research on workplace participation shows that HRM practices can foster a culture of ownership and motivate employees, thereby delivering higher levels of organisational performance. But these benefits are likely only to be achieved when such practices are pursued intensively and consistently, and create opportunities to participate that are meaningful to staff. Above all, this means enabling staff to shape their roles and work environment. The literature on managerial and leadership effects indicates that it is not just the initiatives that are pursued, but the broader culture into which they are introduced that matters. This may explain why the combination of employee participation with a culture of ownership and formal ownership rights appears to make the biggest impact.

7. EMPLOYEE OWNERSHIP CASE STUDIES

Summary points

- Four case studies of employee-owned organisations are described: John Lewis Partnership, Kaiser Permanente, Circle and Central Surrey Health.
- These four organisations have developed different organisational models for employee ownership: Circle and Kaiser are professional partnerships, while Central Surrey Health is a limited liability company in which each staff member has a 1p share.
- A characteristic common to all is the strong emphasis that is placed on communicating with employees and involving them in decision-making. At the John Lewis Partnership, managers can be held to account by staff through democratic mechanisms at every level of the organisation.
- The case study examples provide further evidence of the impact of employee ownership on performance. These organisations are among the most innovative and successful in their sectors.

Much can be learnt from existing employee-owned organisations, operating both within health care and in other sectors. The case studies described below provide insight into four employee-owned organisations: John Lewis Partnership, the medical groups in Kaiser Permanente, Circle and Central Surrey Health. In particular, and in view of the findings from the previous chapter, these case studies explore the mechanisms that have been put in place in the four organisations concerned to foster a culture of ownership in the workplace and provide opportunities for staff participation.

7.1 John Lewis Partnership

John Lewis Partnership is the UK's oldest and largest employee-owned company. John Lewis was originally opened as a small draper's shop on London's Oxford Street in 1864. It was John Lewis's son, Spedan, who was responsible for establishing the company's co-ownership

principles. Spedan Lewis assumed management of the Peter Jones store – bought out by his father in 1905 – and began an experiment in staff participation. He set up a representative staff council, a house journal and, in 1920, introduced the first profit-sharing scheme.

The death of John Lewis in 1928 left Spedan in control of the company, which he subsequently passed into employee ownership in two trust settlements. The first settlement, in 1929, established the John Lewis Partnership as a trust for the benefit of employees and enshrined the principles of profit-sharing. In the second settlement in 1950, Spedan Lewis passed his remaining shares and ultimate control of the company to the Partnership's trustees.

By 2009, the John Lewis Partnership operated 27 department stores, 198 Waitrose supermarkets and a direct services company, Greenbee. All permanent staff – currently around 69,000 –

are 'Partners' in the business and entitled to receive an annual share of the company's profits (called the Partnership Bonus). Profit-sharing is calculated as a proportion of an individual's salary, which is set each year based on the company's financial performance.

The Partnership Bonus has varied from as low as eight per cent to as high as 24 per cent of Partners' annual salaries. In early 2008, following a strong financial year, Partners received 20 per cent of their salary which was equivalent to more than ten weeks' pay; in 2009, the Bonus is 13 per cent. In 2007, John Lewis Partnership set up BonusSave, a share incentive plan which allows Partners to invest up to £4,500 of their annual bonus tax-free. Profits are also invested into a non-contributory final salary pension scheme, and after 25 years of service Partners are entitled to take paid leave for six months.

The democratic principles which drove the establishment of the Partnership in the early 20th century continue to this day and help to foster a culture of Partner engagement. Every John Lewis and Waitrose store has an elected branch forum, which discusses local issues at the store. Above this are two divisional councils, to which at least one councillor is elected from each branch.

The apex of the democratic structure is the Partnership Council, which represents all Partners across the business and whose role is to hold the Chairman to account, influence the development of policy and agree (with the Chairman) changes in governance. There is a weekly in-house newsletter – *The Gazette* – which publishes letters from Partners (anonymous or signed). All letters have to be published, with comment from an appropriate member of management, within 21 days of receipt.

The Partner voice is also heard through an annual survey, first conducted in 2003. Response rates to the survey are very good, reaching a high of 94 per cent in 2007. The survey demonstrates

Partners' strong sense of loyalty to their organisation. In 2008, the highest-rated question was 'I care about the Partnership', closely followed by 'I feel proud to work for the Partnership'.

Responses also show that Partners feel happy in their jobs, supported by their managers, and satisfied with the wider benefits they receive. The effectiveness of the democratic bodies has scored much lower, and the Partnership has taken steps to improve local democracy in light of this. For example, Partners are now much more involved in determining and recommending to management the trading hours at key times of the year (rather than simply formally accepting them). Their approach to power-sharing sees this as an ongoing process rather than an end in itself.

John Lewis Partnership is one of a small number of organisations in the UK to have a written constitution. It opens by stating that

The Partnership's ultimate purpose is the happiness of all its members, through their worthwhile and satisfying employment in a successful business. Because the Partnership is owned in trust for its members, they share the responsibilities of ownership as well as its rewards – profit, knowledge and power.

The Constitution also sets out the Partnership's governance arrangements. Power is shared by three governing authorities: the Chairman, who has overall executive control; the Partnership Board, which is responsible for commercial activities; and the Partnership Council, whose role is described above. The Partnership Council has 91 members, the majority of whom are elected by employees through a democratic one-person one-vote system. It in turn elects five directors to the Partnership Board, with a further five directors appointed by the Chairman. Equipping Partners to participate on the Board has been a challenge for the company, and many serve more than one term to build on their knowledge for the role.

Partner directors are mentored early in their term by appointed directors, and are supported by the company secretariat to access training and prepare for meetings. The Chairman appears before the Council twice a year, but at any time the Council may put questions to the Chairman or Partnership Board who are obliged, under the terms of the Constitution, to provide an answer unless doing so would damage the Partnership's interests. The Council's ultimate authority is that, by a two-thirds majority vote, it can trigger the process which removes the Chairman from office.

Partners have an undoubted influence on the business. In 1999, following a fall in profits, there were calls from some Partners for the company to be demutualised and floated on the stock market. Given the nature of the two Trust Settlements, it would have been extremely difficult for this to happen. But had it happened, Partners would each have received a significant amount of money as a windfall. The issue was discussed by the Partnership Council which, aside from one person, unanimously decided to support the co-ownership model and block the potential move to demutualise.

7.2 Kaiser Permanente

Kaiser Permanente (KP) is one of the oldest established integrated health care systems in the United States. The origins of KP can be traced to the Mojave Desert in southern California in the 1930s when a physician named Sidney Garfield, in partnership with the industrialist Henry Kaiser, set up a group pre-payment health plan for workers constructing an aqueduct in the desert. Subsequently, Kaiser persuaded Garfield to establish a similar plan in Washington State for construction workers involved in the Grand Coulee Dam project. Kaiser and Garfield extended these principles during the second world war to workers at Kaiser-managed shipyards and a steel mill on the west coast of the United States. In the process, membership of the plan came to

include workers' dependents. At the end of the war, membership of the plan was opened up to the public.

Following a period of expansion on the west coast, the basis of the current organisation was established. This involved the separation of the three functions of KP into the Health Plan, Hospitals and the Permanente Medical Group. Taken together, these three entities comprised the integrated system that KP had become. At the same time, it was decided to decentralise management into the three regions then covered by KP – Northern California, Southern California and Oregon. The emphasis on regional responsibility continued as KP established a presence in other states, and today it serves over eight million members in nine states and the District of Columbia.

The core principles of KP have remained constant throughout its history. These principles include pre-payment as opposed to fee-for-service medicine; a focus on prevention and not just treatment; physicians working in group practice rather than solo practice; and physicians taking responsibility for the quality of work they do and the cost of care they deliver, through a long-term partnership with each other and with the Kaiser Foundation Health Plan. This partnership entails two principal elements: a relationship of mutual exclusivity with the health plan, in which the physicians work only with the plan and the plan contracts only with physicians in the Permanente medical group; and the role of the medical group as an independent self-governing organisation owned and managed by physicians for their mutual benefit. On a day-to-day basis, physician leaders work in partnership with professional managers employed by Kaiser Foundation Hospitals in running services in hospitals and in ambulatory settings.

For much of its history, KP was strongly opposed by the forces of organised medicine. These

forces were critical of what they saw as the restrictive nature of pre-payment and group practice, and the exclusive relationship between the plan and the medical group. The principles on which KP was based were anathema to many physicians working in solo practice who believed passionately in the freedom of doctors to practice independently and of patients to have an unlimited choice of doctor. Garfield, Kaiser and their colleagues eventually succeeded in overcoming these objections and in establishing KP as the largest health plan in California. Along the way, they had to counter the argument that KP was a form of socialised medicine that contradicted the values of choice and competition that were seen as important both in health care and in American society as a whole.

The Permanente Medical Group was first separated from the health plan in 1948 when it became a taxable professional partnership of physicians, and the health plan remained a not-for-profit, tax exempt, community benefit foundation. Initially, there were three categories of physicians in the group: senior partners, junior partners and physician employees. Both senior and junior partners were required to buy an ownership share in the group. As it evolved, the medical group expanded and newly appointed physicians were expected to serve a period of 'apprenticeship' before being elected by peers as partners.

New partners must buy shares in the medical group and these shares can only be held by partners. The medical group is usually able to select physicians from a field of qualified applicants. One of the factors in the selection process is an assessment of the likelihood that a newly appointed doctor will be comfortable within a model of group practice in which a willingness to work collaboratively with colleagues is highly valued. There is a degree of self-selection in this process, with physicians

choosing to apply to work in KP because of a preference for team work within an organised framework rather than competitive office-based practice.

The work of the group was led originally by an executive committee comprising six permanent members and two elected members. A greater element of democracy was introduced in the 1970s, involving each medical centre having two seats on the executive committee. One of these seats is for the physician in chief and the other for a physician elected by his or her colleagues at the medical centre. The executive medical director of the group is nominated by the executive committee (now known as the board of directors) and must be confirmed by a majority of the partners. Each KP region has its own Permanente medical group and the term *The Permanente Medical Group* is reserved for the founding group of physicians in northern California. The length of time physicians have to serve an apprenticeship and the value of the shares they have to buy varies from region to region.

The partnership model continued until 1982 when a decision was taken to turn the group into a professional corporation, to protect the pension benefits available to physicians and provide immunity from legal claims based on their partners' actions. All of the medical groups except the one in southern California became professional corporations at around this time. At a national level The Permanente Federation acts on behalf of all the medical groups in working with the health plan and making strategic decisions that affect KP as a whole (such as decisions on the major investment in information technology that has occurred in the last decade).

Throughout the history of KP, there has been a creative tension between the Health Plan/Hospitals on the one hand and the Permanente Medical Groups on the other. Smillie (2000) has described in detail the nature of this tension,

centred on debate as to whether the medical group was in the driving seat with the plan enrolling members and the hospitals providing facilities for physicians to carry out their craft, or whether the plan and the hospitals were in the driving seat, with the medical group delivering services needed by members under the terms of their insurance contract with the plan. These tensions came to a head in the early 1950s and were only resolved under the Lake Tahoe Agreement in 1955. It was this agreement that led to the plan and the medical group determining to work in a mutually exclusive relationship based on a partnership of equals, and the plan accepting that the medical group would be self-governing.

As a consequence, there is close alignment between the interests of the plan and the interests of the medical groups. Each party is aware that the relationship is one of assured mutual success or assured mutual failure, and this creates a strong incentive to find solutions that will benefit all concerned. A key characteristic of the medical groups, as self-governing organisations, is that physicians are led by their peers. Performance improvement results more from the commitment of physicians to provide high-quality care than from compliance with externally important standards and requirements, although the latter cannot be ignored. Where there is evidence of under-performance, this is addressed mainly through peer comparison, leading to peer review and peer pressure to improve.

Within the medical group, physician leaders appeal first and foremost to the intrinsic motivation of doctors to do a good job, using comparative information to tap into the inherently competitive desire of physicians to perform well. Other levers, such as financial incentives, are also used, but are seen as secondary to physician leadership and the use of collegial mechanisms to bring about change. The result is that the medical group has developed a deeply ingrained

culture that helps to explain the high level of performance achieved. This culture is promoted through a significant investment in the induction of physicians into the group and is reinforced by continuing professional development throughout a physician's career. In exceptional cases, where it is clear that there is not a good fit between the culture of the group and a physician, then he or she may choose to leave or be asked to move on.

One of the other characteristics of the medical group is the high proportion of physicians involved in leadership roles. Each medical centre has a physician in chief and each specialty or clinic within the medical centre is led by a physician. Other physicians take on leadership roles in relation to quality improvement, information technology, patient safety, education and development, and related functions. In practice this means that one fifth or more of physicians have some kind of leadership role and around one third have had such a role at some stage in their career. The significance of this is that medical leadership is not an activity undertaken by a small proportion of the medical group but becomes the expectation of those working in the group and 'the way business is done around here'.

Visitors from the NHS who have studied KP often comment on the positive attitude of its physicians and the strong sense of corporate commitment they convey. This is explained by the full engagement of physicians in the work of the medical group, the sense of pride they feel and express, the leadership provided by peers, the mutual respect physicians have for their peers, and above all the culture within which physicians practice. The ownership of the medical groups by physicians, and the highly developed arrangements for participative management, are major factors that contribute to this culture, and the alignment between the group and the plan that is essential to the continuing success of KP.

7.3 Circle

Circle is a private health care provider, established in 2004. In five years it has become Europe's largest health care partnership. The company is based on a professional partnership model that was developed to achieve three key aims. The first was to use co-ownership to create a 'partnership of equals' and align incentives across the organisation. The second was to foster a culture of clinical leadership and shared accountability. This was strongly influenced by the experience of two US health care organisations: Kaiser Permanente (see above) and the Mayo Clinic, which is run by a physician-led governing board. An alignment of incentives and leadership culture would, in turn, help the company achieve its final key aim: continuous improvement based on the translation of clinical and research evidence into benefit.

At the end of 2008, there were nearly 1,200 consultants in the Circle Partnership. The development of clinics and community services has seen the Partnership expand to include GPs (now numbering 600) and practice staff. The Partnership model is fully inclusive and all clinical and non-clinical staff are invited into it when they join the company or commit a proportion of their practice to a Circle facility.

Like the John Lewis Partnership, staff at every level are referred to as Partners. Every year from 2004 to 2013, shares are being made available for allocation to Partners until 100 million shares (all equal in value) have been issued. These are allocated on the basis of performance – the more an individual contributes, the more shares they will receive – as well as rewarding the quality of care and recognising teamwork skills. Allocations are agreed locally and are ratified by the company board.

The company comprises two constituent parts. One is the Circle Partnership, which owns 49.9 per cent of the business. The other is Circle International Plc, owned by a group of City

financial institutions that receive shares for investment; this owns the remaining 50.1 per cent. Clinical services are provided in health care facilities which are developed, owned and leased to Circle by its sister company, Health Properties Ltd.

The partnership approach is not only fostered through the financial incentives of co-ownership. Circle's governance structure places a strong emphasis on bottom-up management and includes both democratic and executive elements. The overall company is run by a senior management team, with clinical professionals in the majority. A central coordination committee brings together Partners from each of the local partnerships on a monthly basis to discuss strategic issues. Local facilities are run independently by local executive boards, which consist of clinical unit leads, operations, finance and risk assurance leads, the general manager and a clinical chairman. Local steering groups fulfil a similar function to the central coordination committee in representing Partner views.

In June 2007, Circle acquired Nations Healthcare which had won three independent sector treatment centre (ISTC) contracts in Bradford, Burton and Nottingham. Within a year, revenue day case volume had increased by 22 per cent and cost reduced by 19 per cent, and overall revenue was 26 per cent higher. Generally, only staff who are directly employed in the former Nations facilities, and not those who are seconded from the NHS, have equity ownership rights. This suggests that the company's participative management style – based on devolving power and responsibility to the frontline – is as important in terms of motivating staff and delivering higher performance as financial reward (confirming the combination effect outlined in section 6.3). The Nottingham ISTC, which opened in July 2008, is the largest day case treatment centre in Europe.

Circle currently operates five acute facilities and has recently expanded into community services. Here it is planning to use an integrated care network model to provide a range of services in partnership with local health and social care providers. For example, in Whitstable, Circle has worked with key local stakeholders to establish arrangements for the provision of chronic disease management, urgent care, elective and diagnostic and enhanced rehabilitation services. This integrated care model is also being pursued through the construction of a series of purpose-built community clinics to enable co-location of GPs, primary care professionals and specialist doctors.

7.4 Central Surrey Health

In January 2005, East Elmbridge and Mid Surrey PCT made the decision to move away from directly providing services and focus on commissioning. This triggered a review of the PCT's provider arm and the directors of therapies and nursing were asked to carry out a detailed options appraisal. With 35 senior clinicians, they reviewed a number of possible models including care trusts, community trusts, private companies and partnership arrangements with local GPs.

Six months later the group presented an outline business case to the PCT board, setting out its preferred model: a not-for-profit limited liability company, owned by its staff. The company would operate as a social enterprise to combine the values and principles of the NHS with a 'can do' business culture. The proposal received the Board's support in principle, and Jo Pritchard (Director of Nursing) and Tricia McGregor (Director of Therapies) started a two-year journey to transform the idea into a reality.

After two months operating in a shadow form within the PCT, Central Surrey Health (CSH) was formally launched on 1 October 2006. At

that time, 650 nurses and therapists at East Elmbridge and Surrey PCT were transferred under Transfers of Undertakings (Protection of Employment) Regulations (TUPE) arrangements into the new company, while retaining their NHS employment terms and conditions. By early 2009, the organisation employed 780 staff. CSH was established with a three-year contract from the PCT to deliver services within community and hospital settings. All major assets continued to be owned by the PCT and are leased or used by CSH to fulfil its contract.

The process of setting up CSH was beset with challenges. It was one of the first social enterprises to emerge from the NHS, and remains the only employee-owned NHS organisation to date. A number of practical issues had to be addressed as the organisation was developing, including writing a business plan, establishing risk management arrangements and agreeing a contract for the provision of nursing and community services with the commissioners. They drew widely on the experience of experts in social enterprise, co-ownership and the finance, legal and business fields, including advice from John Lewis Partnership.

CSH was established before the Department of Health announced that staff transferring to new social enterprises could remain in the NHS pension scheme. This issue of pension rights was addressed using a primary care contracting route – the specialist personal medical services (SPMS) contract. Under this type of contract, new and existing CSH staff are able to be members of the NHS pension scheme.

In addition to practical obstacles, a major issue was how to foster an organisational culture that would make co-ownership real. This meant developing an organisational model that suited the values of staff, while also being responsive and flexible to the changing health care system,

and able to deliver efficient, integrated and patient-centred services (Walsham and Dingwall, 2007). Making sure that staff were informed and involved from the beginning of the process was felt to be critical. In the event this was also important in terms of managing uncertainty about the transition and enabling staff concerns to be raised and acted upon.

All staff own a single 1p share in the company and are referred to as 'co-owners'. As co-owners, they are responsible for delivering patient services and shaping the company's future. Staff elect representatives to sit on a council of co-owners – called The Voice – which contributes to strategy development and shaping the overall direction of the organisation. Increasing co-owner involvement in decision-making is seen as an ongoing process, and various mechanisms have been developed to foster communication and engagement including formal briefings and drop-in sessions.

Co-owners appoint a non-executive director to sit on the board, which has been kept deliberately small in size to allow for a quick turnaround on decision-making. Services are managed on a day-to-day basis by clinical teams and CSH is working to break down professional boundaries to achieve greater integration of services along pathways of care. In its next stage of development, CSH is looking to advance its social enterprise mission through stronger community involvement and delivering new services to improve health and well-being.

A surplus generated in the first year of operation has been used to address two areas identified by co-owners as needing improvement: the organisation's IT system and the training and development budget (which has more than doubled). This makes CSH different from many of the employee-owned companies in the UK, where staff share the fruits of ownership through dividends or other direct financial benefits.

In the case of CSH, the potential benefits of co-ownership arise not only from investment in staff through activities such as training, but from the greater control that staff have over the services they provide and the mechanisms for collective voice within the organisation. A key aim for the future is to demonstrate the added value that this approach brings to staff as co-owners and to patients, commissioners and the local community.

8. CHALLENGES TO DEVELOPING EMPLOYEE OWNERSHIP OF HEALTH SERVICES

Summary points

- There are a number of challenges in developing employee ownership in the NHS. These include whether there is sufficient political will and practical and financial support available to make this happen. The establishment of any new type of organisation within the NHS also requires support from leaders at a regional and local level, including strategic health authorities who will have a major role to play in approving local plans and business cases.
- Trade unions are concerned about moves to introduce new types of provider organisation and create a mixed economy in health. However, employee-owned organisations may be seen as more closely aligned to core NHS values, and an acceptable alternative to commercial providers.
- Employee-owned organisations in the NHS will be operating in an increasingly competitive market environment. While this poses a risk in terms of their long-term sustainability, choice and competition may prevent employee ownership leading to provider capture.
- Access to NHS pensions remains a major barrier to PCT provider arms becoming social enterprises. Unless the rules on new staff employed by social enterprises not being entitled to join the NHS pension scheme are changed, then the number of provider arms choosing to go down this route is likely to be extremely limited.
- Clarity about the migration path to employee ownership is also needed before this is seen as a viable option. Organisations will need to access business and legal support and other practical advice on organisational options, the transfer of staff and related issues.

As the evidence shows, employee-owned companies achieve good financial results, deliver higher levels of innovation, provide a more harmonious working environment and may yet prove to be particularly effective at meeting the needs of customers. At a time when the NHS is seeking to engage its staff and is exploring alternative models of provider services, the potential value of employee ownership should be seriously considered. As we noted in Chapter 3, a major driving force in the engagement and motivation of NHS staff is their ability to influence

the running of their organisation to deliver a good service. This demonstrates that employee ownership, insofar as it fosters greater staff participation and control, closely aligns with the strong values of NHS staff.

The promotion of social enterprises within the NHS suggests that new forms of public sector ownership are increasingly recognised and accepted. Nonetheless, there are likely to be a number of potential challenges in terms of developing employee-owned health service organisations, sustaining their involvement

and ensuring that they are able to deliver their expected benefits. While most of these challenges take the form of practical barriers to facilitating the transfer of equity and control to employees, there are also issues about how newly formed employee-owned health care providers would fare in an increasingly competitive commissioning environment. Moreover, while there is a strong rationale for more actively engaging staff in the management of local health services, there is also the risk that a service which is run by its employees is vulnerable to provider capture. Each of these challenges, and others, is outlined below.

- **Political will** – given the complexity of transferring NHS staff and services into new organisations, the successful development of employee ownership in the health service will depend on sustained political encouragement and support. This means not only a favourable policy and legislative environment, but also the provision of practical resources to help organisations develop their business cases and make the transition. Ultimately, it may also mean making funding available to help with set-up costs as happened with the early waves of foundation trusts and the social enterprise pathfinders. The growth of the sector may be being restricted by the government's own narrow vision of employee ownership. As the All Party Parliamentary Group on Employee Ownership noted in its review of the sector, 'Attention has focused almost entirely on employee share ownership... rather than on the broader option of co-ownership' (2008: p 28).
- **Support from NHS leadership** – in addition to political will and encouragement from the centre, the establishment of any new type of organisation within the NHS requires support from leaders at a regional and local level. Strategic health authorities (SHAs) have a major role to play in approving local plans and business cases, and are likely to be closely monitoring public consultations where major service changes are proposed. The extent to which they endorse and encourage, for example, the establishment of social enterprises through the right to request could prove to be a critical factor in their future development. Similarly, the potential of employee ownership depends on the willingness of senior managers to embrace an organisational model that emphasises greater staff participation and which may grant employees formal ownership rights.
- **Union concerns** – unions have been opposed to moves to create a market in the NHS and introduce new forms of provider organisation. Although their opposition has been principally focused on the increased involvement of commercial companies, this underlies a more general unease about what is seen as dismantling of the NHS family and erosion of public service values. Key issues include conditions of employment for staff transferring into non-NHS organisations, and the capacity of a plural provider market to deliver coordinated services and ensure continuity of care. There have also been longstanding concerns about the potential for employee ownership to weaken trade unions, with ownership rights effectively replacing the need for union membership and collective bargaining (see for example Pendleton et al, 1995). Nonetheless, as a recent report by Unison acknowledged, organisations such as social enterprises may combine elements of the public and private sectors, but are more closely aligned to the values and ethos of the former (Marks and Hunter, 2007). If the benefits of employee ownership can be demonstrated, then it may be possible to win union support for this model as a viable and more acceptable alternative to commercial providers.

The response of professional associations is a further consideration. A briefing paper by the Royal College of Nursing's policy unit indicates that they are cautiously optimistic about the possibilities for nurse-led social enterprises (RCN Policy Unit, 2006). Opportunities for nurses to develop leadership roles and entrepreneurial activities were welcomed, but the need for clear governance arrangements that embed staff involvement was also emphasised. The RCN policy briefing also raised concerns about the lack of research evidence on the impact of social enterprise as a model for public service delivery.

- **Viability in a competitive environment**

– a key issue for any new entrant into the NHS provider market is building and sustaining a position in what is an increasingly competitive environment, which may also include international companies looking to win NHS contracts. By virtue of their newness and relative obscurity, employee-owned organisations may be especially vulnerable to the effects of market forces. If the experience of the third sector is anything to go by then employee-owned organisations might expect to face particular difficulties in competing against locally established and recognised public sector providers on the one hand, and well-resourced commercial companies on the other.

The role of PCTs is critical, both as local commissioners and market regulators. A careful balance needs to be struck by PCTs between promoting fair and open competition between providers, and encouraging and supporting new market entrants in order to build local capacity and promote service stability. While contestability demands the former, the needs of employee-owned organisations (and, of course, service users) will principally be met by the latter. The Department of Health's guarantee of an uncontested contract of up to five years for

community health services transferring into the social enterprise model will provide a degree of financial security as organisations establish themselves.

- **Managing external pressures** – a major attraction of employee ownership to the NHS is its potential to enhance the engagement and motivation of front-line staff as their interests become more closely aligned with their employing organisation. The issue is whether such an alignment can be achieved in an environment that is characterised by strong external pressures and demands from government and regulators to improve performance. Ultimately, this might come down to the question of whether a commitment to localised decision-making and building staff participation can be sustained in a performance culture that continues to be based on nationally set targets and hierarchical control.
- **Provider capture** – at the heart of the government's vision for a self-improving NHS is the empowerment of front-line staff to devise and implement the changes that will bring about a better quality of service. The extent to which employee ownership can deliver this goal depends on its capacity to grant ownership and participation rights to staff, in particular through having a greater say in the management of their organisation. However, this also carries the risk that employee interests come to dominate decision-making, to the exclusion of other stakeholder interests, leading to 'provider capture'. Provider capture is much more likely where an organisation is a monopoly supplier. Given this, the increasing emphasis on provider plurality and competition within the NHS might act as a safeguard, as well as incentivising providers to deliver a more customer-oriented and responsive service.

Provider capture might also be avoided, and public accountability secured, by developing organisations with multi-stakeholder governance structures rather than adopting a ‘pure’ form of employee ownership. The Greenwich Leisure example (described in Chapter 5) shows how such a model can be both staff-owned and inclusive of broader stakeholder interests, and may be a useful reference point for the health service. Lewis and colleagues (2006) have suggested that a mutual model in which staff and patients are involved is more likely to promote the wider public interest and avoid provider capture. Outside the UK, Group Health Cooperative in Seattle is an example of a health care organisation that is governed in this way.

- **The migration path** – the particular route that organisations take to employee ownership, and indeed the destination they intend to reach, is another consideration. The selection of an appropriate legal and governance structure will itself depend on the answer to a more fundamental question: what degree of employee ownership is sought and how is this achieved? The paucity of case study examples in the public sector leaves a gap in terms of established models and practical advice for organisations to draw on when making the transition to employee ownership. Moreover, clarification will need to be sought on how this type of organisation is regarded in policy and legislative terms.
- **Pensions** – a major barrier is access to NHS pensions for PCT provider arms that become social enterprises. The government has determined that organisations that go down this route can retain access to NHS pensions for existing staff who deliver care to NHS patients. New staff appointed after the establishment of a social enterprise are not eligible to join the NHS pension scheme. This is likely to be

a significant deterrent to the use of the social enterprise model in the NHS. It will also make it harder for any organisation that does take this path to establish a culture of mutuality among its staff when these staff have access to different pension entitlements depending on when they were appointed. Central Surrey Health was able to retain NHS pensions for its staff by agreeing a specialist personal medical services (sPMS) contract with its PCT, but the Department of Health has ruled out the use of this kind of contract for other social enterprises in future.

While the NHS pension scheme was renegotiated in 2006 and is unlikely to be changed again in the short term, the ending of a number of similar final salary schemes suggests that its long-term future is uncertain. The current drive is to achieve parity in pension provision by giving social enterprises access to the NHS scheme, but it is equally possible that a levelling of entitlements across different types of provider organisation could result from an ending of the NHS scheme in its current form to new entrants. This would clearly be a controversial move but it cannot be ruled out in view of the parlous state of public finances and statements by some politicians about the need to review public sector pay and benefits after the next general election.

- **Tax and legislative constraints** – the constraints imposed on employee ownership by the current tax regime were noted in Chapter 5, but they are worth restating here. The establishment of, and transfer of equity into, an EBT is one of the principal routes into employee ownership. Moves to counter the abuse of EBTs for tax avoidance removed their tax-exempt status, thereby increasing the likelihood that companies passing ownership to their employees in this way would need to secure external financing. There is a

further barrier in the health sector insofar as primary care legislation requires that shares in companies holding either general medical services (GMS) or personal medical services (PMS) contracts must be legally and beneficially owned by individual shareholders (All Party Parliamentary Group on Employee Ownership, 2008). A company whose shares were held collectively in an EBT would not qualify under these terms and, therefore, would be ruled out of bidding for much NHS work. A different tax issue is the liability for VAT of social enterprises compared with NHS organisations.

- **Raising capital** – it is likely that capital will have to be raised, to fund the initial set-up of employee-owned organisations and for ongoing operating and investment costs. While organisations are able to borrow from banks and other specialist lenders – such as The Baxi Partnership and Futurebuilders – and use any surpluses generated to repay loans, this may present challenges in practice. For example, in a 2005 survey of British employee-owned companies, more than one third reported difficulties in accessing finance for investment (Burns, 2006). On this issue, the All Party Parliamentary Group on Employee Ownership (2008) found that there was a general lack of awareness among investors, the professional advisor community (accountants and lawyers, for example) and public policy-makers about employee ownership. One company giving evidence to the group noted that the sector suffers from ‘being promoted on an evangelical, social experiment level when it should be viewed as an alternative, commercial, credible capital structure’.

The experience of Central Surrey Health suggests that PCT provider arms will be able to make the transition into employee ownership without having to take responsibility for capital assets which remain in public ownership.

Furthermore, social enterprises set up under the right to request will have a guaranteed contract of up to five years. By making income for new organisations more reliable and predictable, this is likely to help in negotiations with lenders. In the United States, Hansmann (2000) found that employee-owned companies were able to raise capital through borrowing and that there were many such companies in capital-intensive industries. He concluded that ‘there is good reason to believe that capital accumulation is not an insuperable obstacle to employee ownership in most industries’ (Hansmann, 2000: p 76).

Hansmann’s analysis, together with moves to make funding available through other sources, including the Department of Health’s Social Enterprise Investment Fund, suggests that obtaining access to capital may not be an insurmountable problem. Proposals to establish a Social Investment Bank may also provide a source of support if they are taken up by government.

Summary

In addressing these challenges, the key point to emphasise, as illustrated by the experience of Central Surrey Health, is the need for practical advice and support for NHS staff thinking of setting up a social enterprise and for existing social enterprises wanting to play a bigger part in the provision of health care. In the local government field, Greenwich Leisure has extended beyond its original area and now has responsibility for running a number of leisure centres within the M25 area. In the process, it has been able to draw on its experience to enable staff in areas outside Greenwich to share in the benefits of social enterprise.

At the time of writing, there is no organisation within the NHS able to take on this kind of role. The Department of Health Social Enterprise

Unit is doing valuable work to raise awareness of the social enterprise option within the NHS, but it lacks the resources needed to move social enterprises out of the margins and into the mainstream. This suggests that the rhetoric behind social enterprises needs to be matched with appropriate funding and practical support in the next stage of reform. This comes back to there being the political will to ensure that this happens and to address barriers like access to NHS pensions, which is likely to be a major stumbling block.

9. CONCLUSIONS

Summary points

- Employee ownership may help the NHS to further empower staff and unlock their potential to drive service improvements. There are at least five ways in which employee ownership in the NHS might be fostered.
- **Option 1: Greater voice and participation.** At a minimum, local NHS organisations can increase the extent and ways in which staff can play a role in shaping the services they deliver. This should be informed by the evidence about the factors that promote effective staff participation, in particular the importance of leadership styles and managerial commitment.
- **Option 2: Employee-owned community health services.** New models for community health services are being sought and appraised, and could include employee-owned social enterprise. Given the opportunity, participation structures could be built into the governance framework of an employee-owned social enterprise from the outset.
- **Option 3: Multi-professional partnerships in general practice.** Employee ownership is well established in general practice and the new primary care contract made multi-professional partnerships possible for the first time. Ownership of GP services could be extended to other primary care professionals, non-clinical staff such as practice managers and medical specialists, whose work is increasingly community-oriented.
- **Option 4: A social enterprise model for primary care and community health services.** A further possibility is for primary care and community health services to combine elements of options 2 and 3 above. General practices would continue to be run as partnerships but would collaborate with a wider range of community and stakeholder interests through a social enterprise approach.
- **Option 5: Multi-professional chambers within NHS foundation trusts.** In NHS foundation trusts, a multi-professional ‘chambers’-type arrangement, in which clinical staff within the same directorate or service unit take greater ownership, would be possible. This is consistent with the development of service line management in these organisations.
- These options are not mutually exclusive and the time is now right for government to support the testing out of different approaches, to support the engagement of staff and to achieve a better alignment of incentives.

Engaging and empowering staff has been a longstanding aspiration in the NHS, supported by numerous policy documents and initiatives. Most recently, it formed a central theme of Lord Darzi's

NHS Next Stage Review, with greater freedom for front-line staff seen as the key to delivering high-quality and responsive care. Evidence from NHS staff surveys suggests that the efforts made

by most local NHS organisations to engage their employees have met with limited success to date and may not go far enough.

As well as continuing to make efforts to engage staff and value their contribution, these organisations need to consider other approaches, including employee ownership. The evidence on employee ownership that we have reviewed suggests that this has the potential to help the NHS achieve some of its primary goals, including but not limited to empowering staff members and unlocking their potential to drive service improvements. As this study has shown, it is the combined effect of employee ownership and staff participation that is critical.

To return to our starting point, employee ownership and staff participation have the potential to help the NHS achieve closer alignment between staff, their organisations and the aims of the NHS as a whole. They do so by harnessing the intrinsic motivation of staff to do a good job in the interests of the organisations they work for and the people they serve. More specifically, by giving staff a real stake and share in their organisations, employee ownership enables staff to see how their work contributes to the success of these organisations and vice versa. In our view, alignment is one of the essential preconditions of a self-improving NHS in which change is led from within rather than by national targets.

So what does this mean for NHS organisations? It is possible to envisage five main routes by which employee ownership might be fostered:

Option 1: Greater voice and participation

There is considerable scope to increase the extent and ways in which NHS staff can play a role in shaping the services that they deliver. For some organisations this may mean putting into practice

existing recommendations such as those made by the NHS Taskforce on Staff Involvement. Others may be ready to go further, for example by taking up Lord Darzi's challenge to give clinicians greater control over budgets and HR decisions.

One of the major issues emerging from the literature on human resource management is that policies to increase staff participation are unlikely to achieve their goal if managers are not visibly committed to them. Moreover, the approach to staff involvement must be consistent; it is not enough to give staff greater control in one area of their work if they continue to be denied it elsewhere. These findings may explain why NHS organisations have hitherto had limited success in engaging their staff and should be taken into account in the development of any future initiatives.

The emphasis placed by the Department of Health on staff engagement is a welcome step in the right direction but much more needs to be done to ensure that the examples of good practice identified in this report, such as at Sandwell and West Birmingham NHS Trust, become common practice.

Option 2: Employee-owned community health services

In the current drive for PCTs to divest themselves of their provider arms, new models for community health services are being sought and appraised. This provides a timely opportunity to consider the viability of employee ownership.

The Government's moves to promote social enterprises suggest that this might yet emerge as a preferred model. PCTs are obliged to consider requests from staff to set up a social enterprise and, if the business case is approved, will also be expected to support the new organisation and award it an uncontested contract of up to five years.

Social enterprises can take a number of different organisational forms, including employee-owned organisations. One of the most innovative social enterprises in health care – Central Surrey Health – is owned by its employees, former PCT staff. If this option is considered by other PCTs, then the research evidence pointing to the combined effect of employee ownership and workplace participation should be heeded. Given the opportunity, participation structures could be built into the governance framework of an employee-owned social enterprise from the outset. Enabling new as well as existing staff to have access to NHS pensions will be critical in translating the interest in social enterprises among PCT staff into reality.

Recent guidance from the Department of Health (2009) on the future of community services has given encouragement and support to developments of this kind. A variant of this approach could see a subset of community services – rather than entire PCT provider arms – transferred into social enterprises. In effect, this would be the community equivalent of multi-professional chambers in the acute sector, described in option 5 below.

Option 3: Multi-professional partnerships in general practice

Employee ownership is already well-established in general practice – at least in a restricted sense – in the form of GP partnership arrangements. In this case, ownership could be extended to other professional groups including nurses and allied health professionals, as well as to non-clinical staff such as practice managers. A further possibility is that partnerships could be extended to include medical specialists who currently work in hospitals. This is likely to be particularly appropriate in the case of specialists whose work is increasingly community-oriented (examples include diabetologists and dermatologists).

By transferring the contractual relationship from individual GPs to practice level, the new primary care contract (introduced in 2004) effectively removed restrictions on practice ownership and made multi-professional partnerships possible for the first time. Only a small number of non-GPs have so far entered into partnerships, but this opportunity could be more fully exploited by practices as a way of developing leadership roles among practice staff. However, if this is to happen, then the recent trend for GP partners to recruit new doctors to their practices on salaried contracts will have to be reversed. This may be difficult in view of the changes to the primary care workforce discussed in this monograph, and the incentives contained within the new general practice contract for GP partners to benefit from the additional profits now available in general practice.

Option 4: A social enterprise model for primary care and community health services

A further possibility is for primary care and community health services to combine elements of options 2 and 3 above. General practices would continue to be run as partnerships but would collaborate with a wider range of community and stakeholder interests through a social enterprise approach. Patient and community representatives would contribute to the governance of the social enterprise alongside practices and community health services staff.

This approach is already being used by Nottingham-based social enterprise Principia, which is run by a board made up of local GPs, community-based service providers such as district nurses, and patients. The outcome would be a blend of staff leadership and community governance of the kind advocated by Lewis and colleagues (2006). Other examples include East London Integrated Care, Willowbank Community Interest Company and Cuckoo Lane Healthcare.

As in the case of option 3, it is possible to envisage how medical specialists who currently work in hospitals might become involved in these social enterprises. Indeed, social enterprises that involve a network of general practices and community health services staff might lend themselves more to integration with hospital-based teams because they would operate on a sufficiently large scale to support this model of care.

Option 5: Multi-professional chambers within NHS foundation trusts

In the acute sector, devolved decision-making has been principally pursued through the NHS foundation trust (FT) model. While FTs formally incorporate the workforce into governance arrangements, questions remain about the extent to which this makes staff feel more engaged in their day-to-day work. There is little evidence that FTs have developed innovative approaches to staff engagement to date and it is therefore opportune to consider other approaches.

The freedoms possessed by FTs provide an opportunity to give staff greater control at the level of clinical directorates and the service units with which they most closely identify. This is important in view of the key role played by these clinical microsystems in the delivery of health care. The development of a multi-professional ‘chambers’-type arrangement in which the clinical staff delivering care to patients within the same directorates or service units take greater ownership of their work would be a practical way of testing out the ideas discussed in this monograph. They would also be consistent with the development of service line management in NHS foundation trusts.

If employee ownership at this level can be shown to offer benefits, then over time it is possible to envisage how hospitals might become more like

facilities used by a variety of multi-professional chambers instead of organisations that own and run the facilities and employ all the staff. In employment terms, there is a clear parallel with the established model of general practice in the NHS under which GP partners are owner/managers and at the same time have access to NHS benefits. The main difference in the approach proposed here is that clinical staff other than doctors would share in the ownership and management of clinical directorates and service units, and would work under contract to the FT.

Summary

These are not either/or options and it is likely that, in practice, a combination of some or all of them could be developed within a single health system. In the process, there are a number of uncertainties about the development of employee ownership models within the NHS which will need to be more fully explored. Not least, there is the important question of whether NHS staff would actually want to take on ownership of their organisations, and what this means in terms of the sharing of risk and responsibility.

Given this, testing out different ownership models is highly advisable. A similar approach could be taken to that used to develop social enterprises, where the Department of Health has funded 26 organisations to act as pathfinder projects and created a £100 million fund to help with set-up costs. A national programme of this kind would also serve to raise the profile of employee ownership as a business model for health care organisations. With political will, backing from senior NHS leaders and practical support, there is a real opportunity to apply employee ownership principles in the next stage of health reform.

REFERENCES

- Alimo-Metcalf, B et al (2007) *The Impact of Leadership Factors in Implementing Change in Complex Health and Social Care Environments: NHS Plan clinical priority for mental health crises resolution teams*. London: Department of Health NHS SDO.
- All Party Parliamentary Group on Employee Ownership (2008) *Share Value: How employee ownership is changing the face of business*. Hertfordshire: All Party Parliamentary Group on Employee Ownership.
- Blasi, J et al (1996) 'Employee stock ownership and corporate performance among public companies', *Industrial and Labour Relations*, 50 (1): 60–79.
- Blasi, J et al (2003a) *In the Company of Owners: The truth about stock options*. New York: Basic Books.
- Blasi, J et al (2003b) 'An assessment of employee ownership in the United States with implications for the EU', *International Journal of Human Resource Management*, 14 (6): 893–919.
- Blasi, J et al (2008) *Creating a Bigger Pie? The effects of employee ownership, profit sharing and stock options on workplace performance*. Working paper 14230. Cambridge, Massachusetts: National Bureau of Economic Research.
- Bourbonnais, R et al (2006) 'Development and implementation of a participative intervention to improve the psychosocial work environment and mental health in an acute care hospital', *Occupational and Environmental Medicine*, 63: 326–334.
- Brown, S et al (1999) 'Absenteeism and employee sharing: an empirical analysis based on French panel data', *Industrial and Labor Relations Review*, 52 (2): 234–251.
- Brun, J-P (2008) *Links Between Mental Wellbeing at Work and Productivity. State-of-science review: SR-C2. Report by the Foresight Project*. London: Government Office for Science.
- Bryant, C (2009) 'Workers bid to own their future', *Financial Times*, 28 May, p 14.
- Buchko, A (1992) 'Effects of employee ownership on employee attitudes: a test of three theoretical perspectives', *Work and Occupations*, 19 (1): 59–78.
- Burns, P (2006) *Good Business: The employee ownership experience*. London: Job Ownership Limited.
- Cabinet Office Strategy Unit (2008) *Excellence and Fairness: achieving world class public services*. London: HMSO.
- Cabinet Office Strategy Unit (2009) *Working Together. Public services on your side*. London: HMSO.
- Cappelli, P and Neumark, D (2001) 'Do 'high-performance' work practices improve establishment level outcomes?', *Industrial and Labor Relations Review*, 54: 737–776.
- Chapman, C (2008) 'Leading is engaging'. Speech to *The Guardian Public Services Summit*, 6 March 2008.
- Conyon, M and Freeman, R (2001) *Shared Modes of Compensation and Firm Performance: UK evidence*. Working Paper No. 8448. Cambridge, Massachusetts: National Bureau of Economic Research.
- Cook, J et al (2003) *Trust Rewards: Realising the mutual advantage*. London: Mutuo.
- Cully, M et al (1999) *The 1999 Workplace Employee Relations Survey: First findings*. London: Department for Trade and Industry.
- Culpepper, R et al (2004) 'Employee stock ownership plans and three-component commitment', *Journal of Occupational and Organizational Psychology*, 77: 155–170.
- Davies, C et al (2005) *Links Between Governance, Incentives and Outcomes: A review of the literature*. London: NCCSDO.
- Day, P and Klein, R (2005) *Governance of Foundation Trusts: Dilemmas of diversity*. London: The Nuffield Trust.
- de Geus, A (1997) *The Living Company*. London: Nicholas Brealey Publishing.
- Department of Health (1998) *Working Together: Securing a quality workforce for the NHS*. London: DH.

- Department of Health (1999) *Report of the NHS Taskforce on Staff Involvement*. London: DH.
- Department of Health (2000) *Partnership in Action: The action plan to implement the recommendations of the NHS Taskforce on Staff Involvement*. London: DH/NHS Executive.
- Department of Health (2001) *Shifting the Balance of Power within the NHS: Securing delivery*. London: DH.
- Department of Health (2002) *HR in the NHS Plan: More staff working differently*. London: DH.
- Department of Health (2003) *Staff Involvement: Better decisions, better care*. London: DH.
- Department of Health (2005a) *A National Framework to Support Local Workforce Strategy Development*. London: DH.
- Department of Health (2005b) *A Short Guide to NHS Foundation Trusts*. London: DH.
- Department of Health (2006) *Guidance on How to Develop and Implement Workforce Scorecards in NHS Organisations*. London: DH.
- Department of Health (2008a) *A High Quality Workforce: NHS next stage review*. London: DH.
- Department of Health (2008b) *The Operating Framework for 2009/2010 for the NHS in England*. London: DH.
- Department of Health (2009) *The NHS Constitution*. London: DH.
- Egan, M et al (2007) 'The psychosocial and health effects of workplace reorganisation 1: a systematic review of organisational-level interventions that aim to increase employee control', *Journal of Epidemiology and Community Health*, 61: 945–954.
- Employee Ownership Association (EOA) (2007) *EOA Submission to the All Party Parliamentary Group on Employee Ownership*, unpublished paper.
- Estrin, S and Shlomowitz, R (2007) 'Income sharing, employee ownership and worker democracy', *Annals of Public and Cooperative Economics*, 59 (1): 43–66.
- Farnham, D (2003) 'Organisational change and staff participation and involvement in Britain's public services', *The International Journal of Public Sector Management*, 16 (6): 434–445.
- Festing, M et al (1999) 'Financial participation in Europe – determinants and outcomes', *Economic and Industrial Democracy*, 20 (2): 295–329.
- Finlayson, B (2002) *Counting the Smiles: Morale and motivation in the NHS*. London: King's Fund.
- Freeman, R et al (2004) *Monitoring Colleagues at Work: Profit sharing, employee ownership, broad-based stock options and workplace performance in the United States*. Paper presented at the Allied Social Science Associations Meeting, San Diego.
- Gamble, J et al (2002) 'ESOPs and employee attitudes: the importance of empowerment and financial value', *Personnel Review*, 31 (1): 9–26.
- General Accounting Office (1987) *Employee Stock Ownership Plans: Little evidence of effects on corporate performance*. Washington, DC: GAO.
- Gerada, C (2009) *Changing Partnerships*. London: Royal College of General Practitioners.
- Goddard, J (2004) 'A critical assessment of the high-performance paradigm', *British Journal of Industrial Relations*, 42 (2): 349–378.
- Guest, D and Peccei, R (2001) 'Partnership at work: mutuality and the balance of advantage', *British Journal of Industrial Relations*, 39 (2): 207–236.
- Ham, C and Hunt, P (2008) *Membership Governance in NHS Foundation Trusts: A review for the Department of Health*. Birmingham: University of Birmingham/Mutuo.
- Hansmann, H (2000) *The Ownership of Enterprise*. Cambridge, Massachusetts: Harvard University Press.
- Healthcare Commission (2009) *National Survey of NHS Staff 2008*. www.cqc.org.uk (accessed 13 May 2009).
- Hewitt, P (2005) 'Annual health and social care lecture – Investment and reform: transforming health and healthcare'. Speech to the London School of Economics, 13 December 2005.
- House of Commons Health Committee (2007) *Workforce Planning. Fourth Report of the Session 2006–7*. London: Stationery Office.
- House of Commons Public Administration Select Committee (2008) *Public Services and the Third Sector: Rhetoric and reality*. London: The Stationery Office.
- Ichniowski, C et al (1996) 'What works at work', *Industrial Relations*, 35: 299–333.
- Involvement and Participation Association (2008) *NHS Social Partnership Forum Review – Final Report November 2008*. London: IPA.
- Ipsos MORI (2008) *What Matters to Staff in the NHS. Research study conducted for the Department of Health*. London: DH/ Ipsos MORI.

- Kaarsemaker, E (2006) *Employee Ownership and its Consequences: Synthesis-generated evidence for the effects of employee ownership and gaps in the research literature*, unpublished report.
- Karasek, R and Theorell, T (1990) *Healthy Work: Stress, productivity and the reconstruction of working life*. New York: Basic Books.
- Kardas, P et al (1998) 'Wealth and income consequences of employee ownership: a comparative study from Washington State', *Journal of Employee Ownership Law and Finance*, 10 (4): 3–52.
- Kerr, J and Tait, C (2008) *Evaluation of Tax-advantaged All-employee Share Schemes*. London: HM Revenue and Customs.
- Kruse, D (2002) 'Research evidence on prevalence and effects of employee ownership', *Journal of Employee Ownership, Law and Finance*, 14 (4): 65–90.
- Kuvaas, B (2003) 'Employee ownership and affective organizational commitment: employees' perceptions of fairness and their preference for company shares over cash', *Scandinavian Journal of Management*, 19 (2): 193–212.
- Lawler, E (1988) 'Choosing an involvement strategy', *Academy of Management Executive*, 2 (3): 197–204.
- Leadbeater, C and Christie, I (1999) *To Our Mutual Advantage*. London: DEMOS.
- Le Grand, J (2008) *Consistent Care Matters: Exploring the potential of social work practices*. London: Department for Education and Skills.
- Levine, D and Tyson, L (1990) 'Participation, productivity, and the firm's environment', in Blinder, A ed. *Paying for Productivity*. Washington, DC: Brookings Institution.
- Lewis, R (2005) *Putting Health in Local Hands: Early experiences of Homerton University Hospital NHS Foundation Trust*. London: King's Fund.
- Lewis, R et al (2006) *Social Enterprise and Community Based Care*. London: King's Fund.
- Logue, J and Yates, Y (1999) 'Worker ownership American style: pluralism, participation and performance', *Economic and Industrial Democracy*, 20 (2): 225–252.
- Marks, L and Hunter, D (2007) *Social Enterprises and the NHS: Changing patterns of ownership and accountability*. London: Unison.
- Mathieu, M (2008) *Annual Economic Survey of Employee Ownership in European Countries, 2007*, presentation to the Seventh European Meeting of Employee Ownership, Brussels, 23 May 2008.
- Meyer, J and Allen, N (1991) 'A three component conceptualization of organizational commitment', *Human Resource Management Review*, 1: 61–89.
- Michie, J (2007) *The Economic Case for HM Treasury to Support the Employee Owned Business Sector through Tax Breaks and Reform of the Treatment of Employee Trusts*, unpublished report submitted to the All Party Parliamentary Group on Employee Ownership.
- Michie, J and Oughton, C (2003) 'HRM, employee share ownership and corporate performance', *Research and Practice in Human Resource Management*, 11 (1): 15–36.
- Michie, J et al (2002) *Employee Ownership, Motivation and Productivity*. London: The Work Foundation.
- Mooney, H (2009) 'Leading from the frontline', *Healthcare Manager*, February/March, 15–17.
- Moore, A (2009) 'How long can Southend remain off the agenda?', *Health Service Journal*, 21 May, 12–13.
- Nguyen, A et al (2003) *Job Autonomy and Job Satisfaction: New evidence*. Leicester: Leicester University Management School.
- NHS Employers (2008) *Staff Engagement in the NHS. Briefing 50*. London: NHS Employers.
- Pencavel, J (2001) *Worker Participation*. New York: Russell Sage Foundation.
- Pendleton, A (2001) *Employee Ownership, Participation and Governance: A study of ESOPs*. London: Routledge.
- Pendleton, A et al (1995) 'Does employee ownership weaken trade unions? Recent evidence from the UK bus industry', *Economic and Industrial Democracy*, 16 (4): 577–605.
- Pendleton, A et al (1996) 'Employee participation and corporate governance in employee-owned firms', *Work, Employment and Society*, 10 (2): 205–226.
- Pendleton, A et al (1998) 'The perception and effects of share ownership: empirical evidence from employee buy-outs', *British Journal of Industrial Relations*, 36 (1): 99–124.
- Pfeffer, J (1998) *The Human Equation: Building profits by putting people first*. Boston, Massachusetts: Harvard Business School Press.
- Postlethwaite, R et al (2005) *Shared Company. How employee ownership works*. London: Job Ownership Limited.
- Poutsma, E et al (1999) 'Promotion of employee ownership and profit sharing in Europe', *Economic and Industrial Democracy*, 20: 171–196.
- Raleigh, V (2008) *Surveys of Inpatients and Staff in NHS Acute Trusts: Is there an association?*, unpublished report. London: Healthcare Commission.

- RCN Policy Unit (2006) *Policy Briefing 04/2006. Nurse led social enterprise*. London: Royal College of Nursing.
- Reeves, R (2007) *CoCo companies. Work, happiness and employee ownership*. London: Employee Ownership Association.
- Robinson, D (2007) *Employee Engagement: Opinion paper OP11*. Brighton: Institute for Employment Studies.
- Secretary of State for Health (2000) *The NHS Plan: A plan for investment, a plan for reform*. Cm 4818. London: The Stationery Office.
- Secretary of State for Health (2008) *High Quality Care for All: NHS next stage review final report*. London: DH.
- Semmer, N (2008) *Stress Management and Wellbeing Interventions in the Workplace. State-of-science review: SR-C6. Report by the Foresight Project*. London: Government Office for Science.
- Smillie, J (2000) *Can Physicians Manage the Quality and Costs of Health Care? The story of the Permanente Medical Group*. Oakland: The Permanente Federation.
- Smith, J et al (2006) *Options for Primary Care Trust Provider Services: An evidence-based policy analysis for NHS West Midlands*. Birmingham: Health Services Management Centre.
- Spear, R (1999) 'The rise and fall of employee-owned UK bus companies', *Economic and Industrial Democracy*, 20: 253–268.
- Summers, J and Hyman, J (2005) *Employee Participation and Company Performance. A review of the literature*. York: Joseph Rowntree Foundation.
- Ulrich, D et al (2002) *The GE Work-Out*. New York: McGraw-Hill.
- Walsham, M and Dingwall, C (2007) *Healthy Business: A guide to social enterprises in health and social care*. London: Social Enterprise Coalition/Hempsons.
- West M et al (2005) *Working Together: Staff involvement and organisational performance in the NHS*, unpublished report. Birmingham: Aston Business School.
- Witt, L et al (2000) 'The role of participation in decision-making in the organizational politics–job satisfaction relationship', *Human Relations*, 53: 341–358.

NHS MUTUAL

ENGAGING STAFF AND ALIGNING INCENTIVES TO
ACHIEVE HIGHER LEVELS OF PERFORMANCE

Jo Ellins and Chris Ham

Increasing staff involvement and motivation is critical to NHS reform. Since 1998, the NHS has launched many policy initiatives aimed at improving staff engagement. Despite some success, there is evidence that exhortation and guidance alone will not bring widespread changes to practice, and that ways for staff to participate formally in the running of their organisations should be explored.

NHS Mutual: Engaging staff and aligning incentives to achieve higher levels of performance looks at the factors that drive staff engagement in the health service, and examines various models of employee ownership in use both within and outside the NHS. The authors conclude that there are at least five ways in which employee ownership can be fostered within the health service, and that the time is now right for the Government to support those willing to test different approaches.

NHS Mutual is important reading for health care leaders and policy-makers. It will also be of interest to researchers and academic institutions with an interest in this area, as well as all those concerned with improving staff motivation and reviewing the options for social ownership in the public sector.

“NHS Mutual covers all the key issues, discusses them clearly and comes up with helpful policy conclusions”

Professor Jonathan Michie, *President, Kellogg College, Oxford*

“An interesting and timely report, given current interest in this issue and in related HR policies”

Professor James Buchan, *Queen Margaret University*

The Nuffield Trust
59 New Cavendish Street, London W1G 7LP

Email: info@nuffieldtrust.org.uk
Website: www.nuffieldtrust.org.uk



The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES