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Human relations management, expectations and healthcare: A qualitative study

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ABSTRACT

Despite substantial evidence for a relationship between human resource management (HRM) and the performance of individuals, relatively few studies have examined the role of employee expectations. This article reports on a study involving six National Health Service (NHS) organizations across England. Healthcare employees expected their employers to provide: infrastructure, HR practices and support, which they linked to improved performance especially in relation to patient care and service innovations. Counterintuitively, effort was maintained towards immediate patient care when expectations were unmet, seemingly, because of public service values. The findings indicate that public service values may be a strong determinant of performance as it relates to patients, moderating potential short-term adverse effects of unmet expectations. In contrast, longer term effects on patient care and service development were less readily moderated by these values. This study offers differential accounts illustrating effects on performance gained through improved working conditions and through work intensification.

KEYWORDS

expectations ▪ healthcare ▪ human resource management ▪ individual performance ▪ psychological contract ▪ values

Introduction

Despite a body of quantitative research demonstrating a positive relationship between HRM and performance (see, for example, Combs et al., 2007; Delery & Doty, 1996; Huselid, 1995), there are fewer studies about how effects on performance are achieved (for exceptions, see Mueller, 1996; Truss, 2001). This article contributes to two key areas of this debate. First, potential processes through which HRM influences performance are indicated. This account draws on the concept of the psychological contract as a framework for understanding the employer–employee relationship. Second, through analysis of interviews with employees from organizations that were successful by external performance standards (Truss, 2001), this relationship is further elaborated.

Research about the psychological contract (e.g. Turnley & Feldman, 1999), the currency of the psychological contract (e.g. Macneil, 1985; Thompson & Bunderson, 2003) and the process by which the psychological contract affects work attitudes and behaviours (e.g. Morrison & Robinson, 1997), is a recent development in the healthcare sector (for exceptions, see Bunderson, 2001; Cortvriend, 2004, 2005; Fielden & Whiting, 2007; Purvis & Cropley, 2003). The psychological contract involves a 'set of expectations and rules which forms the psychological basis for the continuing commitment of an employee to their employer' (Cavanagh, 1996: 80). The NHS offers an important context for study because it has been recognized as a good employer having made promises and commitments to staff, which have been associated with higher levels of satisfaction, commitment, loyalty to clients, motivation and lower intention to leave (Guest & Conway, 2004). The study reported here sought to identify expectations held by healthcare employees and any process by which expectations are thought to affect their performance.

This is important because the healthcare sector faces specific challenges, not least complex dynamic work environments involving multiple professions and stakeholders (Ramanujam & Rousseau, 2006), and strong value-based (ideological) influences (Bunderson, 2001). These factors shape both the content of the psychological contract and the process by which work-related behaviours are affected. Understanding NHS employee expectations should indicate the contribution of HRM to performance.

This article explores how HRM affects the psychological contracts of individuals working in relatively high performing healthcare organizations; how employee expectations are met or otherwise and how this might affect employee performance. It goes on to suggest potential relationships between HRM, expectations and performance. The article begins by examining

existing frameworks for understanding relationships between HRM and performance.

HRM and individual performance

Many theoretical frameworks have been drawn on to explain links between HRM and performance. Some frameworks reflect a strategic conceptualization of what HRM does to complement other organizational systems or respond to the organizational environment (e.g. contingency theory; see Miles & Snow, 1984) while others focus on adding value through the development of rare resources (e.g. resource-based view; see Barney, 1991). Other frameworks reflect employee focused behavioural theories highlighting the direct contribution of employees to organizational performance through work intensification (e.g. labour process theory, see Ramsay et al., 2000) or through the development of abilities, motivation and opportunity to participate (e.g. AMO theory; see Appelbaum et al., 2000; Bailey et al., 2001; Boxall & Purcell, 2003). These employee-focused behavioural theories suggest that effects on performance are achieved either through improvements for workers or through work intensification (see Boselie et al., 2005).

We draw upon behavioural theories for two reasons; first, the study was concerned with employee experiences of HRM and, second, it considered how attitudes might moderate the HRM performance relationship. We elaborate further on AMO theory because the limited research that has been conducted in the health sector tends to challenge the notion that performance effects of HRM are brought about through work intensification. For example, Harley et al. (2007) studied health service workers in Australia and reported support for a clear link between the adoption of high-performance HR practices and 'overwhelmingly positive' (2007: 620) outcomes for employees. This finding may be due to the team based nature of healthcare work which may afford genuine autonomy as opposed to lean systems working which may afford a high degree of command and control and hence work intensification.

AMO theory highlights how HRM contributes to improvements in employee performance through three interrelated mechanisms, a) by developing employee skills and abilities (ability to perform), b) by increasing employee motivation to put in additional effort (motivation to perform) and c) by providing employees with the opportunity to make full use of their knowledge, skills and abilities in their job (opportunity to perform). *Ability* sets capability of employees to perform, *motivation* influences the degree to which employees enact their ability to perform and *opportunity* refers to

infrastructure available to employees to enact ability and motivation to perform. In a simple form, HRM aims to enhance performance behaviour, for example, through training to increase ability, through pay to increase motivation and through communication and involvement to provide opportunities to enact ability and motivation. So combinations or 'bundles' of HR practices are said to improve individual performance (Hyde et al., 2006).

This suggests a relationship whereby HRM can modify employee behaviours and the context in which those behaviours are enacted, to enhance the performance of individuals (Macky & Boxall, 2008). A further stream of research within the AMO framework concerns the extent to which employee work attitudes play a role in moderating the HRM performance relationship (Harter et al., 2002; Ostroff, 1992; Wright & Bonnett, 2002). This article draws on two attitudinal constructs related to the psychological contract; employee expectations and values.

The psychological contract, employee expectations and employee values

The psychological contract encompasses the social exchange relationship between individuals and organizations (Blau, 1964). Early researchers focused on expectations held implicitly by employers and employees (e.g. Argyris, 1960; Levinson et al., 1962; Schein, 1965, 1978). With the re-emergence of interest in the psychological contract in the 1980s, Rousseau (1989) shifted the focus on to the employee, specifically, their belief in mutual promises and obligations from their employer. She argued that unmet obligations have a stronger impact on individual behaviour than unmet expectations. However, Guest (1998: 651) argued that conceptual distinctions between 'promises and obligations' on the one hand and 'expectations' on the other, was less important because promises led to related and, therefore, relevant expectations. Nevertheless, employees are rarely asked directly about their expectations.

Expectations develop when employees believe their organization has agreed to provide them with certain rewards (e.g. training, pay) in return for their organizational contributions (performance). The meeting or not of these expectations may be an important moderator of discretionary effort and subsequent performance. Expectations develop from various sources including HRM; 'HR practices send strong messages to individuals regarding what the organization expects of them and what they can expect in return' (Rousseau, 1995: 162). Organizational representatives such as HR specialists, direct supervisors and upper level managers (Turnley & Feldman, 1999)

may make specific promises about what employees can expect to receive from the organization. Thus HRM plays an important role in both forming and meeting employee expectations and HRM can assert an influence on individual behaviour by developing and meeting employee expectations. Figure 1 summarizes the relationship between expectations and individual performance incorporating the AMO framework.

Individuals generally hold expectations of HRM that can be both economic (e.g. pay and work environment; Macneil, 1985) and socio-emotional (e.g. training, career development, security), in nature giving rise to transactional and relational contracts respectively. However, a third aspect, ideology was added recently; rewards based on values as a medium for exchange (Blau, 1964; Thompson & Bunderson, 2003). Employee relationships primarily based on value-based exchanges (i.e. employee contributes towards organizational pursuit of a cause in exchange for a legitimate claim to participate in the cause) are ideological in nature; based on shared values. It is important to note, however, that most exchange relationships involve a combination of economic, socio-emotional (Robinson et al., 1994) and ideological elements (Thompson & Bunderson, 2003).

HRM, expectations and performance in the healthcare sector

The majority of HRM and performance studies have been conducted in manufacturing (Preuss, 2003). There are fewer empirical studies in service sectors (Harley et al., 2007). However, the body of research is growing (Berg & Frost, 2005; Harmon et al., 2003). Batt (2002) explored the relationship between HRM, quit rates and performance and found that quit rates were lower and sales higher in organizations that emphasized high skills, employee participation, team work, high relative pay and employment security. In the health sector, specifically, relationships between HRM and performance have been suggested. For example, sophistication of appraisal, training and the percentage of people working in teams has been linked to reduced patient

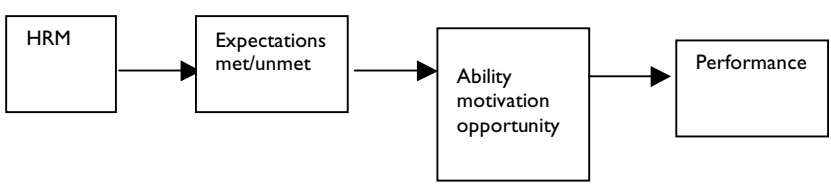

Figure 1 Relationship between expectations and performance

mortality (West et al., 2002), high involvement HRM (training, performance management, participation, involvement, security) contributed to high quality care (West et al., 2006), improving nurses' knowledge and enabling them to use their skills promoted high performance (Preuss, 2003), and HRM had positive outcomes for employees in aged care organizations (Harley et al., 2007). Yet contradictory findings have been reported (Berg & Frost, 2005); employees' perceptions of dignity at work in US hospitals were enhanced by HRM practices such as training, adequate staffing and resources but not by union representation or high involvement practices.

Moreover, Bunderson (2001) argued that values formed a strong element of the psychological contracts of professional employees. Bunderson (2001) reported two distinct but potentially dual values among doctors: administrative values – delivering efficient services, and professional values characterizing the doctor's role as a 'community servant'. Arnold et al. (2003) found that working with patients and the desire to make a difference were powerful factors that attracted people to working in healthcare. The healthcare sector provides the employee with the context in which to enact these values. Because of the ideological component of healthcare work (Bunderson, 2001), public service values about the delivery of patient care may act as a powerful determinant of individual performance.

Research method

A qualitative research design was used to identify employee expectations, whether or not they were being met and any reported effects on their performance of having expectations met/unmet. Whilst qualitative methods are unusual in HRM-performance research, such methods were employed because of their capacity to explain everyday practices and their meaning for participants (Hartley, 2004). Qualitative inquiry was used specifically in the current research to offer a better understanding of the underlying process through which HRM affects performance through the meeting (or otherwise) of individually specified expectations.

Six organizations were purposively selected. The research design focused on three types of NHS organization; acute trusts, mental health trusts and primary care trusts (PCTs). Two examples of each type of organization were selected using the criteria of: either long-term high performance or recently improved performance according to national performance metrics. Table 1 shows key characteristics of each case organization against performance indicators (star rating and annual health check results) as well as showing how the performance of the individual trusts compared with all

Table 1 Case study sites performance indicators[a]

Organiztion type	*Key characteristics*	*Star ratings*			*Annual health check 2005/2006*	
		2002/2003	*2003/2004*	*2004/2005*	*Quality of services*	*Use of resources*
1 Acute trust	Few recent structural changes compared to other NHS organizations, with most service provision in-house	*** [top 36% of trusts]	*** [top 44% of trusts]	*** [top 42% of trusts]	Good [48% of trusts with 6% of trusts rated better than good]	Fair [28% of trusts with 30% rated better than fair]
2 Acute trust	Undergone a major redevelopment programme including a PFI hospital and resultant outsourcing of ancillary services	* [18% of trusts with 8% rated lower than *]	***	***	Good	Fair
3 Mental health trust	Foundation status awarded May 06	* [31% of trusts with 3% rated lower than *]	*** [top 18% of trusts]	*** [top 25% of trusts]	Good [30% of trusts with 10% of trusts rated better than good]	Fair [74% of trusts with 12% rated better than fair]
4 Mental health trust	Foundation status awarded May 06	*** [top 17% of trusts]	***	***	Good	Excellent [top 2% in England]
5 Primary care trust[b]	Internal reconfiguration including separation of provider and commissioner elements as a result of merger in 2006	** [46% of trusts with 15% rated more highly]	** [60% of trusts with 15% rated more highly]	** [52% of trusts with 19% rated more highly]	Good [31% of trusts with 2% rated better than good]	Fair [51% of trusts with 8% rated better than fair]
6 Primary care trust	Works closely in partnership with the local council, including social care, with joint provision of some services	* [32% of trusts with 7% rated lower]	**	**	Fair [59% of trusts with 33% rated better than fair]	Fair

[a] Star ratings were replaced by annual health check in 2005.

[b] Primary care trusts were undergoing national reconfiguration reducing the total number of trusts at the time of the study. Trust 5 was reconfigured whereas trust 6 was largely unaffected.

other trusts of a similar type in England (the percentage of similar trusts gaining the same rating is given as well as percentage above/below to give a broad indication of rank). The table shows that trusts 1, 4 and 5 had received consistently high ratings whereas trusts 2, 3 and 6 received improved performance ratings in the two years prior to the study.

The study involved interviews with 152 employees from six healthcare organizations between January 2006 and January 2007. Local contacts at each organization were asked to invite participants according to the following criteria: three from each NHS pay band to include representatives of the main professional groupings; clinical (including doctors, nurses, therapists, pharmacists), administrative, hotel and estates, support staff and directors/senior managers. HR professionals were categorized separately because of their subject matter expertise. All participants were guaranteed anonymity and participation was voluntary. Table 2 gives details of participant numbers.

Participants were asked what they expected from their employer, whether their expectations had been met and were asked to describe any emotional or behavioural effects on performance as well as impact on patient care. They were encouraged to draw upon recent incidents for examples. These semi-structured interviews were used as a means of producing comparable data whilst eliciting participants' expectations without using predefined categories of investigation.

Interview transcripts were subjected to thematic analysis (Boyatzis, 1998; Braun & Clarke, 2006). Whilst existing categorization schemes for expectations exist (e.g. Herriot et al., 1997), the analytic process began with identification of emergent themes. A small sample of transcripts was read to advance inductive code development. Two researchers coded a sample of

Table 2 Research participants

	Staff group						
	HR	*Director*	*Clinical*	*Admin*	*Hotel & Estates*	*Support*	*Total*
Acute hospital 1	3	3	9	5	7	2	29
Acute hospital 2	4	3	8	6	1	1	23
Mental health 3	5	1	6	6	0	5	23
Mental health 4	1	5	10	7	2	3	28
Primary care trust 5	0	2	8	5	3	5	23
Primary care trust 6	6	2	8	9	0	1	26
Total	19	16	49	38	13	17	152

transcripts independently and any resultant anomalies were discussed. New themes were added to the coding frame as they emerged. One researcher then coded the remaining transcripts. This coding process enabled expectations data to be organized into categories. Participant explanations of how expectations affected attitudes, behaviour, performance and patient care were also analysed and a conceptual model of the process was developed. The remainder of the article discusses the findings in four sections: what employees expect, effects on performance of met/unmet expectations, public service values as a moderator and the extent to which performance improvements derive from a better work environment or from work intensification.

What employees expect

Ninety-six percent (n = 147) of participants (n = 152) identified one or more expectation of their employer. Three inter-related themes emerged regarding employee expectations: 1) Infrastructure (e.g. equipment to do the job, suitable physical environment), 2) HR practices (e.g. training, flexible working hours, induction), and 3) Help and support (e.g. support from managers and colleagues). The following extract highlights expectations under these three themes:

> Obviously the means to do my job; *somewhere to do my job* because when I did start . . . there wouldn't be anywhere to sit. It was nice to have the appropriate place to sit and be. The *training* to know what they wanted of me obviously I needed training and *support* . . . you need support; somebody to speak to and ask questions.
>
> (Ward clerk, Acute hospital 2)

Frequency distributions of expectations were as follows: infrastructure 22 percent, HR practices 45 percent and help and support 33 percent. Expectations were remarkably consistent across organization and job role. However, formal training was not mentioned by directors and support from colleagues and managers was expected more frequently by administrative employees. Details of each set of expectations are shown below.

1. Infrastructure

Employees expected adequate infrastructure including: *physical environment* such as, office and locker space, equipment, suitable work space; *resources* such as, a budget, secretarial support, uniforms and other staff to work with,

and; *safety* – a safe physical and social environment. Participants described infrastructure expectations as 'basic', rudimentary expectations. Additional, basic expectations included pay and job security. The following extracts illustrate these expectations:

> On a fairly basic level [I expected] that I'd get *an office*, some *secretarial support* and that *I'd be paid* at the end of the month.
>
> (Consultant, PCT5)

> Primarily, the *right environment*, the *right equipment* to do the job and a *fair salary* for the job I was doing. It seemed to be a safe job in that once you were employed you are almost in a *job for life*.
>
> (Radiographer, Acute hospital 2)

> One of the main things is *safety*, health and safety, which has definitely improved a lot over the last few years.
>
> (Porter, Acute hospital 1)

2. HR practices

Expectations relating to HR practices included: pay and job security as basic expectations (described above). They also included: training, flexible working hours, career development opportunities, appraisal and rewards. Training accounted for 18 percent of all expectations (by frequency) and often involved both formal and informal elements. Formal training referred to in-house courses and externally provided training and informal training referred to opportunities to learn 'on the job' and from others in the organization. Training was less of an expectation for directors and HR professionals. The following extracts illustrate these expectations:

> *Training* for the job, which I didn't get.
>
> (Clerical officer, Mental health 3)

> *Informal and formal training*, like shadowing, learning by experience, being exposed to different meetings, different people, that type of thing, plus some of the formal educational stuff with the University and in-house training.
>
> (Unit manager, PCT5)

> *Training* and a safe environment – 24 years ago when I started that was all you would expect, now I would be expecting *flexible working*, *child care*, all those sorts of things.
>
> (Podiatry assistant, PCT6)

3. Help and support

Expectations of help and support to do a good job included: support from managers and colleagues, role clarity, supervision and leadership. Support from managers and colleagues was more frequently mentioned by administrative employees and accounted for 20 percent of all expectations (by frequency).

> I was looking for a mixture of experience at board level but also a level of *mentoring and support* . . . so coming here and learning from someone that had done the job. My other expectations were *having an organization that would tolerate a few mistakes*, on the basis that if you don't make mistakes you never learn.
>
> (Director of finance, PCT5)

> I hoped I would get . . . a lot of *support from the trained staff* really.
>
> (Rehabilitation assistant, Mental health 4)

Expectations of a range of HR practices such as training and support, indicates the role HRM can play in setting expectations (Rousseau, 1995). Previous research suggested that employees expected HR practices such as: training, consultation (communication), work–life balance, recognition, pay, benefits and security (Herriot et al., 1997). These socio-emotional expectations formed the largest group of expectations and included: support, training, career management and supervision. This domination of socio-emotional expectations of healthcare employees suggests a somewhat relational psychological contract and is consistent with other research within the healthcare sector (Purvis & Cropley, 2003).

Effects of met/unmet expectations

Of these expectations, 79 percent were said to have been met and 13 percent were not met (remaining 8% unsure). Reporting such a high percentage of met expectations may be directly related to the fact that these were employees of relatively high performing organizations according to national performance standards. An exchange relationship was described whereby having expectations met under each theme contributed towards perceptions of being treated well, being supported, being valued, or appreciated which in turn affected willingness to work longer, differently and/or harder.

Perceived relationships between expectations and performance were highlighted where expectations had not been met. The results included

withdrawing extra effort, and/or working to rule. Limiting work time to contracted hours and withdrawing additional effort was a commonly described response to not having expectations met under each thematic heading. Participants who worked in more than one department also described withdrawing effort in one setting where their expectations were unmet, while continuing to offer more in settings where their expectations were being met. Although many participants described combined effects of met or unmet expectations under more than one thematic heading, the following subsections describe the effects on performance related to specific expectations.

1. Infrastructure, expectations and work performance

Two routes to the effects on performance through expectations of infrastructure being met were described: direct and indirect, although these often overlapped. There was a relatively obvious, direct relationship between having infrastructure in place and being able to do a good job, regardless of expectations. A less obvious, indirect relationship was described whereby having expected infrastructure in place affected motivation and willingness to put in extra effort:

> It motivates me and it's always a bit of a two way thing in any job, if you feel your employer looks after you, I feel that you are much more likely to put a little bit extra in to the job . . . obviously, if the mechanisms are in place where I can do my job more effectively I'm going to help my patients more effectively because I'm not having to worry about things to chase up to do my job properly.
>
> (Physiotherapist, PCT5)

Where expectations of infrastructure were not met, both direct effects and indirect effects were suggested. Patients had to wait longer to be seen both as a direct result of poor infrastructure and as a result of staff working to fixed hours. Whilst staff went elsewhere to express their frustration, out of sight of the patients, they were more likely to work to fixed hours when infrastructure expectations were unmet:

> It is irritating when you are stuck with the structure of the building. The waiting room is too small; too many ward patients and outpatients waiting at any one time. Some patients are hanging around a couple of hours . . . basically it's too small but that is something we can do nothing with at all . . . You can't lay your views on patients . . . it's

> different once we're in private . . . having a coffee break and it tends to come out as a major bitching session with everyone wanting to off load.
>
> (Radiographer, Acute hospital 2)

> I can't wait to get out of here, then on the stroke of 2.30 I'm gone.
>
> (Charge nurse, Mental health 4)

2. HR practices, role competency and innovation

Expectations of HR practices were said to improve role competency and provide opportunities for service development. Perhaps unsurprisingly, the provision of training was more often linked to increased confidence and perceived support from the organization than it was to improved knowledge as a direct result of the training itself. It was more surprising to find that where training was expected and offered, participants described not only feeling supported by the organization, more confident and able to do the job, but also willing to introduce new and innovative practices. Improved confidence did not only apply to the trainee but to colleagues as well:

> [as a result of training] I am becoming much more knowledgeable, much more confident. I know how to manage change, how to develop my own staff, my own team . . . I entered a project for the quality award, we didn't win, we came second and so the staff, my team are much more confident.
>
> (Ward manager, Mental health 4)

> It made me a lot more confident to do my job. The confidence just grew and then enabled me to diversify a bit and bring in my own techniques as well.
>
> (Housekeeper, PCT5)

Flexible work hours and career development opportunities were more often linked to perceived support from the organization and willingness to put in extra effort than they were to having a direct effect on ability to do the job as might have been expected.

3. Help and support, confidence and innovation

Reported effects of having help and support included increased self-esteem, morale, confidence and more surprisingly, these were linked again by

participants to increased willingness to innovate. The following extract describes how being supported can lead to increased service innovation through a willingness to take risks, whereas lack of support may have an inhibiting effect:

> If you feel supported you have got more confidence to actually be more innovative; to push boundaries in terms of delivering services . . . [without support] you feel less enthusiastic for being innovative for one thing because you think 'what's the point, if I am not appreciated, why bother?'
>
> (Team manager, PCT6)

The following extract describes debilitating effects on ability to do the job through lack of support:

> I had no support from the nursing staff . . . they just wanted the job done, it was a really difficult ride . . . it really was terrible. I used to walk on the ward when I first started and by the time I'd got to the Sister I couldn't keep still, I used to shake so much . . . you're on your own and you don't know who to go to for support. The volume of work was very intimidating. I was useless. I would take a phone call and by the time I got to the person it was for I couldn't remember who it was. I was in a state of panic.
>
> (Ward clerk, Acute hospital 2)

These findings illustrate why expectations form an important component of the psychological contract and how the meeting (or not) of expectations can affect performance as well as service innovation, support for other team members, seeing patients on time and working to the best of one's ability.

Public service values as a moderator

Employees described effects on their ability to do the job (19%), motivation (34%) and opportunity to do a good job (30%). However, they also suggested that underlying values concerning patients directed their efforts (12%, remaining 5% unsure). These values influenced the effect of met expectations on performance. The concept of public service values has been investigated in relation to performance (e.g. Brewer et al., 2000; Kim, 2005) but has not previously been used to explain *how* values influence performance (Wright & Pandey, 2008). About half of participants described positive

effects of met expectations on patient care. Conversely, 35 percent suggested that unmet expectations adversely affected patients; directly by increasing the time patients had to wait and less tangibly because of reduced staff confidence and morale. About half the participants tried to prevent any impact on patients as a result of unmet expectations. Instead they tended to choose to work to contracted hours and withdraw additional effort where patients might be unaffected. In some instances, public service values about patient care formed stronger determinants of behaviour even where expectations were not met as employees described preventing adverse effects for patients:

> I don't think it does [affect patient care] at the time that you are actually with your service user . . . because in my view that person has probably had to wait a long time to see me and it is their right to get as good a service from me as they deserve.
>
> (Speech therapist, PCT6)

However, the prevention of adverse effects through public service values seemed to relate to patients who were already physically present, whereas patient waiting lists and service developments could be delayed:

> Patient care was the priority, I wasn't producing reports but my clinic lists were seen, my patients were seen. The most important thing was that we saw patients but, of course, developing services are the things that in the long term, promoting patient care, that wasn't done. I think that the short-term needs were met and long-term needs may have suffered.
>
> (Nurse consultant, Mental health 4)

So public service values militated against short-term adverse effects on performance, whilst storing up longer-term problems resulting from increased work pressures and lack of ability, motivation or opportunity to perform in the future. Participants identified a range of mechanisms through which having expectations met affected patient care. These were categorized as: ability, motivation and opportunity and are consistent with work on discretionary behaviour by Bailey et al. (2001). However, an additional category of public service values was added which is consistent with previous research involving physicians (Bunderson, 2001). This research extends the inclusion of public service values to other non-clinical healthcare staff who also identified values around patient care contributing to positive effects on performance.

In contrast however, only clinicians used values to explain their performance as a result of met and unmet expectations whereas non-clinical staff only used values to explain their performance as a result of met expectations. The relationship between unmet expectations and performance may be weaker for value-based expectations than economic or socio-emotional expectations (Thompson & Bunderson, 2003) because economic and socio-emotional expectations usually require short-term gratification whereas staff that premise their organizational relationship on ideological goals will be more likely to 'wait out' short-term disappointment. Additionally, fulfilled expectations for public service values may compensate for unfulfilled expectations in other areas.

Figure 2 presents a conceptual model relating public service values to individual effects on performance of HRM. It suggests HRM can influence performance through enhancing individual abilities, motivation and opportunity to perform and through expectations. Whether or not expectations are met can affect performance dependent upon the strength of individually held public service values. These values moderate effects on performance. This research suggests two potential mechanisms by which HRM affects performance and one potential moderator:

- Direct route – HRM affects performance directly through effects on ability, motivation and/or opportunity regardless of expectations;
- Indirect route – HRM affects performance indirectly through met/unmet expectations and their effect on ability, motivation and/or opportunity;
- Moderated route – Public service values moderate effects on performance of the direct or indirect route.

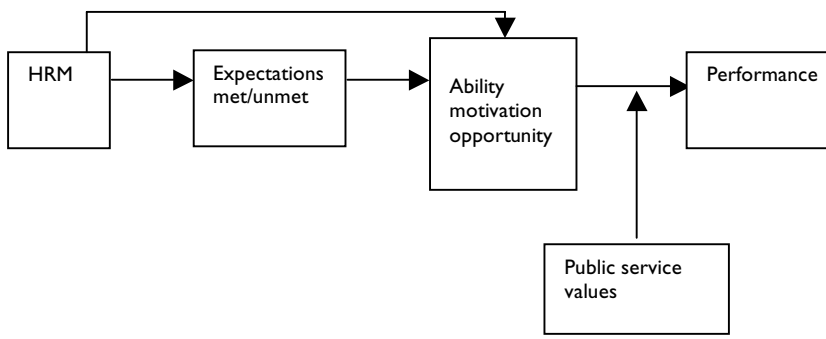

Figure 2 HRM, expectations and performance moderated by public service values

It seems that having expectations of HRM met enhances performance. Yet this research suggests differential impact of unmet HRM expectations on performance for clinical and non-clinical staff and that values may be an important moderator of the HRM performance process. Expectations moderated by values and having the opportunity to contribute to patient care appeared to be a stronger driver for behaviour than other expectations and in some instances public service values towards patient care appeared to enhance staff performance, even when other elements were lacking (Mitroff & Denton, 1999). It remains important for organizations to understand when and in what circumstances public service values override the effects of unmet expectations for infrastructure, HRM and support.

Better work or work intensification? Two case examples

In contrast to the findings above, Ramsay et al. (2000) argued that effects on performance related to HRM were achieved through work intensification and this was a feature of this study. Table 3 shows HRM measures for each site (Healthcare Commission, 2006). This illustrates that whilst each of the trusts were rated as relatively high performers according to national organizational performance metrics, only trusts 4 and 6 scored high across the board

Table 3 Case study site by HRM indicator

Organization type	*Supportive manager*	*Well structured appraisal*	*Job satisfaction*	*Work pressure felt by staff (reversed)*	*Intention to leave (reversed)*
	Information from 2005–6 staff survey				
1 Acute trust	+	++	+	++	+
2 Acute trust	—	—	—	++	–
3 Mental health trust	++	++	++	+	++
4 Mental health trust	++	++	++	++	++
5 Primary care trust	Avge	++	Avge	–	–
6 Primary care trust	++	++	++	++	++

Key:

++	Scored in the best 20% of trusts surveyed that year
+	Above average of trusts surveyed that year
Avge	Average of trusts surveyed that year
–	Below average of trusts surveyed that year
—	Scored in the poorest 20% of trusts surveyed that year

using HRM indicators alone. Trusts 1 and 3 scored above average on all five indicators. However, trust 5 reported high levels of work pressure and intention to leave and trust 2 scored in the poorest 20 percent for four out of five indicators (except for work pressure which was reported in the lowest 20%).

Of the acute trusts, trust 1 had undergone few recent structural changes in contrast to trust 2 which had undergone a major redevelopment programme including a privately financed hospital build. Both mental health trusts had been awarded foundation trust status (trusts 3 and 4). One primary care trust (trust 5) was undergoing internal reconfiguration following a merger the previous year, whereas the other, trust 6, was unaffected by national reconfiguration (see Table 1). The combination of high levels of performance according to national metrics and low levels of HRM performance according to staff survey makes trust 2 interesting. This might be due to recent significant changes including a large, privately financed hospital redevelopment and outsourcing of ancillary services (see Table 1). This trust had the highest number of reported unmet expectations in respect of infrastructure. A radiographer at this trust described having unmet expectations for infrastructure and managerial support and the consequent effects upon performance:

> The job has got to be done whether [or not] you agree with the choices of equipment . . . you've just got to get on with it because the main focus is to provide the care to that particular patient and to see as many patients as possible within the given time . . . you're given a piece of equipment that is difficult to use and told to get on with it . . . you feel more like clock watching, like it is 5pm. I finish at 5pm. I'll tidy this lot up in the morning rather than staying 10 minutes.

She added:

> It's concerning, the move towards a more market driven NHS . . . the money follows the patient so we are expected to work our nuts off in order to put our colleagues in the hospital next door out of work by attracting their patients. I honestly don't feel that's an environment the NHS should be attempting to create.
>
> (Radiographer, Acute hospital 2)

The ability to control working hours enabled clinicians, at least, to reduce work pressure (an indicator this trust scored well on) whilst other indicators such as job satisfaction diminished. This is important because it illustrates how variable HRM performance might indicate underlying work intensification.

In contrast, PCT5 was undergoing major organizational restructuring and more participants reported unmet expectations for managerial support. This organization reported high levels of work pressure and intention to leave. One director described how his contributions to effects on performance were achieved at his own expense:

> I adopted a pattern of working about 70 hours for the first two years . . . I understand that I performed very well but my own sense was that I was causing myself to go to an early grave.
>
> (Director Public Health, PCT5)

This offers one example of how effects on performance were achieved via work intensification. However, some participants were able to increase the support available to them:

> I recently changed my manager . . . [previously] I got extremely frustrated. I didn't get enough administrative support so the production of reports had gone by the board. I got very stressed and unhappy whereas previously I had been very enthusiastic . . . I was very overloaded, extremely overloaded.
>
> (Consultant nurse, PCT5)

In some cases it was possible for participants to mitigate for unmet expectations, for example, for support, whereas for others there was no such opportunity. These findings illustrate how HRM measures might indicate whether the effects on performance have been gained through improvements in working conditions or through work intensification. Organizations 2 and 5 demonstrate work intensification described by participants that was also highlighted in HRM measures, whereas examples earlier in the article seemed to genuinely describe improvements in the work experience.

Conclusions

Expectations held by healthcare staff form one part of the psychological contract mediating their performance and influenced by public service values. Workers hold expectations of basic infrastructure, HR practices and help and support. Many expectations concern HR practices and other aspects of HRM, so the HR function has an important role to play in developing, negotiating and aligning expectations, especially as healthcare organizations and consequent expectations of staff are changing (McKee et al., 2008). Met

expectations were associated with better patient care and service innovation, whereas unmet expectations were associated with working-to-rule and to contracted hours and procedures. This article has demonstrated the process through which expectations can affect performance moderated by public service values.

This relationship is far from simple, however, as these effects on performance may incorporate work intensification and/or improved working conditions as illustrated in the preceding section. Each of six NHS organizations achieved high performance ratings whilst HR indicators were more varied. This study has shown how local circumstances, such as unmet infrastructure expectations as a result of a new hospital build led people to work to contracted hours. This gave rise to a good score for work pressure and to poor scores, for example, for job satisfaction. In contrast, restructuring at organization 5 resulted in unmet expectations for managerial support and involved work intensification for some people. Therefore, we have illustrated how HRM measures might indicate these contrasting sources of performance improvements. Furthermore, HRM affects performance in subtle ways. For example, people were able to reduce work pressure by limiting working hours whilst job satisfaction diminished. Hence organizations can score well on one indicator and not on another. What is important here is to understand the realities of work underlying HRM and performance measures.

As organizations change, messages from the organization about what staff can expect will need to change. Current changes to healthcare organization and delivery mean that the development of congruent expectations is important if adverse performance and HRM effects are to be avoided. Future research may seek to quantify the impact of unmet expectations on performance as well as the role that HR systems and policies play in aligning expectations. As public service values appear to moderate effects on patient care in the short term, the exploration of the antecedents of such value-based contracts would be useful. This would enable both a better understanding of where and when these types of psychological contracts are likely to develop and could illuminate the effects of values on expectations. Future research might also seek to delve further into the utility of HRM measures for indicating realities of the work experience.

In terms of limitations, this research was conducted in the English NHS, healthcare in different countries is organized and operated in a variety of different ways. We might expect similar findings in healthcare organizations employing people who hold similar public sector values. The more universal nature of professionalism within the healthcare sector across the world may contribute to such values (Bunderson, 2001). We also chose to

focus on high performing healthcare organizations however it would be useful to explore how HRM, expectations and public service values contribute to the effects on performance in poorer performing healthcare organizations. Further research could also explore the impact of other types of values such as social responsibility on the HRM–performance relationship and explore the role of values in other industry sectors.

This article has identified the expectations of health service workers specifically and has indicated effects on performance from each set of expectations being met. Furthermore, the study adds to the small body of research which explores the impact of values, in this case, public service values on performance by showing how ideological beliefs provide a strong driver of performance for clinical staff in the healthcare sector in the short term. Finally, it has illustrated the complex relationship between HRM and performance. Rather than being a simple algorithm, humans at work mitigate for unmet expectations in creative ways such as finding alternative sources of support. Only when they are unable to do so, do they limit their effort and even then they do so in a targeted way.

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