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Human Resource Management Innovation in Healthcare: The Institutionalization of New Support Roles

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Abstract: This article draws upon the notion of a 'human resource management (HRM) innovation' to explore the development of two new work roles in different healthcare settings. Arguing that the establishment of a new work role represents a distinctive form of HRM innovation, the article elaborates on and refines an influential theoretical model on how and why such roles become institutionalised. Principally based on interview data from key actors actively engaged with the new roles, the article elaborates by focusing on underdeveloped features of this theoretical model, identifying a range of micro processes underpinning the emergence and acceptance of the new work roles. In refining, the article highlights: the fragility of new work roles; the contribution of key actors to their development; and the interaction between workplace, organisation and system level processes in their emergence and acceptance.

Introduction

Research on the relationship between workforce management and innovation has taken a number of forms, often framed by debates in the strategic human resource management (HRM) literature. First, organisational innovation has been presented as one of a number of corporate outcomes associated with various bundles of HRM practice. Such bundles have typically been correlated with process or product innovation, on the assumption that the composite HR practices foster the employee attitudes and behaviours needed to stimulate and support such innovation (Laursen and Foss, 2003; Shipton et al, 2006; Cooke and Saini, 2010; Zhou et al, 2013). Second, attention has focused on the 'black box' issue of whether and how HRM practices more directly stimulate innovative performance amongst employees, particularly those involved in creative work (Mumford, 2000; Lopez-Cabrales et al, 2009; Jiang et al 2012). Studies have, for example, explored the nature and antecedents of knowledge generation and sharing capabilities amongst staff working in R&D departments (Thompson and Heron, 2006) and high technology firms (Collins and Smith, 2006).

Third, and less commonly, an HRM practice has been viewed as an innovation in its own right. Drawing upon Kossek's work (1978), Wolfe (1995) defines a human resource management innovation as 'an idea, programme, or system of practice which is related to the HRM function and new to the adopting organisation.' As a new approach to workforce management, high commitment practices have sometimes been presented in these terms (Thompson, 2007), with studies drawing upon the organisational studies literature on the diffusion of innovation to explore their take-up (Wood and Albanese, 2007).

This article contributes to debate on the latter stream of research, human resource management practice as an innovation. Wolfe's (1995) broadly drawn definition of HRM innovation as including an HR practice 'new to the adopting organisation' is inclusive and likely to embrace experience in many employment contexts. It is, however, a definition in need of refinement. Wolfe (1995) is unnecessarily restrictive in equating HRM innovation solely with the HR function. Human resource management is a generic activity as well as a specialist function (Legge, 1995), and in

exploring the source and development of innovative HR practice consideration needs to be given to the potential contribution of organisational actors other than or complementary to the HR practitioner, for example the line manager or employee. We therefore view an HRM innovation as any workforce related idea, programme, or system new to the adopting organisation.

Moreover, there is scope to sharpen Wolfe's (1995) conceptualisation of an HRM innovation by recognising that it can take different forms. Thus, an HRM innovation might be associated with:

- **Ways of managing**: new systems to recruit, retain and motivate employees;
- **Ways of working**: new routines to deliver products by those in established work roles; and
- **Work roles**: the assignment of tasks to a completely new job role.

This article focuses on the development of two new clinical support roles in the healthcare sector as an example of an innovative HRM practice. In exploring the development of new work roles rather than new ways of managing or working, the study highlights the analytical value of distinguishing between different forms of HRM innovation. We argue that establishing a new role is marked by a distinctive set of drivers, processes and outcomes. The article also draws upon an influential but incomplete model developed by Reay et al (2006) to explain how a new work role becomes institutionalised. In applying this model we elaborate on and refine it, so deepening our understanding of how new work roles, as an HRM innovation, become established.

The article is divided into the following parts: the policy context for HRM innovation in healthcare; a review of new institutional analysis; the research approach; the findings; and a concluding discussion.

THE POLICY CONTEXT

As governments in developed countries seek to 'modernise' healthcare delivery, often by privileging patient choice, and by addressing rising service demand in the context of a shrinking resource base (Sermeus and Bruyneel, 2010), so an interest in service innovation has come to the fore. In England, for example, the (former) National Health Service (NHS) Chief Executive has claimed that:

> We need to radically transform the way we deliver services. Innovation is the way – the only way – we can meet challenges. Innovation must become core business for the NHS (Department of Health, 2011:1).

In a labour intensive sector, where despite the ongoing introduction of new medical technologies service provision remains rooted in the unmediated relationship between the carer and the patient, it is unsurprising that an interest in healthcare innovation has increasingly centred on human resource management. In most OECD countries, labour still constitutes around two thirds of total healthcare costs (Dubois, McKee and Nolte, 2006:13). Buchan (2004:2) has noted 'getting HR policy and management right has been seen as core to any sustainable solution to health system performance'.

Traditionally, the three forms of HRM innovation (distinguished above) have not been pursued with ease or alacrity in healthcare. Often centrally funded by the state and comprising highly regulated professions, national healthcare systems have been characterised by an institutional inertia rendering HRM innovation difficult (Pierson, 2004). Whilst innovation typically has positive connotations, it can bring uncertainty and tension, and it is rarely welcomed by risk-sensitive organisations dealing with the sick and the vulnerable. However, a conservative bias in the management of the healthcare workforce militates against the improvements in service efficiency and effectiveness increasingly sought by policy makers in response to mounting demand and supply side pressures in the context of financial constraint.

The tussle between institutional inertia and HRM innovation is illustrated by developments in the UK NHS. Attempts by Conservative governments in the 1980s to weaken well established, collectively bargained national agreements on terms and conditions of healthcare workers not least through 'innovative' practices associated with the new public management (Hood, 1991), such as local forms of individual performance pay (Marsden and Richardson, 1994), had only a limited impact on the sector (Grimshaw, 1999). While retaining elements of the Conservative approach to public service reform (Whitfield, 2006), New Labour governments from the late nineties were more prepared to challenge existing institutions. They explicitly connected 'the modernisation' of public services to workforce innovation, viewing the development of user-centred services as resting not only of new ways of managing

but also on new ways of working and new work roles (Bach and Kessler, 2012). For example, a key reform theme, 'joined-up government', encouraged more integrated ways of working (Department of Education and Skills, 2003).

Various research streams developed around these New Labour HRM innovations. The first adopted a critical perspective, suggesting increases in managerial control underpinning HRM innovation in the public services with negative consequences for the quality of working life (Mooney and Law, 2007). The second was more evaluative and tied to the policy making process. It reviewed the development of workforce innovations as devised and imposed top down by national policymakers on provider organisations. In health care, this latter evaluative research stream assessed: new ways of managing, for instance, the introduction of a reformed national pay structure under Agenda for Change, (Buchan and Evans, 2007); new ways of working drawing upon the principles of lean production (Radnor et al, 2012); and new roles such as the nurse consultant (Guest et al, 2004) and the emergency care practitioner (Mason et al, 2006).

This evaluative research stream established a strong evidence base on the impact of HRM innovation in healthcare. It was, however, predicated on a particular set of questions focusing on whether and how a new practice was introduced by national policy makers and with what consequences for stakeholders - including staff, managers and patients. Often overlooked were issues associated with how and why an HRM innovation emerged and developed, especially from within, rather than beyond, the healthcare organisation.

HRM INNOVATION AND INSTITUTIONAL ANALYSIS

New institutional theory provides a more useful basis for exploring endogenous HRM innovation than the evaluative stream of research tied to the policy making process. Reacting against a preoccupation with macro-level inter-organisational relations and conformity as the source of legitimacy within given fields (DiMaggio and Powell, 1983), institutional theory has increasingly concentrated on the micro processes leading to innovation within organisations (Lounsbury and Crumley, 2007). Explaining innovation within this literature had traditionally proved problematic, given its emphasis on the constraining influence of extant institutions. Path dependency was seen to generate strong support for established institutions from

various actors with a vested interest in their continuity (Pierson, 2004). Indeed, the 'problem' of change was often presented as the paradox of embeddedness, with those best positioned to lead institutional change typically having the most to lose from it (Dacin et al, 1999).

These difficulties in accounting for change have encouraged a growing interest in **how** new institutions develop. This has been reflected in research on 'institutional entrepreneurs' - individuals able to stimulate change (DiMaggio, 1988) - and 'institutional work' - the more routine, often hidden activity performed by actors 'to maintain, change or disrupt' an institutional practice (Lawrence and Suddaby, 2006). This literature has included studies related to new work roles in different healthcare settings. Currie et al (2012) examine the 'institutional work' undertaken by specialist doctors to maintain a professional status threatened by new more generic clinical roles and Kitchener and Mertz (2012) consider the techniques used by dentists to resist the challenge posed by the dental hygienist role. These studies have, however, been more concerned with the defensive response of established healthcare professions to new roles than with the development of the new roles themselves.

The Institutionalisation of New Work Roles

One of the few studies to focus on the establishment of a new role in healthcare has been undertaken by Reay et al (2006). This study examines how a new role, the nurse practitioner, became fully institutionalised - that is 'taken-for-granted'- in a provincial Canadian healthcare system. It is a study which centres on two issues. The first relates to how the paradox of embeddedness is overcome to establish a new work role. Second, the development of a model by which a new role becomes institutionalised. This model comprises three macro-level stages:

1. Isolated examples of the 'new way of working' emerging alongside an 'old way of working';
2. The 'new way' being legitimised; and
3. The 'new way' being taken-for-granted.

Reay et al (2006) focus exclusively on the second of these stages, identifying a number of micro processes that underpin the **legitimisation** of the new role:

- Recognising and creating opportunities to advance 'the new way';

- Fitting ‘the new way’ into established structures and systems;
- Proving the value of ‘the new way’ to others; and
- Acknowledging and celebrating small wins (a micro process, cutting across all three macro level stages).

Reay et al (2006) bring their central themes together by arguing that in the case of the new nurse practitioner role, the paradox of embeddedness was overcome by the decisive contribution of a cadre of nurse middle managers who, by virtue of their very embeddedness, had the capabilities and resources to overcome inertia and support the enactment of the requisite micro processes. It is, however, a framework which invites elaboration and refinement.

By focusing on the second legitimisation stage alone, Reay et al (2006) acknowledge that their model is incomplete and in need of elaboration. Indeed this same preoccupation with legitimisation characterises the studies by Currie et al (2012) and Kitchener and Mertz (2012), which also concentrate on how new healthcare roles ‘compete’ with the more traditional professions to gain initial recognition. An area left unexplored by these studies is how a new role emerges in the first place and then becomes taken-for-granted. We elaborate by asking:

> What are the micro-processes underpinning the first and third stages of Reay et al*’s* (2006) model, that we have labelled the emergence and acceptance stages?

The refinement of the Reay et al (2006) model is prompted by various difficulties that derive from a combination of conceptual ambiguity and analytical imprecision. The first difficulty relates to the **form** of the HRM innovation. While Reay et al (2006) ostensibly concentrate on the development of a new role, they repeatedly refer to the nurse practitioner as a ‘new way of working’. The line between the two is a fine one: a new role is likely to involve a new way of working. However, we have suggested above that these remain conceptually discrete forms of HRM innovation. As a more profound challenge to the traditional allocation of tasks the establishment of a new role is arguably a more challenging process than the development of a new way of working or managing. This encourages us to consider whether:

> The institutionalisation of a new work role is characterised by distinctive processes and outcomes.

The second difficulty connects to the **level** of analysis. Reay et al (2006) are keen to illustrate how micro processes at lower levels contribute to the institutionalisation of a new role at the macro level, in their case the provincial healthcare system. There is, however, scope to unpack and more precisely define these lower levels. Thus, an organisational level might usefully be distinguished from a workplace level. This distinction is especially important in healthcare, where **within** any given provider organisation, services will be delivered in a range of distinctive clinical settings. This suggests differences between setting in the internal workplace process and outcomes underpinning innovation, raising issues about how readily any such innovation can be transferred to the organisational or system levels.

We therefore consider:

> *At what levels do Reay et al's (2006) micro proce*sses play themselves out: system, organisational and or workplace?
>
> Do micro processes played out at the workplace level necessarily lead to the emergence of the new role at the organisational or systems level?

The third difficulty lies in the identity and influence of the **actors** involved in the institutionalisation of a new role. The nurse middle manager is seen by Reay et al (2006) as the actor crucial to resolving the paradox of embeddedness. Yet it is unclear whether it is the experience of these nurse managers and or their middle management status that allows them to make this decisive input. More broadly, uncertainties remain as to whether Reay et al (2006) are seeking to generalise the central contribution of this particular actor to the development of any new role. It might more plausibly be argued that the key actor and requisite capabilities in supporting the development of a new role are dependent on context and circumstances:

> Are the identity of the key actor(s), supporting the development of new role, and the capabilities required contingent on different contexts and circumstances?

The final difficulty is associated with the **sequencing and stability** of the three macro stages of institutionalisation. As conceptualised by Reay et al (2006), these stages unfold in a linear fashion. However, within the terms of institutional analysis, a 'final' taken-for- granted stage remains problematic: the very notion of 'institutional work' is predicated on the recurring activities required by actors to preserve a practice. Indeed as Abbott (1988) has noted, job boundaries often remain fragile and subject to ongoing challenge. This prompts consideration of whether:

> Any new role is ever fully accepted and how vulnerable is it to ongoing challenge.

RESEARCH APPROACH

Focus

In addressing our research questions we focus on whether and how two new healthcare support roles became institutionalised or taken-for-granted in a hospital setting. These are unambiguously new roles, rather than new ways of working or managing. They are presented as an HRM innovation in being new to their host organisations. The two new roles– the surgical assistant practitioner (SAP) and the colorectal support worker (CSW) - were each performed by a single, female post holder. They fall within the broader category of healthcare support worker (HSW), a group of unregistered staff providing assistance to registered nurses and other clinical professionals. Whilst HSWs have an established position in the nursing workforce they have, in recent years, assumed increasing importance in the delivery of bedside care (Spilsbury and Meyer, 2005; Kessler et al, 2011). The unregistered status of the HSW has facilitated this process, allowing the role to become a flexible resource, readily deployed in innovative ways. At the same time, weak regulation has created risks in the innovative use of HSWs, particularly following high profile healthcare failures in England, related by some to the increasing use of these workers (Francis, 2009).

The development of the SAP and CSW roles was considered as part of a larger scale project on HSWs in English hospitals. A research stream on the innovative use of HSWs comprised: scoping interviews with over 100 healthcare practitioners and policy makers across the NHS; a survey of HR and nursing directors, eliciting

responses from 94 (that is 57%) of acute hospitals; and six follow-up case studies on innovative practice. Both the scoping interviews and the survey suggested that new ways of managing HSWs -the use of new recruitment methods and induction programmes- were more common than the introduction of new roles or ways of working, supporting our view that these were distinctive forms of HRM innovation. The scoping and survey phases also generated examples of new HSW roles including the colorectal support worker (CSW) and the surgical assistant practitioner (SAP) roles. These roles represented two of our six innovation cases, with their findings presented in this article.

The CSW role was performed in a medium sized hospital in London (henceforth 'London'). The role was part of a small team of specialist coloproctology nurses headed by a nurse consultant and comprising a colorectal nurse and a senior colorectal nurse. The team worked with four medical consultants along the care pathway for colorectal patients, many with cancer, and often requiring a stoma. This care pathway generated three work streams for the specialist nurse team:

- Nurse-led clinics;
- Pre- and post-surgical on-ward work; and
- Outreach work with patients following their hospital discharge.

The CSW was principally engaged in the second stream: on-ward work dealing with those patients in need of stoma care. The hospital carried out around 100 stoma procedures a year, with the CSW involved in most of these cases. The CSW made pre-operative ward visits to establish a relationship with the patient, but the work was mainly post-operative, helping the patient cope with their stoma before being discharged from the hospital.

The SAP role was undertaken in the dermatology department of a hospital in the south of England (henceforth 'South').The department was divided into two main parts: the '**upstairs'** consultant-led clinics and the ***'downstairs'*** operating theatres. The theatres provided elective surgery, but also a same day service for those referred by consultants in the clinics. The operating theatres were staffed by four consultants along with two specialist nurses. Although the SAP was not authorised to obtain

patient consent, she could: administer local anaesthetic; conduct shave and puncture biopsies; remove moles; suture; and apply dressings.

Methods and Data Analysis

Our research approach to the study of these roles was inductive and exploratory. The Reay et al (2006) model provided a strong sensitising framework (Glaser, 1978) for our research but we were keen, from outset, to elaborate on micro processes comprising the institutionalisation model. However, we remained uncertain about the nature and range of these processes. By examining two new roles we aimed to pick up a variety of micro processes, although our decision to compare roles was influenced more by an interest in the contingent identity of key actors.

Given a focus on the 'how' and 'why' of new role development, our research methods were selected to generate qualitative data. The study was based on a total of fourteen interviews with relevant actors. The interviewees in the respective cases are set out in Table 1 below, along with the codes for the interviewees (used to identify the source of quotes in the findings section). The CSW case involved nine interviews carried out in November 2012. The SAP case was founded on five interviews conducted in March 2013. The SAP was observed working during a morning shift. In both cases, documentary material, for example job descriptions, was also collected.

Table 1 here

Clearly the sample of interviewees is small, although as O'Reilly and Parker (2012:2) note, 'In qualitative inquiry the aim is not to acquire a fixed number of participants rather to gather sufficient depth of information as a way of fully describing the phenomenon being studied'. Thus the sample covers most of the actors directly involved in and affected by the development of the respective roles. The post holders were in small specialist teams, and at least one registered nurse team member was interviewed. The post holders worked closely with a medical consultant: both consultants were included in the sample. Clinical training leads in the respective hospitals helped to prepare the post holders for their roles: these leads were interviewed. The larger number of interviewees in the CSW case is partly explained by clinical context. While the SAP worked in a surgical theatre for day patients, the CSW worked on an in- patient ward, encouraging interviews with the CSW's ward

matron and a regular ward nurse. The CSW role was also funded by a commercial company (referred to as StomCo) providing stoma bags, prompting an interview with a company representative.

To reflect our inductive and exploratory approach, the interviews were based on open questions seeking information about the tasks performed by the roles and then, following the stages of institutionalisation, questions focused on: how and why the role had emerged; how they and others viewed and used the role; how it contributed to patient care and the performance of other work roles.

Lasting around one hour, all interviews were transcribed. The analysis of the transcripts comprised three main phases. Open coding (Glaser, 1978) distinguished the factors and elements which contributed the development of the new roles. This provided the basis for two, largely descriptive case study report given to interviewees for comment on the perceived accuracy of the narratives. Following receipt of this feedback, the final phase involved us returning to the transcripts and engaging in a process of theoretical coding (Glaser, 1978). This allowed us in a more direct way to identify micro processes and their dimensions which mapped onto the macro level stages identified by Reay et al (2006).

Our findings are presented in two parts, respectively setting out the micro processes contributing to their emergence and acceptance.

FINDINGS

Emergence

Micro process 1.1: aligning with an explicit need

The emergence of both new roles was driven by various pressures facing the respective hospitals. These pressures mainly related to service and workforce capacity, prompting decision makers at the workplace level to consider re-calibrating the distribution of tasks and responsibilities across the workforce. Government policy sought improvements in care quality, in particular with regard to access to diagnosis and treatment. For example, with public health campaigns on both skin and bowel cancers there was growing awareness of these conditions, increasing in the number of people presenting themselves at clinics:

> We've had a lot of drives from the government: there was a bowel campaign and you see all the patients coming in now because on the telly, 'go and check your bowels'. There's the screening programmes that have been set up for the over 60s and that has an impact on all the patients that are coming in through the doors. …Probably two thirds of them are colorectal patients. (London_Mg3)

Government access targets generated service and workforce pressures:

> The volume (of work) is huge and we've got a (skin) clinic of forty patients upstairs and a third of those are going to need surgery. We've got cancer targets, so these patients have to be treated within four weeks from when they arrive at our doorstep, which means that we can't really take our foot off the pedal. So having the flexibility of (the SAP) that was 'here we are, someone else who can help'. (South_D1)

However, with these broader policy developments affecting all NHS hospitals, it was equally clear that London and South had made specific choices on service design, accentuating the need for workforce re-organisation. London adopted an enhanced recovery programme based upon the rapid discharge of patients following surgery. In colorectal surgery, this generated a particular need for patients with a newly formed stome to quickly become confident in caring for their stoma as a pre-condition for discharge:

> The enhanced recovery programme, where we get patients in and out quicker, meant that we needed more intensive teaching in order to get them home...This brought about the need for something a healthcare assistant could do. (London_RN2)

Similarly it was the development of a same day diagnosis and surgery service at South's dermatology department that placed heavy demands on the operating theatres, with workforce implications:

> We try and do as much surgery as we can on the same day as the first consultation. We have so many referrals that it's really hard to keep on top of

> all the skin cancers that we need to perform surgery on. So having that supportive role, somebody to stitch up a hole while you're finishing the paperwork, it means that we can get through everything so much more efficiently. (South_RN1)

These hospital choices on services design generated an explicit and precisely defined workplace need for the new roles.

Micro process 1.2: identifying a post holder.

The establishment of both roles not only required the identification of a viable potential post holder, but one with a distinctive configuration of capabilities. There was a striking symmetry in the characteristics of the CSW and SAP post holders which combined person- and task- centred qualities. Both had:

- Relevant work experience providing a platform for developing within the new hospital-based support role: the SAP had been a healthcare worker in the military; the CSW had worked in community healthcare;
- Worked in the hospital for a number of years becoming familiar with workplace routines: the CSW had been employed at London for eight years and the SAP for seven years as an HSW before taking-up their new roles.
- Experience within their respective clinical areas, not only building knowledge and capability, but becoming trusted by co-workers:

> [Stoma care] is hands-on. We knew [CSW's name] already had a real keen interest in and a good understanding of and background in stoma care, so she was an ideal candidate to sort of train-up. (London_RN2)

> I (the SAP) worked with (the specialist nurse team) beforehand. If I was unhappy or unsure I would always seek advice from them. (South_AP1)

Micro-process 1.3: finding champions

The new roles were not explicitly connected to a 'strategic' organisational initiative or sanctioned by senior nurse managers- the hospital directors of nursing, their deputies and divisional nurses- or managers- the Operational Director. Indeed, beyond some involvement in formulating job descriptions (see below), the specialist HR

practitioners were notable by their absence. Rather the shape and contribution of the roles evolved at the workplace level as post holders acquired capabilities and became comfortable with their responsibilities, and as stakeholders, in particular co-workers and patients, came to experience their value.

This organic, bottom-up approach did not, however, detract from the need for a workplace champion to directly support the role and to take the initiative in addressing broader organisational barriers to its early development. Emerging in 2010, the CSW was championed by the nurse consultant leading the specialist colorectal nursing team. Reporting to the divisional nurse manager, the nurse consultant was a powerful figure within the trust: a consequence of her professional expertise in colorectal care. The nurse consultant also had the managerial authority to take the CSW role forward by establishing a formal remit for it and then seeking the necessary funding. The remit was a job description devised in partnership with the hospital's human resource department. However, this job description, comprising thirty six different tasks, was more of a retrospective sanctioning of what the CSW post holder was already performing:

> We discussed it with HR as to what we expected of [post holder name], whether that was reasonable, and [post holder name] knew what we expected and she had a chance to say whether she thought it was reasonable or not and was obviously happy with everything and what we expected her to do. (London_D1)

Funding rested on building a case for sponsorship from StomCo, which agreed to finance the CSW role and by the hospital as helping meet particular service needs:

> I talked to [StomCo] to see if they would be prepared to sponsor her... We put a good case forward but they're very supportive saying they would pay for her… (London_Mg2)

Introduced in 2011, the SAP role was a clinician-led initiative. Pushing the boundaries of an unregistered support role to the limit, the SAP needed a powerful and influential champion. A consultant dermatologist identified a potential SAP post holder: an individual with development potential. As the post holder stresses:

> There was not an existing post, it was created for me. [The consultant] was asked if he would mentor me in the surgical setting because it became apparent that the surgical environment was where I was best suited. I've worked in theatres closely with him; he said he would like to teach me. (South_AP1)

With the substance of the role dependent on skills acquired through workplace learning, the willingness of the clinician to teach-on-the-job was central to the shaping of the role. As the consultant notes:

> I was aware that (SAP's name) could do far more than she was doing, so half way through a procedure I said would you like to finish the sewing and I'll watch. What was interesting was to see how she had taken on-board watching many other people operate and myself operate. (South_D1)

Micro-process 1.4: dealing with organisational concerns

Although both new roles emerged 'below the radar' of senior hospital decision makers, workplace actors were still 'second guessing' organisational concerns and responding to them. The most pressing centred on the requirement for quality-assured training. In the case of the CSW, formal training for the role was limited: the post holder had already acquired a vocational qualification in her capacity as an HSW and this was supplemented by a one week dedicated training course on stoma care. The light touch training reflected the skills and knowledge acquired by the post holder over her years in colorectal work:

> You couldn't go in to this job without knowing anything about it [stoma care]. I was quite fortunate that I had quite a lot of background in it anyway and then I did the week's course. (London_HCA1)

The SAP had broader learning needs, partly met by on-the-job training but also by the completion of a more formal two year (foundation) degree programme, designed by the hospital's education lead. However, given the technically complex tasks performed by the SAP, these training requirements shaded into clinical governance concerns and the need for assurances that patients were not at risk. Robust systems for

assessing competences were used, for example, reflected in the number of times a clinical procedure - such as suturing - was practiced by the SAP and witnessed before being signed-off:

> We ensured that her [the SAP] competencies were such that they were unassailable; they were better than had been done for the junior doctors. So if you were challenged you could say well, it's been done safely, it's been supervised by a consultant, here's a logbook, here it's all recorded. (South_D1)

Indeed the extended nature of the SAP role raised issues associated with clinical accountability and, again, the authority of consultant dermatologist was used to calm organisational concerns. As the consultant noted:

> I would always ultimately be responsible for what goes on surgically and if there are issues with the nurses, ultimately that is my responsibility....They're reporting to me rather than the nursing hierarchy. (South_D1)

The four micro processes associated with the emergence stage are summarised in Table 2 below with their associated dimensions.

Table 2 here

Acceptance

Micro process 2.1: establishing a distinctive contribution.

The foundational micro process underpinning acceptance of the two roles was establishing their distinctive contribution to service delivery. The CSW contribution rested on the expertise the post holder developed in stoma care, drawn upon by patients and co-workers. For patients a dedicated role provided the time and space for the CSW to build a relationship, facilitating teaching in stoma care and allowing the CSW to provide emotional support:

> [Patients] come in confused and worried and depressed… and the stoma care nurse can only give them five or 10 or 15 minutes a day and they might see them twice and that's it. The [CSW] will see patients every day; she becomes a constant to them and so is much more supportive of their actual needs. She is

> the most important psychological support for that patient and their subsequent recovery. (London_Mg5)

For co-workers, the CSW's contribution to their working lives took various forms as:

- **A relief**:

> [The CSW] is taking that workload off the ward nurses. So it's not just that it's the nursing, it's the actual nursing staff group as a whole that she's taking it off. (London_Mg3)

- **A co-ordinator**:

> It's [the CSW role] probably a good bridge. Initially I had my doubts to whether this would work appropriately, but I now think it's a good bridge between the stoma department, the stoma nurses, the department and the general nurses on the ward. (London_D1)

The acceptance of the SAP similarly rested on expertise and availability, but also on the development of all round skills. Paralleling the CSW's capacity to spend time with patients, the SAP was accessible to patients, dealing sensitively with their concerns:

> I am able to chat to the patient and have the time to explain to them what is going to happen in more detail, but in layman's terms. I am not as intimidating as a doctor, so very often the patient will ask me more in depth questions than perhaps they would have done. (South_AP1)

For co-workers, the SAP facilitated partnership working: the SAP and specialist nurse/consultant working together at the same time and on the same patient in a complementary way or the SAP continuing to work on a patient, often 'finishing-off' work, allowing the nurse/consultant to move on to another patient:

> I [the specialist nurse] might go in and consent the patient whilst she's (the SAP) drawing up the local anaesthetic. She'll then numb the patient whilst I'm getting prepped for surgery. [Alternatively] I could remove the lesion and

> leave her to stitch up whilst I do the paperwork. So, potentially the patient's time on the bed is halved. (South_RN1)

Micro process 2.2: ensuring the role is trusted

The two new roles were trusted, particularly by co-workers, to meet these distinctive needs:

> There is a huge amount of trust involved with this role and that's one thing that needs to be stressed, that they (my team members) have to trust me. (South_AP1)

However, it was equally apparent that this trust was closely tied to the person performing the role:

> [The CSW] has got loads of experience behind her and that's [given] her advantages [over] someone who hasn't had experience in like surgery for long periods and they're just starting to develop the role. (London_RN1)

> [The SAP] is so competent and I know that she wouldn't do anything that she wasn't sure of, she'd always seek advice. That's one of her strengths as a practitioner. Whether it may be an issue with somebody else, I don't know. (South_RN1)

Micro process 2.3: creating a dependence on the role

Finally, team members came to depend on the contribution made by the new role with ways found to ensure that the role was routinely used and indispensable to service delivery. In the case of the SAP this was achieved by routine involvement in surgical procedures and by the regular performance of certain tasks, which then became their exclusive territory. In particular, the administration of local anaesthetic emerged as the province of the SAP role:

> I have performed so many [local anaesthetics] now on sites which may be very sensitive or painful. Therefore, if patients have a needle phobia, I am given those patients because their fear and anxiety does not frighten or intimidate me. (South_AP1)

In the case of CSW, the clinical consultant came to rely on the advice of the post holder during ward rounds:

> If I've got a patient with a stoma, I take [the CSW] along with me on the ward round, and find it very useful to get her side of the story….She has a more holistic view rather than nurses who will be looking for the technical problems with stomas. (London_D1).

The three micro processes associated with the acceptance stage are summarised in Table 3 below with their associated dimensions.

Table 3 here

Discussion and Conclusions

This article contributes to an established but relatively neglected stream of research on innovation, which takes HRM practice as an innovation in its own right (Wolfe, 1995). Seeking to sharpen the conceptualisation of an HRM innovation, a distinction was made between creating new roles or developing new ways of working and managing, not least on the grounds that these related but distinct forms of innovation might generate different processes and outcomes. HRM innovation has assumed increasing importance in healthcare as a means of addressing supply and demand side service pressures. It was, however, argued that the main research agenda seeking to evaluate such innovation had been closely tied to the policy-making cycle and consequently limited to examining the take-up and impact of new government- led HR practices.

The article explored more endogenous forms of HRM innovation, in particular, the development of two new support roles emerging in different clinical settings: the CSW in stoma care and the SAP in dermatology. Arguing that institutional theory provided a more useful basis for this work, the article drew upon the model developed by Reay et al (2006) in examining the establishment of a new nurse practitioner role. The model set out three macro level stages by which a new work role became institutionalised, and encouraged consideration of the micro processes underpinning the respective stages. Although the model was one of the few available on the institutionalisation of a new role, it was incomplete,

exclusively focusing on the middle, legitimisation stage. This created the somewhat perverse situation whereby we had a detailed appreciation of how a new role gained legitimacy but not where that role came from or whether it was likely to be fully adopted. Our research sought to elaborate on and refine this model.

In elaborating, we developed a fuller model, unpacking the first and third stages, labelled emergence and acceptance. These two new sets of micro processes are presented in the lower half of the figure below, sitting alongside the micro processes identified by Reay et al (2006) in relation to legitimacy.

Figure here

As the figure indicates the micro processes associated with the emergence of our roles involved: aligning the role with an explicit organisational need; identifying a post holder with distinctive capabilities; finding a role champion(s) and dealing with organisational concerns associated with the new role. The acceptance of our new roles rested on: establishing the distinctive contribution they made to organisational needs; creating trust in the role and its post holder; and ensuring a dependence on the role in performing key tasks. Our study also suggested a new cross-cutting process: shaping the new role. Rather than emerging ready-made, the SAP and CSW roles were moulded across the three stages as the post holders developed their capabilities, and as other stakeholders progressively drew upon them to meet their needs and the service needs.

The micro processes associated with emergence and acceptance were closely related to but distinct from those identified by Reay et al (2006) as underpinning the legitimisation stage. For example, while ‘fitting the new roles into established structures and systems’ was implicitly required for our roles to become legitimised, without an organisational need for these roles (emergence micro process 1.1) and a champion to nurture them (emergence micro process 1.3), ‘fit’ would simply not have arisen as an issue. Similarly, although our two new roles achieved legitimacy by ‘proving their value’, it was only when stakeholders came to trust in (acceptance micro process 2.2) and depend on (acceptance micro process 2.3) these roles that they gained final acceptance.

The refinement of the Reay et al (2006) framework took different forms. **First**, it was argued that the authors had conflated different forms of innovation- a new role and a new way of working- prompting questions about whether the development of these practices was distinctive. The CSW and SAP roles did generate clinical governance issues less likely to be found in developing a new way of working or managing. This was particularly the case with the SAP, a role which in pushing to the limit the tasks viably undertaken by an unregistered healthcare worker required high standards of accountability and training.

Second, there was scope to sharpen the relationship between the different levels of analysis: workplace, organisational and system. It was suggested that a clearer distinction between levels ensured greater analytical precision in examining how a new role might develop. Reay et al (2006) remained somewhat vague about where their micro processes were played-out. By unpacking the levels, our study has revealed how the SAP and CSW roles emerged at the workplace level, from within the clinical team and 'below the radar' of senior decision-makers at the organisational level. The organisational level was significant but less as a driver of these roles and more as the site of various constraints or requirements to be navigated through by workplace actors.

Sensitivity to different levels of analysis also ensured a fuller consideration of innovation transfer and, more specifically in our cases, of whether similar workplace roles might viably be taken-up at the organisation and system levels. For Reay et al (2006) micro processes at lower (unspecified) levels resulted in the unproblematic emergence of a new role at the macro level: the provincial healthcare system. Our analysis suggests new roles deeply rooted in the workplace context might be difficult to prise out and re-create at higher levels, with important implications for managerial policy and practice (see below).

Third, issues were raised about the identity and the qualities of those actors key to the development of new roles. Reay et al (2006) placed emphasis on a cadre of experienced nurse middle managers in overcoming the paradox of embeddedness to establish the nurse practitioner role. Our study suggests the need for caution in generalising from their case. Rather than a single generic actor, the development of our support roles rested on the input of a range of stakeholders including co-

workers and the post holders themselves. This is not to detract from the need for a role champion, but the type of lead actor differed between the two roles, suggesting contingent influences on who came forward and the skills needed.

London's nurse consultant was a middle management figure but relying less on experience than a capacity to combine professional expertise and managerial authority to develop the CSW role. South's consultant dermatologist relied on crude professional power and influence to establish the SAP. Given the risks associated with this role, it is questionable whether an actor with lesser authority would have secured the role. What these two lead actors shared was a degree of professional authority. Given the weight placed on professional status in healthcare management it is a quality likely to be required by any actor seeking to develop a new role in a clinical setting. It remains a more open question as to whether different qualities are needed by an actor championing a new role in other employment settings.

Finally, questions were raised about the stability of the final, taken-for-granted stage in the institutionalisation process. The sustainability of both our roles remained uncertain, a fragility stemming from the intimate relationship between the new role and those performing it. The roles had developed idiosyncratically, reflecting the personal capacities and interests of the post holders and the responses of workplace stakeholders to them. With the roles and the post holders so tightly entwined, the survival of the roles on the departure of the existing post holders remained far from certain. It is a finding which has a bearing on the transferability of innovative work roles beyond the specificities of the workplace context. If acceptance of a new role as a set of tasks and responsibilities is so intimately related to the characteristics of the post holder performing it, detaching one from the other in rolling out that role more broadly becomes a problematic process.

There are limits to the study largely related to the small number of interviewees. Although most of the key actors in the respective clinical teams were interviewed, covering more team members and patients would have provided further weight to the findings. Moreover, our study and the work conducted by Reay et al (2006) have been rooted in the same distinctive employment context: healthcare. There is

scope to explore whether the nature of the micro processes underpinning the institutionalisation of a new role, and their enactment, are sensitive to work and employment context. Thus in an industry less ordered by professional authority, the specialist HR manager or senior line manager might make a more significant contribution to the development of new roles than in our healthcare setting.

Notwithstanding these limitations, the study suggests that practitioners and policy makers, not least those associated with the HR function, need to be sensitive to the different forms assumed by HRM innovation, with the development of new roles, ways of working and managing generating distinctive sets of issues. Indeed for the HRM research community, unpacking the notion of HRM innovation in this ways sharpens consideration of how new practices become institutionalised and encourages interest in the different associated micro processes. More specifically, the organic, bottom-up development of the new roles implies a light touch approach from senior managers at the organisational level which supports rather than directs workplace actors as they re-calibrate the distribution of tasks. In distinguishing micro processes underpinning the emergence and acceptance of new roles, we have developed a more complete model to guide the development of new roles. At the same time, our emphasis on workplace specificity cautions against the straightforward transference of innovative work roles to the organisational and systems level.

References

Abbott, A. (1988). The System of Professions: An Essay on the Division of Expert Labour, Chicago: University of Chicago Press.

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

Buchan, J., (2004). What difference does (good) HRM make? Human Resources for Health, 2:6, 1-7.

Buchan, J. and Evans, D. (2007). Realising the Benefits? Assessing the Implementation of Agenda for Change, London: King's Fund.

Cooke, F. and Saini, D. (2010). Does the HR strategy support an innovation oriented business strategy? Human Resource Management, 49:3, 377-400.

Collins, C. and Smith, K. (2006). Knowledge exchange and combination: The role of human resource practice in the performance of high technology firms. Academy of Management Journal, 49:3, 544-560.

Currie, G., Lockett, A. Finn, R., Martin, G. and Waring, J. (2012). Institutional work to maintain professional power: Recreating the model of medical professionalism. Organization Studies, 33:7, 937-962.

Dacin, M., Ventresca, M., and Beal, B. (1999). The embeddedness of organizations: Dialogue and directions. Journal of Management, 25:317-356.

Department of Education and Skills. (2003). Every Child Matters, London: DfES.

Department of Health. (2011). Innovation Health and Wealth: Accelerating Adoption and Diffusion in the NHS. London: Department of Health.

DiMaggio, P. (1988). Interest and agency in institutional theory in L. Zucker (ed.) Research on Institutional Patterns and Organizations: Culture and environment. pp3-22. Cambridge MA: Ballinger.

DiMaggio, P. and Powell, W. (1983). The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. American Sociological Review, 48: 147-60.

Dubois, C., McKee and Nolte, E., (2006). Human Resources for Health in Europe. Maidenhead: Open University Press.

Francis. R. (2009). Independent Inquiry into Care Provided by Mid Staffordshire NHS Trust 2005-9. London: HMSO.

Glaser, B. (1978), Theoretical Sensitivity: Advances in Methodology of Grounded Theory. Mill Valley, CA.: Sociology Press.

Guest, D., Peccei, R. and Rosenthal, P. (2004). An Evaluation of the Impact of Nurse, Midwife and Health Visitor Consultants, London: King's College.

Grimshaw, D. (1999). Changes in skill mix and pay determination amongst the nursing workforce in the UK. Work, Employment and Society, 13:295-320.

Hood, C. (1991). A public management for all seasons? Public Administration, 69:1, 3-19.

Jiang, J., Wang, S. and Zhao, S. (2012). Does HRM facilitate creativity and organization innovation? A study of Chinese firms. International Journal of Human Resource Management, 23:19, 4025-1047.

Kessler, I., Heron, P. and Dopson, S. (2012). The Modernisation of the Nursing Workforce: Valuing the Healthcare Assistant. Oxford: Oxford University Press.

Kitchener, M. and Mertz, E. (2012). Professional projects and institutional change in healthcare: The case of American dentistry. Social Science and Medicine, 74:3, 327-380.

Kossek. E. (1987). Human resources management innovation. Human Resource Management, 21:1, 71-92.

Laursen, K. and Foss, N. (2003). New human resource management practices, complementarities and the impact on innovation performance. Cambridge Journal of Economics, 27: 243-263.

Lawrence, T. and Suddaby, R. (2006). Institutions and institutional work, in S. Clegg, C. Hardy, T. Lawrence and W. Nord, Sage Handbook of Organizational Studies, London: Sage.

Legge, K. (1995). Human Resource Management: Rhetoric and Realties, London: Palgrave.

Lopez-Cabrales, A., Perez-Luno, A. and Cabrera, R. (2009). Knowledge as a mediator between HMR practices and innovative activity. Human Resource Management, 48:485-503.

Lounsbury, M. and Crumley, E. (2007). New practice creation: An institutional perspective on innovation. Organization Studies, 28:7, 993-1011.

Marsden, D. and Richardson, R. (1994). Performing for pay? The effects of merit pay on the motivation in the public series. British Journal of Industrial Relations, 32:2, 243-261.

Mason, S. Coleman, P. O'Keefe, C. Ratcliffe, J. and Nichol, J. (2006). The evaluation of the emergency care practitioner role in England: experience and impact. Emergency Medicine Journal, 23:6, 435-439.

Mooney, G. and Law, A. (eds.) (2007). New Labour/Hard Labour. Bristol: Policy Press.

Mumford, M. (2000). Managing creative people: Strategies and tactics for innovation. Human Resource Management Review, 10:3, 332-351.

O'Reilly, M. and Parker, N. (2012). Unsatisfactory saturation. Qualitative Research, May, 1-8.

Pierson, P. (2004) Politics in Time: History, Institutions and Social Analysis, Princeton: Princeton University Press.

Radnor, Z., Holweg, M., and Waring, J. (2012). Lean in healthcare: The unfulfilled promise? Social Science and Medicine. 74:3, 364-371.

Reay, T., Golden-Biddle, K. and Germann, K. (2006). Legitimizing a new role: Small wins and mircro processes of change. Academy of Management Journal, 49:5, 977-998.

Sermeus, W. and Bruyneel, L., 2010. *Investing in Europe's health workforce of* tomorrow. Leuven: European Observatory on Health Systems and Policies.

Shipton, H. West, M., Dawson, J., Birdi, K. and Patterson, M. (2006). HRM as a predictor of innovation. Human Resource Management Journal, 16:1, 3-27.

Spilsbury, K. and Meyer, J. (2005). Making claims on nursing work: Exploring the work of Health Care Assistants and the implications for Registered Nurses' roles. Journal of Research in Nursing, 10(1): 65-83.

Thompson, M. (2007). Innovation in work practice. International Journal of Human Resource Management, 18:7, 1298-1317.

Thompson, M. and Heron, P (2006). Relational quality and innovative performance in R&D based science and technology. Human Resource Management Journal, 16:1, 28-47.

Whitfield, D. (2006). *New Labour's Attack on Public Services*, Nottingham: Spokesman.

Wolfe, R. (1995). Human Resource Management Innovations: Determinants of the adoption and implementation. Human Resource Management, 34:2, 313-327.

Wood, S. and Albanese, M. (1995). Can we speak of a high commitment management on the shop floor? Journal of Management Studies, 32:2, 215-247.

Zhou, Y., Hong, Y. and Liu, J. (2013). Internal commitment or external collaboration? The impact of HRM systems on firm innovation and performance, Human Resource Management, 52:2, 263-288.

Table 1: Interviewees			
Surgical Assistant Practitioner in South		**Colorectal Support Worker in London**	
Interviewee	***Code***	***Interviewee***	***Code***
SAP	South_AP_1	CSW	London_HCA_1
Regional nurse manager	South_Mgr_1	Colorectal Instalment Nurse	London_RN_1
Consultant dermatologist	South_D_1	Senior Colorectal Nurse Specialist	London_RN_2
Specialist nurse	South_R_N1	Matron, Surgery	London_Mgr_1
Training lead	South_Mgr_2	Consultant Colorectal Nurse	London_Mgr_2
		Nursing Business Manager for Surgery	London_Mgr_3
		Education Lead	London_Mgr_4
		StomCo rep.	London_Mgr_5
		Consultant Colorectal Surgery	London_D_1

Table 2: Emergence- Micro Processes and Dimensions		
	CSW	**SAP**
Aligning with need	Patient throughput: Enhanced Recovery	Patient throughput: Day surgery
Identifying post holder	- Relevant backgrounds - Service length - Clinical experience	
Finding champion	Nurse consultant: -Advocate -Broker: Corporate sponsorship	Consultant dermatologist: - Advocate - Talent spotter - On-the-job trainer
Addressing concerns	Robust training	-Robust training -clinical accountability

Table 3: Acceptance: Micro Processes and Dimensions		
	CSW	**SAP**
Contribution to:	Patient: - accessibility - emotional support	
	Co-workers: - Relief - Co-ordinator	Co-workers: -Partnership working
Trust in:	Post holder	
Dependence on:	Insider advice	Exclusive territories

Figure: An Elaborated Institutionalisation Model for a New Work Role