Policies, Promises and Trust: Improving Working Lives in the National Health Service

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Abstract

In recent years the UK National Health Service (NHS) has been characterised by radical and continuous change at every level. Within the literature, and the NHS itself, it is argued that successfully changing such an organisation requires the sustained commitment, trust and goodwill of staff. As part of developing and maintaining mutual trust and commitment it is widely argued that employers must meet the employee expectations which form part of the psychological contract, an important element of which, Armstrong (1999) argues, is being able to trust in management to keep their promises. Within this paper we argue that policies can be seen as a visible manifestation of management promises and present the Improving Working Lives (IWL) policy within the NHS as an example of one such 'promise' that has been made to staff in relation to areas which are important to them at a personal level. Using an anonymous questionnaire that explored areas central to IWL, data was collected from staff in five Primary Care Trusts within one Strategic Health Authority in relation to their experiences and awareness of what was being done to address these issues. The research found that although the IWL Standard makes very public promises about work-life balance, harassment, equality and the valuing of staff, at best these have only been partially delivered.

Introduction

In the United Kingdom (UK) the requirement for radical change in the public sector has necessitated significant movement away from traditional structures, approaches and assumptions resulting in new organisational forms and changed psychological contracts (Herriot et al, 1997). The UK National Health Service (NHS) is one such public sector organisation characterised by continuous, radical national and local change in pursuit of a culture change away from bureaucratic and hierarchical processes 'toward newly valued entrepreneurial attitudes and behaviours' (Bolton, 2002:129). Successfully changing an organisation such as the NHS, while maintaining high standards of care on an ongoing basis, requires the sustained trust, commitment and goodwill of staff at every level and in every aspect of the service. Clearly this has implications for the employment relationship in the health service and, given that it constitutes one of the world's largest labour forces employing around one million people (Bloor and Maynard 2001), any change impacts on the working lives of significant numbers of people.

Kiffen-Peterson and Cordery (2003) suggest that employees' trust in management may be a significant factor in their attitude toward major organizational changes that involve extensive structural, philosophical and value changes, as is the case for many in the NHS. They also note the existence of evidence of an association between trust in management and positive organisational outcomes including receptivity to change initiatives and organisational commitment. As part of developing, and maintaining, mutual trust and commitment it is widely argued that employers must meet the employee expectations which form part of the psychological contract, an important element of which, Armstrong (1999) argues, is being able to trust in management to keep their promises. If a promise is seen as a pledge, an undertaking to do or not to do something, or to give reason to expect something as per its dictionary definition (Weiner, 1995), then in an organisational context, policy statements form such commitments. Herriot *et al.*'s (1998) first manifestation of trust is based on the fulfilment of perceived obligations or commitments. Issues of equity and fairness are also important, both as elements of the psychological contract and as contributors to the development of trust during periods of change (Saunders and Thornhill, 2003). Pillai *et al.* (2001) argue that when distributions of organisational outcomes are considered fair, higher levels of trust are likely to ensue. Thus, according to these formulations, the experience of fulfilled obligations or promises is directly related to the generation of trust, which in turn is a necessity for the successful implementation of change.

Within this paper we consider the fulfilment of one such ‘promise’ as made to NHS staff in the form of the Improving Working Lives (IWL) Standard, published by the UK government in 2000. In the context of the NHS and IWL a set of reciprocal expectations and assumptions between the individual employee and the organisation are being created (Brown and Armstrong, 1999; Schein, 1978) but to what extent, in the day to day experience of staff, are the employers delivering on their side of this bargain? The paper begins by considering the links between expectation, commitment and trust within the context of the employment relationship. The ‘promise’ inherent in the IWL initiative currently being implemented within the NHS is then explored. Details are then provided about the organisation in which the research took place and the approach to data collection and analysis that was adopted. This is followed by the presentation and discussion of the findings that emerged and which suggest that, as yet, the promise is, at best, only partially fulfilled.

The significance of promises

Employment relationships in organisations are founded on a set of expectations shared by employer and employee which are conceptualised as the psychological contract, a set of unwritten, often unarticulated, reciprocal expectations and assumptions between an individual employee and the organisation (Brown and Armstrong, 1999; Guest and Conway, 2002; Schein, 1978). This reflects the beliefs, values and aspirations of both employer and employee (Smithson and Lewis, 2000) and refers to employee beliefs about what they will give in return for what they expect to receive from their employer (Roehling, 1997). In the UK Sparrow and Marchington (1998) argue for the central place of trust in coping with radical change and in re-engaging individuals and stakeholders in the employment relationship. In order to develop and maintain mutual trust and commitment Herriot *et al.* (1997) argue that employee expectations that constitute the psychological contract, and which include many of the elements that also appear as part of the equal opportunity and work-life balance agendas, must be met. In his model of the psychological contract in addition to trust in management to keep their promises, Armstrong (2000) presents the need for security, involvement, equity and the opportunity to develop as important elements from the employee perspective. From the employer perspective there are expectations of competence, effort, compliance, commitment and loyalty.

Whitener *et al.* (1998) argue that it is the manager’s responsibility to initiate trusting relationships and that a manager’s actions and behaviours form the foundation for trust. The definition of trust is still a matter of considerable debate but is generally agreed to involve a

relationship in which the trustor makes himself/ herself vulnerable to the outcome of the actions of another (Levi, 2001) some researchers (for example Costa, 2003: 608) adding that it is both a 'psychological state based on perceptions and on perceived motives and intentions of others, but also a manifestation of behaviour towards these others'. It therefore involves expectations of beneficial actions and commitments based on such expectations (Sztompka, 2002). Clearly, in the organisational world relationships are rarely equal and power, dominance and coercion are often the basis on which the division of labour is arranged and social order is maintained (Seligman, 1997). Given the inequity of the power balance and status within most organisations, the creation of a positive climate for trust must require both ability and motivation on the part of management, which inevitably controls the power and resources within the organisation. High trust is often associated with long-term commitment, this being measured as an employee's willingness to remain with an organisation and expend effort in achieving the organisation's goals. Morrow (1983) defines such commitment as the notion of attachment and loyalty, by an individual to an organisation. Singh and Vinnicombe (1998) found that the most frequently cited meanings of commitment given by respondents were: being task or delivery focused; being prepared to 'put yourself out'; being involved; focusing on quality; and doing your best for the organisation. Morrow (1983) suggested that commitment as a process is individualised and related to the personal needs and attachment of an employee.

The NHS and Improving Working Lives

For more than a decade the UK NHS has experienced continual and radical change during which long established traditions, structures and assumptions have been challenged. In addition to the demands of advances in technology, changing demographics and resource limitation, NHS staff have also had to become familiar with the principles of a new health service based on clinical governance and the centrality of the 'customer' (Curley *et al*, 2002). Research undertaken in the NHS by Walker (2000) identified the broad attitudinal implications of such radical change - in particular the findings indicated higher levels of job insecurity, lower morale and an increased concern by staff about quality. These findings were supported by the Department of Health's report *Improving Working Lives* (2001) which suggested that continuous change had resulted in a lack of loyalty and career dissatisfaction within the health care professions and an unwillingness to recommend a career within the Service. Unsurprisingly, recruitment and retention became a significant area of concern reinforced on an ongoing basis by reports from professional bodies such as the Royal College of Nursing (RCN). The situation has shown some recent signs of improvement, however, the RCN's 2003 survey of membership (Ball and Pike, 2004) still found that only 50% of its

members were willing to recommend a nursing career and 29% would like to leave nursing if they could, a figure which included relatively high proportions of minority ethnic and male nurses.

The NHS Human Resources Performance Framework (NHS Executive, 2000) highlighted the importance of ensuring not only that there were the necessary staff to deliver modernisation across the Service and that those staff were working effectively, but also that the NHS was investing in improving the working lives of staff. The stated aim of the IWL Standard (Department of Health, 2001a: 4), subsequently published by the government, is to make the NHS an employer of choice and to maximise the contribution of its staff, for:

achieving the standard means making real and tangible improvements in the working lives of all staff in the NHS. Improvements that are effective, improvements that are embedded, and improvements that deliver better working lives for staff and better patient care.

The Department of Health identifies a number of HR principles which it states are part of the achievement of the reforms outlined in the NHS Plan (DOH, 2000). These include supporting staff through the changes, keeping skills experience and commitment of existing staff, good communication and discussion, and ensuring that no employee will receive less favourable treatment on grounds of age, gender, marital status, ethnicity, religion, sexual orientation, colour, disability, working patterns or on the grounds of Trade Union membership. The IWL Standard was intended to set a model of good HRM practice and made a very public commitment to improving diversity, developing staff and tackling discrimination and harassment. It also made it clear that staff within the NHS were entitled to work in an organisation that was flexible, supportive and family friendly. NHS organisations were to be required to achieve accreditation against the Standard by April 2003, thereby demonstrating that they were improving the working lives of staff. Thus, in the context of the far-reaching NHS change programme, certain commitments or promises are being made to staff in the articulation of policies and aspirations which directly relate to their individual working lives but to what extent does staff experience suggest that they are being fulfilled?

Method

Data for this research were obtained as part of a consultancy project for a group of five Primary Care Trusts (PCTs) that provide services to an urban area and its rural hinterland in a UK Strategic Health Authority located in the Midlands. We refer to this Strategic Health Authority, as “Midshire” for reasons of confidentiality. Primary Care Trusts such as those in

Midshire are, in the context of *Shifting the Balance of Power* (Department of Health, 2001a), intended to be the leading NHS organisation for partnership with Strategic Health Authorities, other Trusts and local communities, having responsibility for the management, development and integration of all primary care services. As freestanding statutory bodies accountable to the Strategic Health Authorities, Primary Care Trusts are positioned by the NHS as offering an unparalleled opportunity for local stakeholders to shape health services and to provide better care.

The *Improving Working Lives Standard* (Department of Health, 2000) had emphasised the importance of an annual staff attitude survey as part of the enabling of each NHS trust to deliver against the national priorities and 'working together' targets which form part of the NHS plan. Although the new National NHS Staff Survey, which all Trusts will be expected to use, provides a core set of questions (Department of Health, 2003) these were not available at the time of this research. Rather, Trusts were expected to comply 'with best practice as set out in national guidance' in designing and administering their annual staff attitude surveys and, subsequently, act upon the key messages (Department of Health, 2000). Consequently, the data used in this research were collected using an anonymous postal questionnaire devised, in accordance with the national guidance by, Midshire's Healthcare Support Service.

The questionnaire was designed and pilot tested by Midshire's Healthcare Support Service. Consisting predominantly of pre-coded questions using five point Likert type scale answers, the questionnaire collected data on:

- General issues including perceptions of work and their Primary Care Trust,
- Equal opportunities, violence and harassment,
- Health, safety and welfare,
- Support and feedback,
- Communications,
- Personal characteristics of respondents.

Respondents were generally asked to select from 'never', 'rarely', 'sometimes', 'mostly' or 'always' for statements relating to themselves such as 'I enjoy my job'. In contrast, for statements relating to their perception of their Primary Care Trust such as 'the organisation is positive about employing disabled people', respondents were asked to select from 'strongly agree', 'agree', 'not sure', 'disagree' or 'strongly disagree'. In addition, the questionnaire

included opportunities for elaboration regarding what was liked most by respondents about their working lives and what would help to improve them.

Prefaced by a covering letter from the Lead Director of Midshire Healthcare Support Service questionnaires were sent to the home addresses of all employees in the five Primary Care Trusts in February 2002. Respondents were requested to return their questionnaire directly to the researchers in the prepaid envelope provided, the researchers only being involved from the data analysis stage onwards. Overall, 668 (24.7%) of the Primary Care Trusts' employees responded to the questionnaire, four of the five Trusts having response rates between 201% and 24.4%, the remaining Trust's rate being 30.7%. These response rates are not unusual for surveys of this kind, response rates of 20-25% being typical (Saunders et al., 2003). Subsequent to this Kolmogorov-Smirnov One Sample tests (Kanji, 1998) confirmed that the distribution of the respondents by ethnic origin did not differ significantly from that of all employees, either within the five individual Trusts or for Midshire as a whole ($D = 0.0134$, $p > 0.2$), approximately 98% classifying themselves as 'white'. However, the high proportion of those working for these Primary Care Trusts whose ethnic origin was not recorded by Midshire's personnel database (36%) means this observation must be treated with caution. Subsequent Kolmogorov-Smirnov One Sample tests did, however, confirm that females (93% of respondents overall) were significantly more likely to be represented in the samples from two of the five Trusts ($D = 0.1005$, $p < 0.01$; $D = 0.0579$, $p < 0.01$) and Midshire as whole ($D = 0.0486$, $p < 0.01$). Difficulties in aligning the categories used in the questionnaire with those used on the staff personnel databases meant it was not possible to explore the distribution of respondents in each Trust with regard to the nature of staff's work. Thus, although the results appear to be reasonably representative of the Primary Care Trusts' employees in terms of ethnic origin, data on gender suggest that overall female employees were more likely to respond. However, given that over 88% of the total employees were female, this is unlikely to have a significant impact on the findings. Where this is not the case it is discussed.

The Findings

Survey questions relating to perceptions of work and each Primary Care Trust in general allow consideration of the context in which the employment relationship and the development of trust takes place. The majority of those who responded to the survey (67.1%) agreed that their organisation was professional (agreed to be a desirable attribute by 76.5% of respondents). The vast majority (85%) stated that they 'mostly' or 'always' enjoyed their job

and felt that it made good use of their skills and abilities (78%). Particular aspects commented upon as being enjoyed included “working with a happy team” and “doing a job I care about”. In relation to their tasks a number of employees also commented that their jobs involved “autonomy and trust and interesting work” and “I am challenged and given freedom to work in the way I think best”.

Clear differences emerged between respondents’ feelings about their work group and in relation to the wider organisation. Despite 63% feeling ‘mostly’ or ‘always’ valued for their work by their own manager, only 33% of respondents felt ‘mostly’ or ‘always’ valued for the work they did by the wider organisation. Although both of these responses were found to be significantly related to respondents’ enjoyment of their jobs, those who felt mostly or always valued for their work by their own manager appeared significantly more likely to mostly or always enjoy their job ($\chi^2 = 124.28$, $df = 12$, $p < .000$). In contrast, those who felt ‘never’ or ‘rarely’ valued for their work by the organisation appeared significantly more likely to rarely or sometimes enjoy their job ($\chi^2 = 128.85$, $df = 12$, $p < .000$). Such perceptions are unlikely to contribute to feelings of job security or organisational commitment, especially where only 36% of respondents agree that the organisation is supportive.

Armstrong (2000) identified involvement as an element of the employee psychological contract, while Wang and Clegg (2002) describe employee involvement as a manifestation of mutual trust between management and employees. One respondent specifically suggested “taking part in decision-making” as a way to improve working life, however, the extent of such involvement by employees in each of the Midshire Primary Care Trusts appears limited. Only 37% of respondents felt ‘mostly’ or ‘always’ involved in the planning and delivery of services and less than half (45%) believed that it was mostly or always safe to speak up and challenge the way things were done in the organisation. Those respondents who did believe it was mostly or always safe to speak up were significantly ($\chi^2 = 318.39$, $df = 16$, $p < .000$) more likely to feel involved, representing over 28% of all respondents. In contrast, of the 20% of respondents who rarely or never felt it was safe to speak up, only 1% felt mostly or always involved. This is of particular concern as a key factor identified within the literature for the establishment of trust is open and frequent communication between parties (for example Blois, 1999; Rogers, 1995; Roy *et al.*, 1998). This is supported by nearly three quarters (72%) of respondents disagreeing with the statement that their Primary Care Trust was ‘open and honest’ although 82% agreed that this was an ideal for the future.

Some 70% of respondents felt well informed about what was happening in their own work area, whilst less than half of respondents (38%) felt the same was true in respect of their organisation. For these respondents the most important channels of communication about what was happening within the organisation were colleagues, the newsletter and team meetings (Table 1). However, despite the importance placed on colleagues as a source of information, there was no significant relationships between whether or not respondents usually got information from colleagues and their perceptions of how well informed they felt about what was happening in their own work area ($\chi^2 = 7.525$, $df = 4$, $p = .111$) or in respect of their organisation ($\chi^2 = 8.023$, $df = 4$, $p = .091$). Rather, respondents' feelings of being well informed at both the work and organisational levels were significantly related to their Newsletters, team meetings, their managers and departmental meetings. Communication through channels such as these is a prime area of behaviour identified as influencing employees perception of managerial trustworthiness, with transparency and openness acting as an antidote to the inherent credibility gap created because all leaders are, inevitably, the objective of suspicion (Bennis, 1993).

Insert table 1 about here

Rogers (1995) and Fairholm and Fairholm (1999) place the responsibility for the creation of mutual trust firmly with senior management who, they argue, have an obligation to create cultures where trust exists between employees and senior managers and vice versa. There was little evidence, however, in the Midshire survey of management being seen to take a proactive role in open communication. Respondents observed that "it would be good to know that management are listening and not paying lip service" and suggested that "more communication with management" and "better communication" would improve working life, as would "a greater understanding by senior managers of the pressures at grassroots level". Little more than a third of respondents agreed that their senior management were usually or always visible (39%) and accessible (40%). Nor was the situation much improved on a one-to-one basis with only 41% believing that they usually or always received constructive feedback from their manager, with one third reporting that this rarely or never happened. One respondent observed that "it's a token management, too busy rearranging their own jobs (deck chairs on the Titanic)", yet, suggestions for improving working lives included "to be more valued by upper management"; "recognition for what you do", "more support from management", "being truly appreciated for the effort".

If, as Saunders and Thornhill (2003) and Pillai *et al.* (2001) argue issues of equity and fairness are factors in the development of trust then the enactments of policies ensuring equality of opportunity assume importance as contributors to perceptions of justice and fairness of treatment and outcome. Such policies, including statements about harassment and bullying, are a manifestation of an organisation's commitment to equity as part of the employment relationship. As such they embody management promises or obligations to ensure fair treatment of the workforce and support in times of vulnerability. Such policies have a particularly important role in the context of IWL.

In the Midshire survey the majority of respondents 'agreed' or 'strongly agreed' that employees were treated equally regardless of gender (64%), ethnicity (62%), sexual orientation (56%) or part-time working (66%). Those respondents who felt more valued for the work they did in their organisation were significantly more likely to agree or strongly agree that men and women were treated as equals by their organisation ($\chi^2 = 80.95$, $df = 8$, $p < .000$), that staff from all ethnic groups were treated equally ($\chi^2 = 56.37$, $df = 8$, $p < .000$), that their organisation was positive about employing disabled people ($\chi^2 = 36.96$, $df = 8$, $p < .000$), that staff were treated equally irrespective of sexual orientation ($\chi^2 = 60.94$, $df = 8$, $p < .000$) and part time staff were treated equally by their organisation ($\chi^2 = 89.80$, $df = 8$, $p < .000$). However, in relation to the statement 'the organisation is positive about employing disabled people', only 30% of respondents felt that they could 'agree' or 'strongly agree'. Despite this, for all these categories other than part-time working (15%), the number of respondents who disagreed or strongly disagreed with the statements were less than 5%. However, there were a large proportion who were unsure regarding these aspects of equality of treatment. In particular, 64% were 'not sure' as to whether their organisation was positive about employing disabled people, whilst 42% were 'not sure' regarding equality of treatment irrespective of sexual orientation indicating a lack of knowledge or understanding of these policies rather than belief in the existence of discrimination.

In *Working Together: Securing a quality workforce for the NHS* (DOH, 1998: 9) targets and priorities relating to a 'healthy and involved workforce' were set out and included a declaration relating to fairness and equality which stated that staff deserve to be treated fairly and with respect. A key challenge identified was to ensure that equality of opportunity was integrated into everything the NHS did not only in terms of service delivery but also in how staff are treated and valued. Perceptions about obligations and trust are likely to be related not just to an absolute measure, about whether obligations have been fulfilled, but also to one or more relative, social comparisons. High visibility of supportive work-life balance policies

provides a means of demonstrating management commitment to important aspects of the employee psychological contract in addition to being an acknowledged means of improving recruitment and retention. Feelings of trust are likely to be affected by the relative treatment of others and by more generalised opportunities available within a person's occupational group, organisation or perhaps even another organisational context. When asked whether they were aware of their Trust's approach to various measures associated with the achievement of work-life balance many respondents stated they were not (Table 2).

Insert Table 2 about here

Analysis of individual responses found that less than 4% were aware of the full range of policies in place, 75% of employees were only aware of three or less of these initiatives whilst 27% were completely unaware of the existence of any initiatives relating to work/ life balance. These appear to be serious missed opportunities as the existence of such policies are obvious manifestations of each of the five Trusts' actions towards fulfilment of its promises.

A package of national targets and indicators was introduced in the *'The Vital Connection: an equalities framework for the NHS'* including an aim for the NHS 'to nurture and cherish its greatest asset: its people' (DOH, 2000:19). This included reference to harassment, for 'the success of the NHS in tackling harassment is a touchstone of its success in making tangible progress in ending discrimination, whether direct or indirect'. (DOH, 2000: 20). Some 53% of respondents reported being subject to some form of abuse, harassment or bullying at work in the past year, although only 60% of these had actually reported an incident. Respondents were significantly more likely to report incidents of abuse (60.4% of all incidents) than racial harassment (41% of all incidents), bullying (30.2% of all incidents) or sexual harassment (16% of all incidents) ($\chi^2 = 12.72$, $df = 3$, $p = 0.0054$). Within this, incidents of physical and verbal abuse were significantly more likely to be reported (74% of all incidents) than verbal abuse (56% of all incidents) or physical abuse (50% of all incidents); whilst they appeared far less likely to report bullying from patients/clients or visitor/carer/relative than from managers or colleagues (10.5% of all such incidents). It is not clear why there is reluctance amongst staff to report such incidents but it may, at least to some extent, reflect the problems with communication and the relationship with management noted earlier.

Training and development are obviously important aspects of the employment relationship both in terms of expectations embedded in the psychological contract and as a manifestation of an employee being valued. The majority of respondents agreed or strongly agreed that they

had received adequate training for their current job (83.6%), had sufficient information about training opportunities (71.7%), and had adequate access to those opportunities (63.6%). In terms of the employment relationship these PCTs would therefore appear to be meeting the expectations of the majority of respondents in this context through provision of training and development opportunities. 59.6% agreed or strongly agreed that there were sufficient opportunities for them to continue their personal development within their organisation although, for one fifth of respondents (19.8%), this aspect of the psychological contract was not being fulfilled as they felt that they would not be able to pursue their personal development within their organisation. One respondent suggested that “to be recognised for skills learnt and acquired over a period of time” would greatly improve working life, while others identified a need for “more encouragement to go on study days” and “more flexible training for part-timers”. These responses were all significantly related to respondents’ feelings of being valued for the work they did both by their organisation and their manager. Respondents who had agreed or strongly agreed with each of the four statements related to training and development were also significantly more likely to feel valued for the work they had done by their organisation and by their manager. In contrast those who disagreed or disagreed strongly appeared significantly less likely to feel valued. Despite this, the role of the individual managers in promoting training, and the corresponding feeling of being valued, is less clear. Although 46% of respondents stated that they have a personal development plan, which had been agreed with their line manager, this did not appear to be significantly related to respondents’ feelings of being valued for the work they did, by their organisation ($\chi^2 = 7.97$, $df = 4$, $p = .093$). In contrast, there did appear to be a significant relationship between their feelings of being valued for the work they did by their manager ($\chi^2 = 39.75$, $df = 4$, $p = .000$) and having a personal development plan.

Conclusions

Decades of change have had a significant impact on the employment relationship in the NHS and many of the structures, processes and norms upon which trust has been based. For the individuals concerned, organisational change is often perceived as threatening (Mabey and Salaman, 1995) and careful implementation is required to address the mistrust associated with vulnerability and loss of security. Such feelings are commonly defined in terms of employees’ confidence in, or reliance upon, someone or something (Guest, 1998). The IWL Standard makes promises in relation to issues that are of direct personal importance to most staff; successful delivery has the potential to offer a foundation for rebuilding trust within the employment relationship but current evidence suggests that there remains a long way to go and the likelihood of success is by no means guaranteed. The IWL Standard publicly

acknowledged the centrality of employees in attaining the achievements and changes required and the reciprocal need for the NHS to invest in its employees. The standard, and the accompanying documentation, very visibly address areas relating to work life balance which previous research has shown to be important in staff recruitment and retention (Boxall and Purcell, 2003) in general terms but also specifically in the context of NHS staff (Munroe, 2002). Promises made in these areas are therefore of significant interest to staff and create a perception of obligation that staff are keen to see fulfilled.

The combined evidence from the five Trusts involved in this survey is that, at best, the NHS has so far only partially delivered on its promises. There appears to be at least a degree of trust within the PCTs on the basis of task and role competence with respondents reporting autonomy and choice in relation to their work. At this level, an environment of professionalism and specialization enables calculus based trust (Shapiro *et al*, 1992) on the basis of consistent behaviour and meeting of expectations. However, in terms of membership of their organisation rather than a profession there is less to support the establishment of trust and mutuality in the employment relationship. In the NHS expectations of employment security have been undermined, established norms overturned and the emphasis has been on short-term goals, all of which challenge the existing psychological contract of employees at all levels.

Attempts to improve working lives through managerial techniques such as involvement, communication, flexibility, training and development are, however, likely to be mitigated by the structures and conditions that exist within organisations. Wang and Clegg (2002) rightly argue that management and employees can more effectively achieve organisational goals if they trust and cooperate with each other and that leadership based purely on the use of power, knowledge and control does not create a sustainable basis for motivating others or for generating commitment. This holds true at all levels of an organisation. In the NHS managers are also under pressure, operating in a climate where they feel unable to raise concerns without fear of reprisals (52% of those responding to the BBC/Institute of Health Service Management 2002 survey). This is clearly not conducive in turn to the development of open and honest communication, argued to be an essential component of trust, with those who work for them. It is not surprising therefore that the evidence from the PCTs is that communication is problematic with less than half of respondents feeling that it is safe to speak up. The evidence suggests that this in turn negatively impacts on feelings of involvement argued to be necessary for the development of mutual trust.

The IWL initiative has emphasized the importance of employees both in achieving change and in supporting the ongoing work of an immensely important public service. To be effective, however, the investment in employees both in terms of their development and their ability to achieve work-life balance needs to be visible to all and there is certainly doubt that this was the case in these five Trusts. Communication has a key role in this context, particularly in large organisations, as employees need to be aware not only of the existence of policies, the statement of management commitment, but also their application, the enactment of policies, for others as well as themselves. This is particularly important at local level for people's perceptions are based not only on their own experience but also on comparison with, and observation of, the treatment of their peers. The picture in these PCTs did contain a number of positive observations related largely to people's experience within their local framework rather than their broader organisation. This emphasizes the important contribution of local management activity to perceptions of, and belief in, successful delivery of the promises but attention must also be paid to the extent to which the promises are being delivered for those managers.

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Table 1: Percentage of respondents agreeing that they usually get information about what is happening around their organisation by channel

Channel	% agreeing
Colleagues	72.5%
Newsletter	55.4%
Trust/Team meetings	54.3%
Manager	48.7%
Departmental meetings	39.7%
Staff representatives	9.4%
Websites	3.8%
Intranet	3.2%
Total (=100%)	680

N.B. Percentages sum to more than 100 due to multiple responses

Table 2: Percentage of Respondents Aware of their Primary Care Trust's Approach to Work Life Balance Issues

Work Life Balance Initiative	Aware	Not aware	Total (= 100%)
Maternity leave	57.8%	42.2%	651
Job share	47.8%	52.2%	667
Special leave	30.6%	69.4%	667
Career break/ retainer scheme	23.9%	76.1%	662
Paternity leave	23.2%	76.8%	624
Career leave	18.5%	81.5%	642
Long service rewards	18.1%	71.9%	654
Adoption leave	7.9%	92.1%	634