



High Performance Work Systems in the Intellectual Disability Care Sector in Ireland; an Exploratory Study at Organisational Level

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Abstract

There is a growing appreciation in the healthcare field of the importance of complementing physician expertise with more effective organisational processes and procedures (Flood 1994). Gowen et al (2006) suggest that Strategic Human Resource Management (SHRM) can effectively address hospital errors in tandem with quality management processes and procedures. To date, there is a growing wealth of research investigating how SHRM practices can increase organisational performance and competitiveness in the private sector. Unfortunately, this is not true of the healthcare sector, or indeed the Intellectual Disability Care (IDC) Sector where there remains a dearth of research addressing the linkages between HRM and organisational effectiveness. The purpose of this paper is two fold. Firstly, the paper will examine the literature investigating SHRM in healthcare, with reference to the IDC Sector where possible, focussing specifically on High Performance Work Systems (HPWS). Secondly, the paper will focus on how far HPWS have expanded in the sector at an organisational level from a management perspective. A postal questionnaire was chosen as the means of gathering this information. One questionnaire was sent to the human resource manager in each IDC centre in Ireland. The findings provide us with some important insights into the differential utilisation of the components of HPWS across the sector. The areas of HPWS in which the centres achieved the highest score were service user focus and teamwork. The area scored least favourably was communication between management and employees.

Keywords: Strategic Human Resource Management, High performance Work systems, Intellectual disabilities, Health services

1. Introduction

The IDC sector plays a significant role within the healthcare sector in Ireland. Approximately 11% (10,953) of the total employment in the health sector in Ireland (101,978) are employed in the IDC sector. The role of human resources (HR) in the IDC sector in Ireland is critical. Services offered within the IDC sector are predominantly based around the interactions between service providers and service users. Given the low level of technical interventions in the sector, services are fundamentally reliant on service personnel, in the form of health professionals and support staff. There have been two key trends in recent years in the profile of people registered with intellectual disabilities: (1) an increase in the number of people in receipt of services and (2) an increase in the percentage of over 35 year olds registered with intellectual disabilities. Both of these increases have and will continue to place increasing pressure on resources. To

date there has been little evidence of changes in the level of funding or staffing in the sector to reflect these increases. Despite the increase in the demand for services and resources, it is critical that the quality of care provided to service users is not jeopardised. This paper argues that by maximising human resources through the implementation of high performance work systems in the IDC sector, the employee body as a whole will become more efficient and effective, thus at least maintaining and potentially increasing the quality of care provided. The objective of this research is to identify the managerial perceptions of HPWS within the IDC centres in Ireland at an organisational level.

1.1 The IDC Sector in Ireland

The Health Service Executive (HSE) (note 1) provides a wide range of services for people with intellectual disabilities in Ireland. One of the key functions of the HSE with regard to intellectual disability services is the co-ordination of the Intellectual Disability Database (note 2) along with the provision of services to individuals with intellectual disabilities. Table 1 illustrates some of the key trends in the IDC sector in Ireland from 2003-2007.

As Table 1 highlights, in 2007 there were 25,613 people registered on the Intellectual Disability Database in Ireland, of which 24,898 are in receipt of services. This represents a prevalence rate of 6.51 per 1,000 population in Ireland. The ratio of males to females registered with intellectual disabilities currently stands at 1.29:1 (Kelly et al, 2007).

There has been an increase of 31% in the number of people registered with intellectual disabilities since the first census of mentally handicapped people in Ireland in 1974 (Mulcahy 1976, Mulcahy & Bennis 1976). The Health Research Board has also identified an increase in the lifespan of those registered with intellectual disabilities. The percentage of over 35 year olds registered with intellectual disabilities has increased from 29% in 1974, to 38% in 1996 to some 48% in 2007. This increase in the number of people over 35 registered with intellectual disabilities has significant implications for resources and an increasing level of demand for residential services along with support services for caregivers (Barron & Mulvany, 2004).

97% of those registered with intellectual disabilities are in receipt of services. This is the highest number of people in receipt of services since the database was established in 1995. 8,262 of these are in full-time residential care and a further 329 are in receipt of care from psychiatric hospitals. Of this 329, only 26 are recorded as being appropriately placed within in psychiatric hospitals (Kelly et al, 2007). Alternative residential facilities have been identified for 207 of these service users during the period 2008-2012, again, placing greater pressure on the services available.

Barron & Mulvany (2004) highlight that in recent years there has been a significant growth in the level of full-time provisions for full-time residential services, residential support services and day services. Since 1996 there has been a 46% increase in the number of people living in full-time group homes within communities. There is currently an ongoing demand for new intellectual disability services and a growing requirement to enhance existing services.

The intellectual disability services sector in Ireland is a sector that has experienced huge growth in recent years, and is a sector which appears will continue to experience further growth in the years to come. The HSE 'works in partnership with all stakeholders to ensure that the HSE is an employer of choice, with a motivated, skilled and flexible workforce, capable of delivering high quality services' (HSE 2005). There are a number of different ways in which the HSE can ensure high performance and high quality. One such example is through the effective management and utilisation of employees.

2. Literature Review

2.1 High Performance Work Systems in the Health Care Sector

SHRM literature has emerged as a major paradigm in the HR field (Dyer & Reeves, 1995). The literature blends the more 'macro' HR literature with 'micro' literature. Traditionally researchers focused on the individual level effect of HRM practices, concentrating on individual employee job satisfaction or individual employee performance. However, in recent years there has been a shift in focus from individual impacts of HRM towards a more 'macro' level approach.

Similar trends have also been noted within the context of the health sector. Khatri (2006) notes the shift from traditional research with a 'micro focus', focusing on individuals, to a more strategic view of the firms' human resources, where a 'macro' view of the firms' HR activities have emerged, paying particular interest to organisational effects of HRM policies and practices. Gowen et al (2006:806) note that SHRM "...can be critical to the efficacy of healthcare errors, error reduction barriers, quality management processes and practices, programme results and competitive advantage".

A number of researchers within the healthcare context suggest that SHRM systems improve organisational success and in particular when quality management programmes are in use (Caron et al 2004; Chen et al 2004; Manion 2004). Gowen et al (2006:818) also suggest "...that hospital errors can be successfully addressed with appropriate quality management practices and strategic HRM". Gowen et al, (2006) found healthcare error sources are highly statistically and significantly related to quality management processes, quality management practices, and strategic HRM. They further suggest that the impact on sustainable competitive advantage is greatest for strategic HRM, which includes employee teams, training, information sharing, rewards, recognition, and promotion opportunity. Their research

suggests that hospitals should exploit strategic HRM practices as they offer unique opportunities for reducing errors, providing results, and creating competitive advantage.

Shih et al (2006) note that scholars of SHRM have turned their attention to 'bundles' of mutually reinforcing and synergetic HR practices that facilitate employee commitment and involvement. One of the common themes they identify in the literature is an "emphasis on utilising a system of management practices that provide employees with skills, information motivation and latitude" (Shih et al, 2006:742), which in turn results in a more productive workforce which become a source of competitive advantage for the organisation. These bundles of practices are collectively known as high performance work systems. The next section explores high performance work systems in greater detail.

The term high performance work systems (HPWSs) was popularised by Appelbaum and Batt (1994). HPWS are known by many different names, amongst others, high performance work practices, high commitment systems, high involvement systems, flexible work systems. Given the variation of terms used to describe the phenomenon, hereafter the term HPWS will encompass all of the aforementioned terms. CIPD (2006:5) define high performance work systems as '... the careful design of work organisation and practices so that they are systematically linked to the achievement of organisational objectives and performance'. Organisations utilising HPWS seek to increase employee involvement, performance and commitment through bundles of "best fit" HR practices that generally include a combination of the following: employee empowerment, training and development, reward and performance management, recognition, information sharing, shared decision making, recruitment and selection, employee involvement and diversity and equality.

To date many studies have been carried out in the private/profit making sector and reported a correlation between HPWS and employee turnover (eg Arthur,1994; Brett, 2002; Guthrie, 2001), productivity (Arthur,1994; Datta et al 2005, Guthrie, 2001; Koch & McGrath, 1996; MacDuffie, 1995; Neal et al 2005; Patterson et al 1997), product/service quality (MacDuffie, 1995; Youndt et al 1996), and firm profitability and market value (eg Delery & Doty, 1996; Huselid, 1995) .

Although a limited amount of research has been carried out to date investigating HWPS in the health sector, a small body of research does exist which supports the effectiveness of HPWS in the health sector. Certain elements of HPWS have also been identified in research as having particular significance in healthcare context. Some of the key findings to date have highlighted a positive relationship between HPWS and employee job satisfaction (Harmon et al 2003, Blegen, 1993), lower job stress and lower patient service costs (Harmon et al 2003), effective information processing and decision-making (Preuss 2003), more effective patient care and decreased patient mortality (Michie & West, 2004) and ultimately superior healthcare (Preuss, 2003). The author is unaware of any similar work carried out in the IDC sector.

Similar to other industries, the healthcare sector is concerned with maximising effectiveness through the adoption of appropriate management policies and practices (West et al., 2006; 983). Research conducted by West et al. (2006) makes an important contribution toward enhancing our understanding of how HPWSs can positively affect hospital performance. They note the importance of performance appraisal/management to clarify individuals' roles and objectives in their work, to provide them with feedback on performance, to determine their development needs and to communicate to them their value and importance to the organisation. They also stress that ongoing staff training and highly effective communication processes, especially among nurses and receptionist staff, are essential in reducing patient mortality and improving quality of care provision.

Preuss (2003) argues that high performance HR systems can help improve healthcare outcomes in a hospital setting. He suggests that HPWS promote effective information processing and decision making in an environment where it is critical. Drawing parallels between the healthcare sector and industry, Preuss notes that in manufacturing plants, information is relatively unequivocal and easily interpreted for ongoing decision making. However, in hospitals, work systems must support employee capacity to interpret equivocal information as part of ongoing decision making (Preuss, 2003). Preuss contends that implementing HPWSs can improve information quality by granting responsibility over information interpretation to employees who have critical knowledge, such as nurses, and making the information available for ongoing process improvement. Therefore he suggests that investing in HPWSs will lead to increased employee knowledge, information sharing and higher quality of care.

The current literature also suggests that team working enables shared knowledge and understanding about patient needs, good decision making, lower error rates, and more effective patient recovery (Borrill et al, 2000; Firth-Cozens, 1998; West & Borrill, 2006: West et al, 2006). Moreover, workers in healthcare settings are better able to act upon the ambiguous information because of their training, involvement in decision making and the shared learning associated with team working (West et al, 2006; 987).

Broadly, findings by West et al (2006:944) suggest that, "HR systems are related to the quality of healthcare and specifically patient mortality in hospitals. Above and beyond the effects of a set of important controls, our results suggest that people management systems that emphasise a set of complementary 'high involvement' policies and

practices (i.e., an emphasis on training, performance management, participation, decentralised decision making, involvement, teams, and employment security) may be successful in contributing to high-quality healthcare.”

3. Rationale for the study

Staffing issues should be central to anyone interested in developing high quality services for people with ID (Reid et al 1989, Rice et al 1991, Hatton et al 1999). Staff provide the interface through which national, regional and organisational philosophies and policies are translated into practical action directly affecting the lives of people with intellectual disabilities. As staff constitute the largest slice of revenue expenditure in services, increasing the quality of staff performance is crucial if scarce resources are to optimally benefit people with ID (Hatton et al 1999). Residential workers, in particular, perform a demanding job, often under difficult circumstances (Hatton et al 1999).

There is evidence to support the notion that staff find organisational factors, rather than aspects of user behaviour as more stressful in the work place (Hatton et al 1999). Working with people with learning disabilities does not inevitably lead to high stress; rather various factors may be important in reducing stress (Hatton et al 1999). Hatton et al (1999) identify a number of different factors, among these factors include: lack of job security (Rose 1995), lack of further training and skill development (Hatton et al 1993, Rose 1995), a lack of participation in organisational decision making (Hatton et al 1993), links between high staff stress and conflicting demands between work and home (Hatton et al 1995, Rose 1995). These areas are of particular interest as they fall under the remit of strategic human resource management.

To date, there remains a dearth of research in addressing the linkages between SHRM and organisational effectiveness within the IDC sector. This research aims to address this gap in the literature, investigating the linkages between the effective management of human resources, with specific reference to HPWS, and organisational effectiveness in the IDC sector in Ireland. The purpose of this research is to investigate the extent to which HPWS are implemented within IDC Centres in Ireland at an organisational level.

3.1 Method

Questionnaires were sent to the Human Resource manager in each of the 93 IDC centres in Ireland. Managers were asked to complete the questionnaire from an organisational perspective. A postal questionnaire was chosen as the most appropriate means of gathering information. It was constructed in a way that was easy to understand, follow and answer. The postal questionnaire ensured that data collected was unbiased and independent. Questionnaires were distributed in a sealed envelope with a stamped addressed return envelope and a covering letter from the researcher. The cover letter outlined the purpose of the research, explained that all of the completed questionnaires would be treated confidentially and provided the address and telephone number of the researcher if further clarification or assistance was required. In an attempt to generate a greater response rate follow up surveys were sent out and a series of follow up telephone calls were conducted.

The questionnaire was designed with a combination of open ended, closed and likert scale questions. There were two objectives in mind when developing this questionnaire. These objectives are outlined below:

3.1.1 Profile of the centres/ IDC sector: Before gathering data about HPWS general organisational information was sought. In an attempt to put the research and findings into context it was necessary to build up a profile of each centre, thus creating an overall profile of the sector. Sections 1-3 of the survey dealt with these issues. These sections explored areas such as employee details, organisational details, details of service users and overall organisational strategy.

3.1.2 HPWS: The remainder of the questionnaire dealt with HPWS within each individual centre. This was broken down into 7 different sections: (1) Recruitment and Selection, (2) Performance/Reward Management, (3) Quality Orientation, (4) Employee Involvement, (5) Work Organisation, (6) Diversity and Equality, and (7) Training and Development.

3.1.3 Sample

The sample used in this research was compiled from “The Directory of Services for People with Intellectual Disabilities” (note 4) which was issued by Inclusion Ireland (note 5). A total of 93 centres were contacted. The total response rate thus far is 26% (note 6). Though this response rate may appear low, it is well within the boundaries of previous HRM studies (Becker and Huselid (1998) reviewed previous HRM studies and reported response rates ranging from 6 to 28 per cent, with an average of 17.4 per cent)

SPSS was used to analyse the data. Some of the key findings are highlighted below.

4. Findings

4.1 Organisational Information

The aim of this section is to help set the context for which this research was carried out. This section examines the services offered within the centres surveyed and the profile of service users and employees in each of the research sites.

Of the total number of centres surveyed 70% were stand alone (note 7) centres. Each of these centres offers one or more services to service users. Table 2 highlights 11 different services, showing the percentage of centres that offer each particular service and the average number of service users that avail of the services in the different centres.

As can be seen from table 2, the most frequently offered service in centres is 7 day residential care which is offered by 90% of centres surveyed, followed by day care services (86%). The service with the highest number of average service users is day services (60%) followed by 7 day residential care. It is worth noting that the day services offered were offered to both residential and non residential service users.

4.2 Profile of Service Users

Figure 1 shows the total breakdown of service users based on the severity of their intellectual disability. As can be seen from figure 1 the largest represented group in the centres surveyed are those with moderate intellectual disability, with 47% fitting into this category. This number is slightly higher than that noted on the intellectual disability database in 2007, where 35% of those with ID were registered as moderate.

Figure 2 shows the breakdown of service users in the centres surveyed by age and gender. The ratio of males to females in the centres surveyed was 1.13:1, this figure is slightly lower than that identified by Kelly et al (2007) where they identified a ratio of males to females at 1.29:1. The total number of male service users in the centres surveyed was greater in all categories except for the >40 age category where the number of males registered was 1% lower than the number of females registered.

A total of 2,636 service users were captured in this survey. The average number of service users per centre was 126 (max 419, min 10). The literature previously highlighted an increase in the number of people registered with an ID. Again this was reflected in the survey conducted. 57% of centres surveyed indicated a change in the number of service users in the last five years. The number of service users increased in all but two centres in the past five years where the centre recorded a 9-12% drop in the number of service users. The average increase in service users across all centres was 25% (range -12% to 125%, SD= 32.74).

When asked if there was a change in staffing levels to reflect the increase in service users 18% said there was no change at all, 24% indicated a little, a further 29% reported somewhat, 18% answered quite a lot and the remaining 11% noted a change in staffing levels to a very great extent. Only one third of centres reported that staffing levels had changed "a lot" or "to a very great extent" as a direct result of the change in the number of service users. This illustrates the increasing demands placed on services and employees in the sector.

When asked of there had been a change in the profile of service users in the past 5 years, 70% noted there had been changes. The two most cited changes in the past five years were

- 1). An ageing population among service users which is putting greater demands on services, especially medical services given the greater level of illness that is associated with old age.
- 2). An increase in the number of males registering and availing of the services.

The next section will look specifically at the breakdown of employees in the IDC centres surveyed.

4.3 Profile of Employees

Across respondent centres the total number of staff was 3,701. The average number of employees per centre was 176 (min=10, max = 635, SD=209.5). The staff to service user ratio ranged from 1:2.91 to 1:0.15 (M= 1:1.4, SD= 0.8). 53% of employees were hired on a full time basis. The second highest category was relief workers (on average 17% per centre). The lowest categories represented were voluntary workers (5%), casual workers (1%) and others (1%).

The highest category of worker represented was care staff (25.3%), with the next highest being nurses (18.9%). The lowest category of workers recorded were doctors, occupational therapists and psychologists (0.2%). The significant difference between the number of care staff and the other categories of employees may lie in the fact that 90% of centres surveyed offered 7 day residential care to service users, thus creating a demand for care staff.

The age profile of those working within the centres surveyed is quite young, with almost 77% of those working in the centres under the age of 50 (77%). This is relatively significant as it means the number of employees lost through retirement in the next few years will be low. On average 76.1% of those working in the centres surveyed are white Irish, with 69% on average of employees in the centres being female.

The following section will look specifically at seven components of HPWS: (1) Recruitment and Selection, (2) Performance/Reward Management, (3) Quality Orientation, (4) Employee Involvement, (5) Work Organisation, (6) Diversity and Equality, and (7) Training and Development, focusing specifically on the usage of each practice.

4.4 Recruitment and Selection

Table 3 shows the main findings relating to recruitment and selection in the centres surveyed.

Only 14% of centres surveyed were administered one or more employment test prior to selection. 62% of centres offered their employees the opportunity to apply for internal promotions, on average this applied to 80% employees. 38% of centres reporting on average 32.6% of their employees holding non-entry jobs as a result of promotions or based upon merit or performance as opposed to seniority. The average range for job security was between 1.5 and 5 (mean = 3.66, SD = 0.779). Here respondents were asked if employment was guaranteed in the centres. Answers were recorded on a scale of 1 (not at all) to 5 (to a very great extent).

4.5 Performance and Reward Management

In the past 12 months, 71% of centres carried out performance appraisals with 34% (on average) of employees. This resulted in 80% of these centres offering training and development to approximately 25% of employees in these centres. While the number of employees being offered training as a result of performance appraisals is relatively low, it is encouraging to see that 80% of centres which carried out performance appraisals followed up on the findings of these interviews. From an employee's point of view this would be significant as it would place greater value and benefit on the process for employees.

Table 4 shows some of the key findings in relation to performance and reward management in the centres surveyed.

From the findings above it can be concluded that there is little reward or recognition given to employees for loyalty to the organisation in most IDC centres surveyed. This is most likely to affect job satisfaction and job commitment among employees. However, it is positive to note that in almost half of the IDC centres surveyed (48%) on average 84% of employees were guaranteed employment based on performance. In essence this should create greater levels of motivation among employees.

Given the high levels of interaction between service users and service providers it is positive to note that in 71% of centres surveyed employees are given feedback on the quality of care they provide to service users. This is a fundamental aspect in ensuring a high quality of care is provided to service users.

It is also worth noting that the benefits of further education is not fully utilised in the IDC centres. In only 24% of centres employees are given extra responsibilities based on the courses they had completed. In many of the centres the true benefit of these courses may not be realised and as a result employees may be reluctant to complete such courses as there is no major benefit to them with regards employment for doing so.

4.6 Quality Orientation

The main focus of this section of the questionnaire was to highlight different aspects of employee quality. Respondents were given a number of statements and asked to answer them on a scale of 1 (strongly disagree) to 5 (strongly agree). These statements included: to what extent do you believe the centres employees; are highly skilled, creative and bright, experts at their job, share information among each other, share ideas, are committed to developing new ideas and solve problems through collaboration. The average range on the employee quality scale was between 3.14 and 4.57 (mean=4.05 SD=0.379)

While looking at the focus in service users, respondents were given a series of statements relating to service user focus within the centres and were asked to rank these statements on a scale of 1 (not at all) to 5 (to a very great extent). The responses ranged between 3.2 and 5 (mean = 4.46, SD 0.43). This showing that for the most part there was a strong user focus in the IDC centres.

4.7 Employee Involvement

Employee involvement looked at the extent to which employees were involved in decision making, how well employees were informed about changes in the centres, employee suggestions with regards changes, involvement with the running of the centres, employees expressing their concerns. The average range for employee involvement was between 3.2 and 4.9 (mean= 4.08 SD=0.389). Furthermore, in 76% of centres, on average 46% of employees are involved in programmes designed to elicit participation and employee input, again showing that employee participation was viewed as important in the centres surveyed. In 81% of centres, on average 76% of employees are provided with strategic information relating to the centres.

Although there is evidence to suggest that emphasis is placed on employee participation within the IDC centres, there is also evidence to suggest that the same emphasis is not placed on communication between managers and employees. The scores for communication between managers and employees on organisational and employment issues was significantly lower with a range between 2.2 and 4 (mean = 3.42, SD 0.517). This indicates that communication between management and employees on issues, for example, such as pay, employee issues, future plans, work organisation, government regulations, ranges from rarely to often.

Although most centres scored relatively well with regards employee involvement, it is worth noting that the area which is lacking is communication between management and employees.

4.8 Diversity and Equality

Although 76% of centres had a formal policy on equal opportunities, only 12% of these (74%) centres measured the effects of the policies on their employees. Only 12% of all centres surveyed measured the effects of equal opportunities as a whole. While it is encouraging to see the uptake on equal opportunities is high, it is worrying to note that the benefits of doing so is not measured in the majority of centres surveyed.

4.9 Work Organisation (*Work Life Balance and Teamwork*)

4.9.1 Work Life Balance

There was quite a disparity in ranges for work life balance in the centres surveyed. The range was between 2 (rarely) and 5 (to a very great extent) (mean= 3.88, SD=0.728). The availability and uptake on flexible work arrangements within the IDC centres surveyed is quite low. Table 5 highlights the main flexible work arrangements and the number of centres which offer these arrangements.

Overall, as can be seen from table 5, the offering of these flexible working arrangements is quite varied. The uptake of each of these flexible work arrangements was also quite low, with uptake being less than 20% (on average) in each case. Reduced working hours had the greatest uptake at 18% while the lowest uptake was recorded for parental leave and annualised hours (6.5% on average).

4.9.2 Team Work

In 62% of centres, on average 81% of employees are organised in self-directed work teams in performing a major part of their role. The average range for teamwork was between 3.5 and 5 (mean =4.27, SD=0.446). From this it can be concluded that a relatively strong emphasis is placed on team work within the IDC centres.

4.10 Training and Development

It is positive to note that 38% of respondents noted their centre carried out diversity training with their employees. On average 48% of employees in these centres were involved in such training, while 38% of centres have an employee at management level assigned as a champion of equality and diversity. Table 6 highlights a number of different types of training, indicating the percentage of centres that offer this type of training.

The centres offering training is low in many areas. Four categories noted over 50% of centres offering training in that particular area (health and safety, abuse guidelines, infection control and how to handle confidential information about service users). However, in centres where training was offered on average over 50% of employees received that particular type of training in the past 12 months.

5. Limitations

There are a number of limitations to the research that the authors would like to highlight. Firstly these findings represent a sample size of 26% of the entire population. Although, as stated earlier Becker and Huselid (1998) reviewed previous HRM studies and reported response rates ranging from 6 to 28 per cent, with an average of 17.4 per cent. Also, there may be a respondent bias between those who choose to return the questionnaire and those who did not. A larger sample size would allow for a more representative analysis of the sector. Secondly, the questionnaire is descriptive in nature which does not allow for in depth statistical analysis.

5.1 Areas for further research

The aim of this survey was to identify how far HPWS have expanded into the sector. Further research is merited to incorporate a larger sample size. Also, this research focuses on an organisational level. Further research needs to be carried out to gain individual and team insights into the application of the different components of HPWS within these research sites. This would allow for a comparison between results reported at an organisational and individual/team level. Also research should be carried to identify the impact of HPWS on the overall quality of care in the sector.

6. Conclusion

Although the findings from the survey are not extensive and the sample size only represents 26% of the IDC centres in Ireland, the findings do give us some important insights into the different utilisation of the components of HPWS in the sector. These findings may offer some practical insights for managers in the IDC sector. The key insights are offered hereafter.

The areas of HPWS in which the centres achieved the highest scores were service user focus (mean 4.46, SD 0.43) and teamwork (mean 4.28, SD 0.446). Having a strong service user focus is essential within IDC centres given the low level of technical interventions in the sector; services are fundamentally reliant on service personnel and the interaction between service users and service providers. Teamwork is essential in healthcare organisations as it enables shared knowledge and understanding about patients' needs, good decision making, lower error rates, and more effective patient recovery (Borrill et al 2000; Firth-Cozens, 1998; West & Borrill, 2006; West et al 2006).

The area scoring least favourably was communication between management and employees (min 2.2, max 4 mean 4.2, SD 0.446). This lack of communication between management and employees is worrying. Lack of communication between managers and employees has a number of implications; it can impact on the quality of care provision, can lead to a lack of information sharing and can lead to ineffective decision making.

In the past 12 months, 71% of centres carried out performance appraisals. This resulted in 80% of these centres offering training and development to approximately 25% of employees in these centres. West et al (2006) note the importance of performance appraisals to clarify individual roles and objectives, to provide feedback on performance, to determine developmental needs and to communicate to employees their importance and value to the organisation. As a result of performance appraisals employees are likely to perform their roles more effectively, there is greater clarity about roles and objectives as well as developmental needs. An important area that needs to be addressed in the IDC sector relates to the developmental needs of staff. The number of employees offered training as a result of performance appraisals is relatively low (approximately 25%). Failing to meet the development needs of employees can lead to stress, as noted by Hatton et al (1999).

The average range for employee involvement was between 3.2 and 4.9 (Mean=4.08 SD =0.389). Employee involvement and decision-making are critical in health care organisations. Preuss (2003) notes that decision making can increase employee knowledge, information sharing and high quality of care. Hatton et al (2003) also notes the importance of employee involvement and participation and decision-making and concludes that lack of same can lead to higher levels of organisational stress among employees.

The offering of flexible working arrangements was quite varied among centres. Where offered, the uptake of each of these flexible work arrangements was also quite low, with uptake being less than 20% (on average) in each case. Reduced working hours had the greatest uptake at 18% while the lowest uptake was recorded for parental leave and annualised hours (6.5% on average). The availability of flexible working arrangements is quite significant given 69% of employees in the centres surveyed are female, in a society where females are viewed predominantly as the primary care giver in the home. Although the percentage of employees availing of these arrangements is low, their availability is significant. Hatton et al (2003) note that high levels of stress in the IDC sector can be linked with conflicting demands between work and home.

Given the recent changes in the sector and the increasing demands being placed on employees and services it is essential to ensure the quality of care to service users is not jeopardised. The literature to date provides arguments that support the importance of SRHM and HPWS in healthcare settings. West et al (2006:944) note that, "HR systems are related to the quality of healthcare and specifically patient mortality in hospitals. Above and beyond the effects of a set of important controls, our results suggest that people management systems that emphasise a set of complementary 'high involvement' policies and practices (i.e., an emphasis on training, performance management, participation, decentralised decision making, involvement, teams, and employment security) may be successful in contributing to high-quality healthcare." This research supports the argument put forward by West et al (2006) and proposes that through the efficient use of employees, and fully utilising employees, the quality of care provided will be maximised and increased through the use of HPWS.

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Notes

Note 1. The HSE has full responsibility for Health Services in Ireland since Jan 1st 2005.

Note 2. The Intellectual Disability Database was set up in 1995. Currently, each HSE area has a co-ordinator who compiles regional statistics regarding intellectual disabilities in his/her area. These regional statistics are then combined to formulate national statistics and are passed onto the Health Research Board where the statistics are analysed and converted into an annual report. The database contains information about people who are receiving intellectual disability services in Ireland along with people who are currently in need of such services.

Note 3. The prevalence rates for 2007 have been calculated using the 2006 census; the population has increased by 8% since 2002, whereas the numbers registered with ID have only increased by 0.4% since 2006, this explains the small decline in the prevalence rates from 2006-2007.

Note 4. This is a comprehensive listing of all the agencies providing services to people with intellectual disability in Ireland.

Note 5. Inclusion Ireland is National Association for People with an intellectual disability. Their mission is to be the independent champion of people with an intellectual disability and their families whose standing and expertise in intellectual disability is acknowledged and to ensure that people with an intellectual disability have their voices heard, are not isolated or segregated and lead more independent lives.

Note 6. 93 surveys were sent out. 9 responded stating that survey did not relate to their centre. 3 of the centres were under the same management. 21 completed surveys in total.

Note 7. Stand alone centres are independent centres that do not fall under an umbrella organisation such as The Brothers of Charity, The Daughters of Charity.

Table 1. Recent Trends within the IDC Sector in Ireland (2003-2007)

Year	2003	2004	2005	2006	2007
Total number registered on the National Intellectual Disability Database	25,557	25,416	24,917	25,518	25,613
Total number in receipt of services	23,464 91.8%	23,843 94%	24,078 97%	24,556 96%	24,898 97%
Total Number in receipt of full-time residential services	8,092	8,093	8,073	8,181	8,262
Total number availing of at least one day programme	23,011	23,645	23,914	24,386	24,729
Ratio of Males to Females	1.26:1	1.28:1	1.27:1	1.31:1	1.29:1
Prevalence rate per 1000 of population	6.52	6.49	6.36	6.51	6.04
Prevalence rate for mild intellectual disabilities per 1000 of population	2.38	2.30	2.16	2.18	1.96*
Prevalence rate for moderate, severe and profound intellectual disabilities per 1000 of population	3.72	3.73	3.72	3.74	3.48

(Adapted from the Intellectual Disability Database Report 2003-2007) (Note 3)

Table 2. Services offered per centre and average percentage of service is each centre

Service Offered	Percentage of centres surveyed that offer this service	Average percentage of service users that avail of this service where offered
7 Day Residential Service	90%	49%
5 Day Residential Service	48%	6%
Community Based Housing	52%	29%
Day Services	86%	60%
Training Services	57%	17%
Respite Care	67%	22%
Shared Care	19%	11%
Home Support Services	38%	8%
Supported Employment Programmes	52%	12%
Special School	29%	15
Other	38%	41

Table 3. Recruitment and Selection Issues

In your centre.....	% of respondents who answered yes
Were employees administered one or more employment tests?	14% (n=3)
Were employees hired on the basis of intensive recruiting efforts resulting in many qualified applicants?	57% (n=12)
Do any employees hold non-entry jobs as a result of internal promotions as opposed to hired from outside the organisation?	38% (n=8)
Do any employees hold non-entry jobs due to promotion based upon merit or performance as opposed to seniority	48% (n=10)
Do any employees have the opportunity to apply for promotion	62% (n=13)

Table 4. Performance and Reward Management

Please answer yes or no to the following statements.	% of respondents who answered yes
Are employees given feedback on the quality of care they provide to service users?	71 (n=15)
Do employees receive pay that is partially determined by a person’s skills or knowledge level as opposed to the particular job they hold?	19 (n=4)
Are employees guaranteed continued employment based on performance?	48 (n=10)
Are employees given rewards based on seniority?	19 (n=4)
Are employees given extra responsibility based on courses they have completed?	24 (n=5)
Are employees rewarded based on loyalty to the organisation?	14 (n=3)
Do employees have access to a formal grievance/complaints procedure?	81 (n=17)

Table5. Flexible Work Arrangements

Flexible work arrangement	% of centres that offer this arrangement
Flexi-time	43% (n=9)
Reduced hours of work	90% (n=19)
Annualised work hours	24% (n=5)
Work only during school term time	24% (n=5)
Job-sharing	71% (n=14)
Parental leave	90% (n=19)

Table 6. Training Offered

Type of training	% of centres that offer this training
Health and Safety	52 (n=11)
Manual Handling	43 (n=9)
Abuse guidelines	52 (n=11)
Basic life support	29 (n=6)
What to do if there is a major incident or emergency	38 (n=8)
How to prevent or handle violence and aggression to either employee, patients or service users (e.g. TMAV training)	43 (n=9)
Infection control (e.g. guidance on hand washing)	71 (n=15)
How to handle confidential information about service users	52 (n=11)

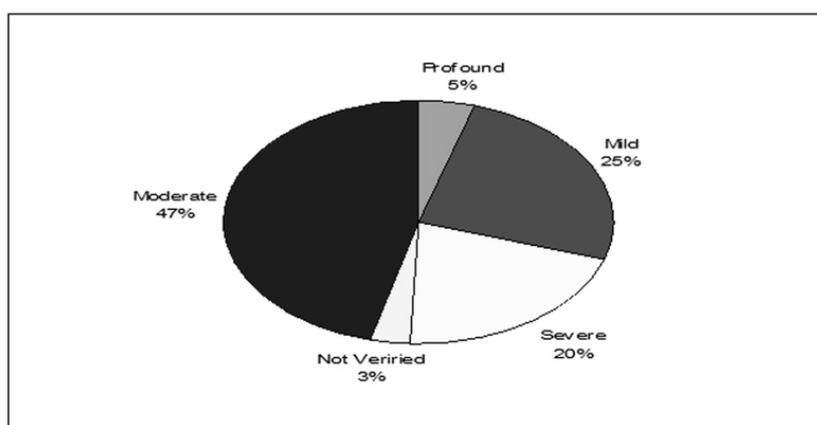


Figure 1. Breakdown of Severity of Intellectual Disability among Respondent Centres

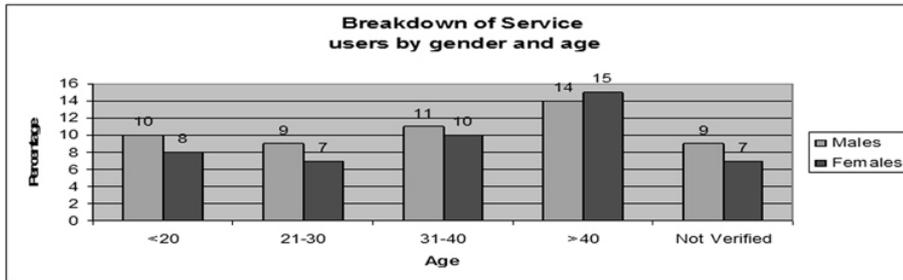


Figure 2. Breakdown of Service Users by Gender and Age