How do department managers in A1 hospitals in Victoria make decisions on the work-life balance (WLB) issues of their staff?

Submitted by

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List of Acronyms and Abbreviations

ADO	Accrued Day Off
AHRP	Australian Human Resources Institute
ANF	Australian Nursing Federation
AWA	Australian Workplace Agreements
BB	Baby Boomers
BCA	Business Council of Australia
CEO	Chief Executive Officer
CSU	Clinical Specialist Unit
DoH	Department of Health
EAP	Employee Assistance Program
EBA	Enterprise Bargaining Agreement
EEO	Equal Employee Opportunity
HR	Human Resources
HREOC	Human Rights and Equal Opportunity Commission
HSUA	Health Services Union Australia
IRPP	Institution for Research on Public Policy
IT	Information Technology
KPI	Key Performance Indicator
LSL	Long Service Leave
LWOP	Leave With-out Pay
MWLBIA	Managing Work Life Balance International Australia
NHS	National Health Service
OH&S	Occupational Health and Safety
SHRM	Society for Human Resource Management
UK	United Kingdom
VMIA	Victorian Managed Insurance Authority

WLB	Work-Life Balance
WR	Workplace Relations

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Abstract

The working environment has been under constant change, as traditional boundaries of work blur, the rapid pace of changing technology, expectations of new generations of workforce and consumers demand a more interactive and accessible service. The paradigm shift is transforming how we view work, and how we perform it. Increasingly policy makers, employees and the workforce are aware of the connections between work and health, and work and wellbeing. Achieving Work/Life Balance is becoming increasingly important to the current and future generation of workforce. In trying to achieve a balance between work and other life demands, organisations and individuals are seeking better ways to address the current discord.

A growing body of literature and research is emerging that looks at the issues and initiatives that surround the attainment of work life balance. Work life balance is an area that is of increasing importance to both employees and organisations, as the former seek to balance work and non work roles, and the later are striving to effectively meet organisational objectives. Middle line managers are often the people who are at the coal face of trying to attain the balance in order to satisfy the individual, organisational and legislative objectives.

The aim of this research was to explore what resources are available to support how department managers, in A1 hospitals in Victoria, make decisions on the work-life balance (WLB) issues of their staff, whilst maintaining service provision and achieving organisation effectiveness. The definition of work life balance for the purpose of this thesis is that work-life balance is achieved when there is no work-family conflict.

The research involved the collection of data from the four A1 public metropolitan teaching hospitals located in Melbourne. The data was collected by conducting structured in-depth interviews of both middle managers (12) and senior human resource managers (4) and examination of their associated WLB documentation. The documents examined included policy and guidelines generated by the organisations and those that the hospitals were required to respond to, including a range of Department of Health policy and regulations. Once the interview data had been collected and analysed using inductive thematic analysis, certain categories were identified and then used for the documentation data comparison.

The findings of this study were that the A1 hospitals utilised for this study had limited policy and or guidelines to assist managers implementing equitable WLB decisions within their own departments. The Managers identified that their decision making in regards to WLB needs were underpinned by the understanding of operation requirements, experience, knowledge of enterprise bargaining agreements, past decisions and direct impact on local departmental service delivery requirements, i.e. roster and skill mix.

The conclusion drawn from this research is that the current state of a lack of WLB organisational strategy and policy in A1 hospitals affects on how middle managers attempt to address the WLB needs of their employees and organisation operational demands with limited direction. Therefore managers are adopting methods which fall short of meeting future employee needs and, potentially, the organisation's. It is essential therefore that A1 hospitals move forward to resolve WLB policy requirements. Hospitals need a plan to maintain happy and healthy staff and assist managers that are under constant pressure and tension to provide basic daily services.

Statement of Authorship

Except where the reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or part from the thesis or any other degree or diploma.

No other person's work has been used without due acknowledgement on the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

All research procedures in this thesis were approved by the Faculty Human Ethics Committee, Faculty of Health Sciences, La Trobe University (Reference: FHEC09 / 60).

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Introduction

The working environment has been under constant change. Managers seek to modify structures and processes to align with current trends and needs. In more recent years, the skilled labour market has grown from local to national and now global, which has increased employers' competition for workers, and the need for employers to create new ways to attract and retain staff (Pocock, 2003, p. 45). This change in context on employment, coupled with younger generations of staff (X and Y's) with distinct differences in values and views on authority and personal needs than Baby Boomers, increases the ability to meet local service requirements (Lander, 2006; McNulty, 2006). In recognising changing employee needs, hospital executives and managers have had to re-examine hospital and departmental service requirements, to incorporate the needs and responsibilities of employees in both their working and non-working environments.

The concept of 'Work-life balance' is discussed in a range of management literature. The literature highlights the importance of exploring and understanding managers' views of WLB and their understanding of what the concept means to their staff". Analysis of the research available showed how current conditions and characteristics of the workplace are directing organisation change, so that managers and leaders are moving to develop environments that can accommodate WLB and associated cultural changes.

Time spent at work and the time spent away from work is defined as 'in balance' when one does not intrude or dominate the other (Carlson et al., 2009). Managers' understanding of their workers' needs is imperative in daily interaction, but also requires accessible hospital resources to assist and enable them to make decisions for staff work-life balance (WLB) requests (McCarthy et al, 2010). Knowing what (if any) resources are available and how managers make use of them, allows an insight into the nature of a manager's job, and the impact on the working environment when deciding on staff WLB requests. Also, whether decisions made by department or middle managers are trialled and tested before being implemented, thus creating an environment and culture in which senior managers perceive the employee as an asset to the organisation. As there are skill shortages in the health workforce, managers' decisions relating to

the work-life balance of their staff have a significant impact on such factors as the employment and retention of workers, and consequent maintenance of service delivery (Chaykowski, 2006).

The central question in this thesis is: How do department managers in A1 hospitals in Victoria make decisions aimed to improve or enhance the work-life balance of their staff? Through individual interviews with managers and senior human resources managers this study establishes the types of WLB requested by staff, and identifies the resources their managers rely on in making decisions in response. This study therefore investigated the following areas:

- Managers' understanding of WLB.
- Types of WLB requests being asked of middle managers and senior human resource managers.
- The resources available to middle managers when making decisions.
- The constraints on middle managers making and implementing these decisions.
- Organisational structures affecting the degree of support for managers.
- Managers' basis for their decision making

The approach used was to interview managers in the five main Victorian Public Metropolitan teaching hospitals in Victoria (known as A1 hospitals). Each is of similar size, complexity of service, with the same funding and policy guidelines, and are all overseen by the Victorian Department of Health. The managers interviewed had to be managing staff WLB issues. Managers also had to be aware of existing processes and be able to use them, and to know the hospital's most senior executives' point of view, the views of Board members, and how these views and opinions, as part of hospital policy, should be incorporated in fulfilling service requirements, and in making and implementing departmental decisions.

To establish the A1's hospital managers' understanding, of what the WLB requirements were within their organisation, it was necessary to investigate and identify the employees' WLB issues and problems that arose within the working environment. It was also important to assess how WLB requests and employee WLB expectations affected management-staff relations within the working environment, in conjunction with the effects of available departmental and organisational support, other managers' decisions, and any employer-employee agreed outcomes (Maxwell, 2005). In addition, hospitals are influenced by the external environment, to the extent

that there are government rules and regulations, and union awards that hospital managers have to take into account when making their decisions on staff requests – e.g., state and federal legislation, Department of Health (DoH) policy, Enterprise Bargaining Agreements (EBAs), etc.

Workers' expectations of job conditions have also changed over the last 20 years. Employers have experienced new generations of workers who view their roles in the workplace differently from past generations of workers (Kehril & Sopp, 2006; Vincola & Farren, 1999). Organisations have to manage these changes and devise policy to accommodate new needs and expectations. Employers have to take the initiative and look at work practices within this new and changing environment, to help balance employees' work-life commitments, so that staff can raise their productivity and remain an asset to the organisation (The Building Commission, 2005).

In response to the changing needs of both employer and employee within the work place, many organisation managers have initiated different strategies to create a productive working environment. These strategies have included seeing the employee as the most important asset, or implementing a versatile workforce which could meet changes in workflow; while others have done little or nothing. The impact of any strategy on day-to-day operations depends on the knowledge and methods of those managers implementing the planned strategy, and a manager's ability to meet the needs of organisations and employees, as well as their own needs.

Reviewing the literature and current policy documents led to further discussion of these issues and problems, and of the problems managers encounter around WLB. The solutions they devise in their workplaces can be compared with what other solutions managers in the wider community are implementing, which could help managers see how decisions made today can create satisfactory future outcomes for both employees and for the organisation and improve outcomes for all groups.

Organisation of Thesis

This chapter (introduction) describes the background and nature of the study to be conducted.

Chapter one covers the literature review, centred on the question of work-life balance in industry in general, and in healthcare, to explain where WLB fits into hospital policy, and the need for

organisations and managers to consider change, to incorporate this new issue into the prevailing culture.

Chapter two contains the methodology, covering the methods for data collection (internal and external documentation, and one-on-one in-depth interviews). It also covers the application for ethics approval, and the organisation of the interviews with A1hospital middle and senior human resource managers. Finally, the use of grounded theory and thematic analysis of interview data collected is discussed, with reference to the process of analysis and formulation of categories and sub-categories of themes.

Chapter three contains discussion of the analysis of the documented legislation and guidelines governing activities in the Victorian A1 hospitals. There are two sections: first, an examination of the official documentation used to assist managers in implementing WLB decisions; and second, discussion of the gaps and shortcomings in the official documentation, with reference to such decisions.

Chapter four covers analysis of the data obtained from in-depth interviews with three middle managers and a senior human resources manager in each of four Victorian A1 hospitals (a total of 16 managers). The discussion focuses on the categories and sub-categories identified through thematic analysis of the data collected, relating to: the types of requests made by staff, resources available to managers to assist in the decision process, and the outcomes of the middle managers' decisions.

Chapter five provides discussion of the data collected and analysed for this study, outlining the key findings of this study, conclusions and recommendations for further research into the topic of work life balance.

Chapter 1 Literature Review

Introduction

The provision of a hospital service to the community in Victoria is a very complex process comprising many individual services provided by employees within different groupings of disciplines and skills. These workers are employed within a Public hospital system under the same rules and regulations across many organisations to promote collaborative care for the benefit of their patients. The success of a service relies heavily on middle managers within the organisation to ensure that the necessary skilled staff are available to provide the service. While these managers are primarily concerned with the provision of the service, they must also consider the needs of staff in order to be able to attract and retain the necessary skilled staff. One aspect of employee needs that impacts on attraction and retention is the need for work-life balance. Work-life balance is therefore a concern of hospital staff and their managers.

In this chapter I review the literature on work-life balance (WLB) within the broader literature on management and healthcare. There were two main areas of WLB identified: the first was related to flexibility within the working environment, and the second focused on conditions outside the working environment. These two areas were each subdivided into two further sections as follows: the needs of the employees, the requirements of the organisation and its policy, the community needs, and other, or external, information. This final aspect incorporated changing labour conditions and social trends. It was these four streams that were explored in detail. The literature was reviewed in relation to the non-healthcare workplace as well as the healthcare environment. In all work environments managers have to manage employees and any consequences that arise from the work/non-work interactions. It follows therefore, that both managers and employees expect that ‘a balance’ between work and non-work, known as work-life balance (WLB), would be desirable to allow functional service provision.

The information within this chapter was derived from searches of academic databases, including ProQuest, Emerald, PubMed, EBSCOhost and Sage. This enabled the identification of relevant books and journals, workplace documentation that provided empirical evidence related to WLB, as well as the views of independent consultants. The terms used to search these resources included: healthcare management; work-life balance; WLB; wellness; human

resources; government; independent consultants; and policy. In addition to these sources I reviewed the relevant legislative and policy documents outlined in the State Annual Policy and Funding Guidelines and the Federal National Healthcare Agreement.

Research in WLB covered a wide group of industries and appeared in a broad range of topics. Many of the research topics covered specific groups such as female workers returning from maternity leave, part time or casual staff (Cameron, 1998), skill retention (Newman & Maylor, 2002) and reviews of work-life initiatives. Another piece of research of a larger groups of workers that included human resources and senior managers, demonstrated similar initiatives (Bardoel et al., 2008). Research about WLB has become increasingly popular in the last 10 to 15 years in line with a broadening employee market, and because organisations need to develop work-life strategies to attract staff and educate the leaders and managers responsible for the implementation of such strategies, and to implement the necessary culture shift within the workplace to achieve them (Managing Work Life Balance International Australia [MWLBIA], 2007b; Jerg-Bretzke & Limbrecht, 2012; Stutzer, 2012).

Government bodies and employee unions have referred to WLB as a desirable characteristic for at least a decade, often under the umbrella of workplace reform (Nursing EBA, 2007-2011; State Services Authority 2005). Most of the discussion and subsequent changes by management to resolve WLB problems have been in the form of adopting the idea of a flexible work environment or flexible work force management (Brannon, 1994; Kropf, 1996; Wagenaar et al., 2011; Moore, 2007). Flexible working environments are becoming a prominent feature in many industries. Discussion documents, relating to both corporations and the broader industry context, have outlined guidelines and initiatives in relation to WLB (Nicholson & Nairn 2006; Bardoel et al., 2008). The Victorian Building Commission (2005) has designed its own ‘spectrum’ diagram that has identified what they believe are required initiatives for meeting the WLB needs their staff. This spectrum provides a comprehensive overview of aspects they have identified as requirements of WLB, namely:

- Health and Wellbeing
- Leave Provisions
- Supporting Families
- Supporting Workers without Caring Responsibilities
- Flexible Work Arrangements
- Supporting Older Workers
- Personal Development

- Information and Resources
- Facilities
- Community

These initiatives are provided with the expectation that by better balancing work and life commitments, organisations will reap the benefits (The Building Commission, 2005). This format may be reproducible and applicable across a range of workplaces (Kropf, 1996; Gresham, 2004; Nicholson & Nairn, 2006; McCarthy et al., 2010; Poelmans et al., 2008). The initiatives highlight four policy areas: the needs of the employees, the requirements of the organisation and its policy, the community needs, and other, or external, information. These four areas (also outlined on page 1) are used throughout this thesis, for consistency and continuity.

The literature can furthermore be understood through the lens of Mulvaney et al's model of work-family issues, developed for use in the tourism industry by Deery and Jaga (2009). See Figure 1.

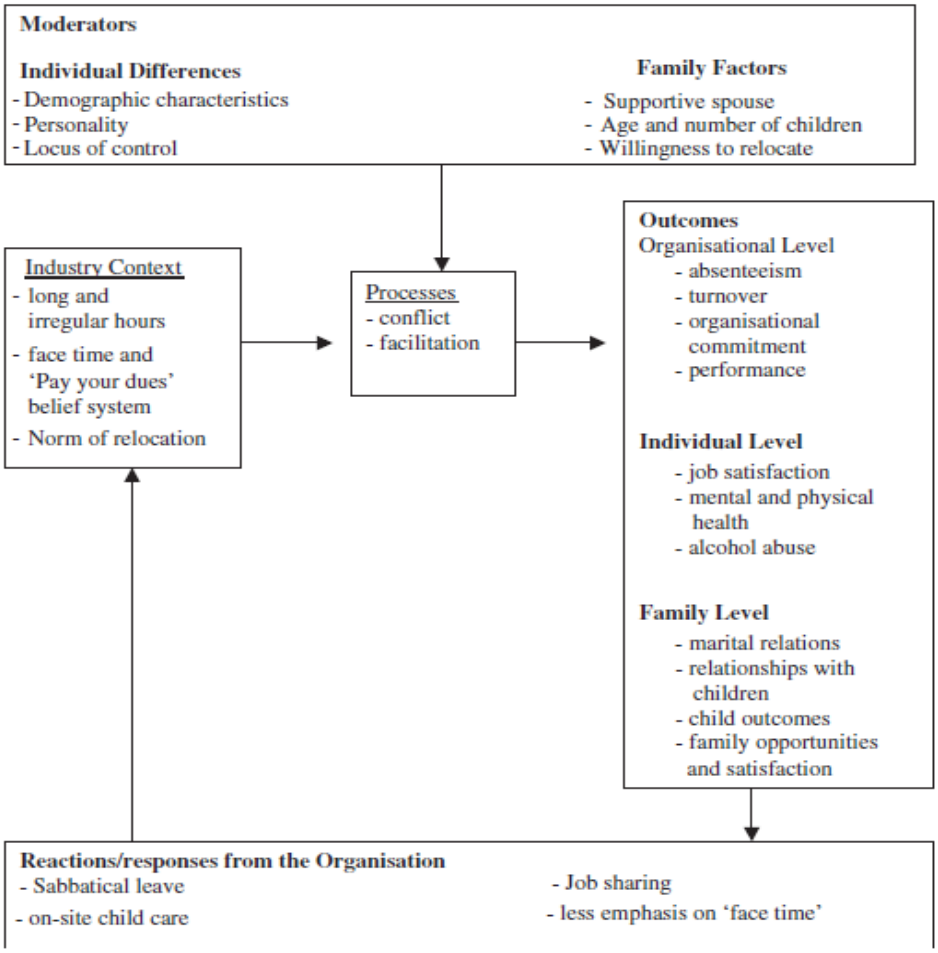

Figure 1: A proposed model of work–family issues for hotel managers (Mulvaney *et al*, 2006).

The model incorporates the four policy areas identified above (p1) the needs of the employees, the requirements of the organisation and its policy, the community needs, and other, or external, information. Specifically these are identified within the model as individual difference, outcomes, industry content and family factors. What is missing from this model is an understanding of the processes or resources that are in place for middle managers to use in WLB decisions and the organisational responses that assist managers in facilitating these processes. This thesis will attempt to fill this gap, focusing in particular on WLB processes within A1 hospitals.

What is Work-Life Balance?

So what is work-life balance? Chaykowski (2006) defines WLB by seeing the role of workers in relation to the conflict between their performance at work and the demands facing them at home, as a work-life conflict or role overload.

The literature review outlines that defining WLB is difficult. More importantly, research shows that the idea of WLB has different meanings to different workers and organisations (Kalliath & Brough, 2008). Researchers have looked at the difference between work and home and have described this difference using a variety of terms that represent a similar concept. These include 'conflict' (Chaykowski, 2006), 'collision' (Pocock, 2003), 'roller coaster' (Bryson et al., 2007), 'effectiveness' (Lingle, 2004), 'initiatives' (Bardoel et al., 2008), 'see-saw' (Gettler, 2007), 'projects' (Schneider, 1996), 'strategy' (MWLBIA, 2007b), 'benefits' (Abbott & De Cieri, 2008), 'work-family interaction' (Halpern & Murphy, 2005), 'work-personal life' (Bourke, 2000) and 'alignment' (Parkes & Langford, 2008). Many of these terms reflect arguments from different perspectives but have not advanced theoretical insight into what WLB is, and the practical human resource interventions for achieving it (Kalliath & Brough, 2008). Overall, these alternative terms suggest that the definition of 'balance' may be elusive but it is important to agree on what it means before moving forward and working on a solution. For the purpose of this thesis the researcher's understanding is that work-life balance is achieved when there is no work-family conflict, a definition provided by Carlson et al. (2009).

What has an impact on Work-Life Balance

There have been fundamental changes in the labour market, including workers' levels of education, new technology, leisure, employment methods, and changes in the roles that men and women have in the household (Wagenaar et al., 2011; Hall, 1990). Chaykowski (2006) looked extensively at work-life conflict in work-family and family-work balance through a range of contexts including; changes in the size of companies, workers with regular jobs and those with non-standard jobs, the ageing workforce, and the increase in women in the workforce. He concludes that there is a cost to the organisation and workers that stress creates, shown in absenteeism and job effort. Therefore policy action is required by both government and organisations to improve WLB policy and work these in parallel with competitive organisational pressures such as labour costs, new technology and management practice. Policy also has an important dimension to not only reduce loss of productivity but to reduce society health costs, therefore policy needs to be carefully targeted to help resolve work-life conflict

Welfare and Community – external influences on Healthcare and Non-Healthcare workers

Many circumstances have changed within the community over time including the makeup of the workforce and community expectations in regard to work and home life (Australian Bureau of Statistics, 2003; Lander, 2006; McDonald et al., 2005). Below are some of these changes that have occurred in the last 15 years:

- Increase in single parent families.
- Same sex parents.
- Changing attitudes towards work – different generations.
- Living longer.
- Older work force.
- Increase in part time and casual staff.
- More specialist roles.
- Connectivity – internet, e-mail.
- Longer working hours.
- Workers' Expectations.
- Responsibilities for older parents

State and Federal Governments and Consultants

The research showed that legislation and government authorities make reference to workers' rights, which have to be integrated into working conditions along with flexibility within the working environment (State Services Authority, 2005). Flexi-time, accrued days off, maternity leave, paternity leave, and time-in-lieu are all examples of inclusions in workplace agreements that have been negotiated with government and enacted for the benefit of employees (Nursing Enterprise Agreement 2007-2011).

In support of the rights of individuals in the workplace there have been Acts such as Equal Employment Opportunities (EEO), Anti-Discrimination and Workplace Relations. These Acts are being incorporated into EBAs to enable some specific work-life issues to be integrated from legislation into a system/industry level. An example of this is outlined in the 2007-11 Australian Nursing Federation (ANF) public sector claim for Victorian legislative changes in Occupational Health and Safety (OH&S) and workers' compensation. The authors of these documents tend to view the rights of individual workers as a whole, and do not necessarily relate the claims to individual distinct work environments. It could be said that the provisions of the EBAs draw on the rights outlined in these documents to assist health care managers (in the Victorian public sector), in bringing the employer and employee together, to

look at how to integrate their separate demands into the work procedures of the organisation (WLB Report; Office for Workforce Development, Department of Premier & Cabinet, 2004).

Queensland governments in the late 1980s and early 1990s introduced measures to enhance workplace flexibility. However, this flexibility produced both greater work efficiency and intensification of employee workload, with a negative effect on staff (Allan, 1998). It has been suggested that organisations need to 'work smarter' to improve efficiency. In hospitals this efficiency is primarily related to the need to reduce waiting times for patient service with fewer staff numbers. Allan (1998) has said that work intensification needs to be looked at independently from labour adjustment, as intensification referred to the efficiency of the labour employed, but employers were using this tool for a labour reform process to reduce staff numbers. Allan (1998), by contrast, concentrated on the well being, turnover, morale, quality of the staff employed, and how they were 'in themselves' while providing services in the hospital. Thanacoody (2009) agrees with Allan but goes further, indicating this intensification can ultimately lead to burnout if there is an inability to balance work and family domains. Other organisations have turned to different kinds of labour reform using the ability to 'flex' up or down the casual or part time staff in required numbers, related to an increase or decrease in workload, and this reduces service and wage costs (Maxwell, 2005). The Business Council of Australia (BCA) (2007) has also reflected that the impact on government change in policy may affect workplace flexibility, therefore hindering employers and employees to set up and implement needed changes in the workplace, around workplace guidelines for current and future growth.

Promotion of WLB flexibility and policy can lead to improvements in the form of recruitment advantages, staff retention, work performance, and employer of choice in addition to staff satisfaction, increased opportunity, and control of work and family responsibilities (State Services Authority, 2005; Newman et al., 2002; Rama-Maceiras et al., 2012). Hence, workplace flexibility requires promotion and communication of policies and guidelines to staff through Human Resources, leadership, technology, training, seminars and memoranda, to make them aware of and participate in the benefits (Drew and Murtagh, 2005; Bowen & Ostroff, 2004; Todd and Binns, 2013).

The Workplace Relations Act 1996 (WR Act 1996) supports the adoption of flexible family-friendly working arrangements, as do the 2007 amendments to the Act, stating its objective is

in "assisting workers to balance work and family responsibilities effectively through the development of mutually beneficial work practices with employers" (p2). McDonald et al. (2005) maintain that family-friendly policies are good for business, and, as it is now essential to recruit and retain suitable staff, flexible work arrangements are good for retention of skilled labour. Organisations still needed to reflect a culture of acceptance of workplace flexibility, and to engender staff perceptions in line with such acceptance. Developing work-life policies and building them into work practices is a necessary strategy, but the culture of acceptance by the organisation has to include both active recognition and support of these policies and acceptance that workers have lives outside of work (Nitzsche et al,. 2013)

Unions and Employees

Unions are seen as organisations that negotiate on behalf of their members and utilise legislative Acts and Agreements to protect the interests of their members or the worker. Many of these benefits are included in workers' EBAs, which have been negotiated between the employer and the unions to a position of shared knowledge (Nursing Enterprise Agreement 2007-2011).

In addition, the workplace within the public arena has occasionally become the focus for some changes in Industrial Relations forums, to portray a vision of individual employees and employers negotiating workplace wages and conditions (Todd & Binns, 2013). Todd and Binns (2013) go on to note that management's aim is to maximise output and therefore these WLB policies and practices are implemented within conflicting interests of the workplace. In response government have suggested policy and regulation guidelines for public institutions to implement new work-life balance processes, and have explained what would be expected from both the employer's and the employee's perspective, and the benefits associated with these changes (State Services Authority 2005). Changes include an initial definition of a flexible environment and culture that encompasses methods of promoting employment, use of leave, flexible attendance arrangements, and working from home, which managers could utilise. The expectations of leaders, managers and employees are also outlined, with suggested tools for assisting the formulation of paths towards improved work environments.

Organisations

Creating a climate and culture for organisational change is a fundamental step for management to implement a change-driven policy and influence structural changes and increased communication (Schneider, 1996). Roger Thompson (2006) states that reforming

the health system has to start from the bottom up rather than a 'big bang' Government-led change. Although this may be ideal for patient care, it does not show what the organisations could do to help introduce change from the bottom up, and maintain a culture to assist long-term WLB. However, the leaders need to promote and be the 'key role' in well being policies to enhance team spirit, effective communication and listen rather than dictating and flattening the hierarchy. This would include bi-directional communication to foster trust and mutual understanding, thus forging good relationships to align the goals of workers and the organisations (Rama-Maceiras et al., 2012).

A supportive culture and having the right structure to manage organisation WLB requires commitment from managers at all levels within an organisation, and is crucial for the long-term success of an organisation's work-life strategy (MWLBIA, 2007b). Management roles in relation to policy implementation may include:

- Confronting intergenerational group issues.
- Making a business cases for flexibility and workplace change.
- Developing strategies for achieving change.
- Learning skills to assist other managers to implement measures.
- Developing conflict resolution skills.
- Undertaking career coaching for staff.

It is imperative, therefore, that managers acquire improved skills to carry out any level of WLB policy implementation.

Enabling managers to gain these skills allows for organisations to implement change. This gives rise to an environment that is open to innovation and adaptation, which reflects a strong HR system (Bowen & Ostroff, 2004). Therefore an improvement or resolutions in isolated staff issues is not the solution to higher standards of quality or staff productivity. A holistic (team) approach is needed from both staff and managers within a flexible family-friendly workplace to gain a systematic growth in staff recruitment, retention and quality services to be maintained (Newman et al., 2002).

Support for workers has been shown as important in assisting them to balance home and work. Social supports in the home, such as relationships with family members, neighbours, friends and care-givers, are just as important as those in the workforce, such as relationships with workmates and supervisors (Thanacoody et al., 2009). Workers have had to design a life model that takes into consideration all their roles, needs and responsibilities, which enables them to start to improve their WLB.

There are varying views on the challenges of families balancing paid work and unpaid care, which were covered in a discussion paper produced by the Human Rights and Equal Opportunity Commission (HREOC) in 2007 that outlines how men and women balance their responsibilities. Von Doussa's (2007) discussion paper on the HREOC paper provides a concept of striking the balance between home and work that proposes a framework of shared workload. This has been seen in the last 30 years, with the growth in numbers of women in the workforce, including after having children, growth in part-time employment (Australian Bureau of Statistics, 2003), and men in nurturing roles. The HREOC (2007) report suggests that organisations need to look at a fair framework to allow for equal commitment from both men and women during the family lifecycle, by examining equality of responsibilities between men and women, incorporating a new shared work and family approach (Von Doussa, 2007). Even within a changing society and a shared work and family approach men are still less likely than women to be satisfied with increased restraints at work, restraints that allow inadequate time to build family relationships.

The State and Federal Governments should be part of the solution and assist the cultural changes required within society/organisations, which could include better access to childcare, aged care and special disability solutions, sharing of paid work and unpaid work, market labour skills and working from home (Von Doussa, 2007). In times of economic recessions, the employer often takes back from workers the flexible environment and hence influences the employee's view of the employer's 'tight squeeze' which could lead to employee backlash or imposed work restrictions. These restrictions will continually reduce family or 'home' time (Stern, 2002). These variations outlined in workers' work-life conflict showed that it was hard for policies to be developed to accommodate all of the issues, and this is reflected in the lack of hospital policy in this area (Chaykowski, 2006).

Why is Work-Life Balance an issue (generational expectations, changing needs in terms of family responsibilities reflecting societal changes, etc);

The impact of research on WLB has been varied in numerous industries, and many organisations have had some success in implementing WLB initiatives. In some organisations researchers have shown that major influences on the commitment to and respect for the 'whole person' is working for them by improving personal and business value (Lingle, 2004; Stutzer, 2012; Carlson et al., 2009). This reflects Honore's (2000) argument that if companies

want to survive, they need to look at employees as the 'citizens' of the company. Employees have the right to be heard and to have a real impact on a company and its success. This suggests that employees, in addition to the shareholders, impact on the value of a company (Stutzer, 2012; Carlson et al., 2009). Changes in organisational policies, legislation, and Enterprise Bargaining Agreements (EBAs) have also led to an introduction of flexibility in the form of different types of paid and unpaid leave management (Nursing Enterprise Agreement 2007-2011). These types of leave have included family leave for fathers or for those caring for dependants, measures promoting employee health and wellbeing, or community involvement, and types of financial support, as well as company culture change interventions (Jerg-Bretzke & Limbrecht, 2012; De Ridde, 2012). These interventions were initiated through a strong leadership culture change from managers, to create optimal flexible environments that included work redesign and eliminated barriers such as gender inequities (Lingle, 2004; Smithson & Stokoe, 2005; Mescher et al., 2010).

There are many desirable changes that can create a 'collision' between employers and employees, such as internal changes in the percentage of male versus female workers, and external changes in patterns of family structure, or changes in the economic and social forces driving the market (Pocock, 2003, p. 19). These changes are shadowed by the 'long hours' culture, whereby a lower amount is paid for workers' overtime. This form of long hour's culture links the personal worker's experience with larger social public and private issues, which include objectives, actions, motivation and culture (Roberts, 2007; Todd & Binns, 2013; Ford et al., 2007). However, some companies have seen the benefits of work-life initiatives that have delivered increased productivity, reduced turnover of staff and the introduction of positive WLB policies enabling managers to attract good employees (MWLBIA, 2009; Stutzer, 2012; Todd & Binns, 2013). These companies have needed to change their organisational culture, so that such initiatives are seen to be important, and as the extension of the existing organisational strategy and objectives (Poelmans et al., 2008; Maxwell, 2005). Such change is significant and many external as well as internal conditions and problems affect it.

Culture change for improved efficiencies for some companies have included employee groups that comprised a core (permanent) staff and changing peripheral (casual and part time) staff, which are used by the company to better align staff resources with activity level within their workload (Wagenaar et al., 2011; Moore, 2007). This approach seemed to be used as a

flexibility strategy rather than a WLB solution that enabled management to control core staff and modify the requirements for peripheral staff according to the organisation's need (Maxwell, 2005). Flexibility, and increasing staff numbers may improve the worker's ability to meet the changing needs of the organisation but does not meet core workers' WLB needs, i.e. work arrangements for staff: set hours or flexible hours (up or down), training and education, higher wages (for core staff) or policy aimed at reducing work hours for employees to meet outside commitments (Chaykowski, 2006).

The impact of imbalance on the worker?

Managing this work-life 'roller-coaster' is more a personal, employee stress, than a broad public health issue, as shown by women workers interviewed, who stated that the lack of control within their work environment increased their overall stress (Bryson et al., 2007). The lack of organisation policies, coupled with their private troubles in maintaining a balance between their home life and work, affected them physically and mentally, causing them to initiate solutions themselves, such as part time work, employing home help, enlisting grandparents, or reducing social activities. Pocock (2003, p. 57) agrees that longer working hours and time-space compression creates the (bad) stress on workers, and Bryson et al. (2007) note that the impact of, or perception created by, 'busyness' and loss of control (between family and employment) needs to be understood, not just for the individual female worker, but also for the longer-term public health problems likely to affect this group as a whole.

The impact on the workplace of measures to address WLB

Organisational flexibility is a key concept in WLB, dominating the literature in regard to gaining a balance between work and non-work in a variety of industries. Workers within organisations require employer solutions to assist them to attain a balance between home and their work environment. In support of this view many private employer groups have moved to incorporate policy that improves the work environment (MWLBIA, 2007a; McDonald et al., 2005; Kalliath & Brough, 2008; Stutzer, 2012).

A number of different issues affect consideration of the flexible workplace concept:

- The degree of availability of specialist skills within the workforce and the ability to retain skilled staff;
- Care for children and older groups;
- Employee health and wellness;

- Employee productivity;
- Workplace awareness

Each are discussed below.

The degree of availability of specialist skills within the workforce and the ability to retain skilled staff

The need for flexibility has been the focus of many research projects, with varied aims, such as to provide incentives, introduce improvements to the work environment, or even influence the 'bottom line', however this flexibility is central to retain existing skilled staff, and attract new staff (Avgar et al., 2011; Kalliath & Brough, 2008; Todd & Binns, 2013; Carlson et al., 2009).

Flexibility utilisation to maintain higher skilled workforce is more complex accross a more diverse working group. As organisations now have three distinct groups or generations of employees: the Baby Boomers (BB), generation X, and generation Y (Kehril & Sopp, 2006). Baby Boomers are defined as those born shortly after World War 2 up to the mid-1960s; Generation X were born from the mid-1960s to 1980; and Generation Y between 1980 and mid-1990s. Lander's (2006) view is that generations hold distinct differences in values and views on subjects that include loyalty, authority and motivation, and separate outlooks on how they wish to be employed and managed. This outlook on work has changed over time due to their personal life expectations and social changes. Managers need to respond to the broadening expectations and increasingly diverse priorities outside of work, that encompasses both generation X and Y employee expectations, which adds another level of complexity to the way that organisations function (Dageforde et al., 2013; McNulty, 2006).

Members of the different generations have a variety of views about the type and terms of employment they prefer. For example, Generation Y's concept of authority and its role within the organisation is much more relaxed compared to that of the Baby Boomers or Generation X. The younger generation Y's have the attitude 'get in, do the job and get out', which is reflected in Scholarios and Marks' (2004) research into IT software workers that found the typical retention period for permanent employees within the sector is between 18 and 36 months. Workers from Generation X generally move from one permanent job to the next and appear to be more generalist managers than those in Generation Y, mainly because they value the importance of a balanced lifestyle. Baby Boomers are generally perceived to be lifelong

employees with detailed knowledge of the companies they work for (Vincola & Farren, 1999). These generational differences suggest managers need to adopt flexible strategies to attract and retain a range of skilled staff. These views, also shared by Lander (2006), would pose that there are issues to be considered within the scope of all three generations, in the WLB debate.

The middle manager's role is to complete a common task, to provide a service with varied generational workers who are employed to execute required tasks efficiently. The concept of a 'working culture' becomes difficult given the manager's task to cultivate a good environment for Baby Boomers and Generation Ys to work in and communicate effectively with each other, without having the common expectations (Kehril & Sopp, 2006). With such different approaches to work, management needs to be aware of the flexibility needs, skills and expectations of each generation for the total group to be productive and provide a collaborative service (Treuren & Anderson, 2010). With Generation Y being transient and Baby Boomers retiring in the near future, organisations will have to deal with retaining newly skilled staff in conjunction with the loss of the older skilled workers, and still provide services, which may be difficult. This can lead to a loss of skills within our organisations, and, as McNulty (2006) observes, even if these skills are present in the younger workers, they may not want to do the necessary tasks in the organisation.

More generally, workforce shortages of skilled staff also require managers to adopt strategies to ensure their service shifts are covered. More generally, workforce shortages of skilled staff also require managers to adopt strategies to ensure their service shifts are covered, such as increasing the breadth of skills of employed staff (Burchielli et al., 2008). This intensification of work increases the output relative to a zero growth in labour (Allan, 1998; Burchielli et al., 2008; Roberts, 2007). Other employers however have used other methods, such as increasing part-time and casual staff to better meet the changing demands upon services provided and when they are required (Working Families Charity, 2005; McCarthy et al., 2010). Working from home or off-site has been initiated in many industries (Hayes, 2007), in addition to giving workers the ability to work flexible hours during the day or job share roles within the organisation. Many strategies are being implemented along-side WLB policy but even the provision of improved working conditions, including WLB policies, does not necessarily guarantee attracting and retaining staff (Poelmans et al., 2008).

Family considerations: Care for children and/or older people

There is increasing pressure on employers to consider workers' needs to look after children and now, more recently, older groups such as parents. This 'sandwich' generation has substantial family pressures that often affect their workplace roles (Kalliath & Brough, 2008). In order to cope with the demands of family life workers may require time away from work, working hours at set times (nights, weekends, etc.) or blocks of time off from work, or they may need to be either more or less connected to work, may not want to work overtime, and have access to benefits (childcare, care for elderly relatives, parental leave, school holidays, for example) (Kaplan-Leiserson, 2003; Belliveau, 2004). In some cases flexi-time (leave management) can assist staff to meet these external obligations as it allows them the ability to control when and how long they work, and in some instances where they work, but also has to be supported by the organisation (Maxwell, 2005).

On the other hand, female employees may believe that 'time off' to care for family members, although needed, will impede their career path in the longer term (Drew & Murtagh, 2005). Only through interactive discussion and possible concessions on both sides can these issues be identified, discussed and resolved. Overall, the research suggests that employers need to align corporate policy and practice with current and future family structures for all employees, to address both career and family considerations (Drew & Murtagh, 2005).

Employee health and wellness

Employee health and wellness is a complex issue, as it is often a struggle between the organisation and the family (O'Donnell & Bensky, 2011). The wellness or good health created by achieving the correct balance is necessary for workers to maintain the levels of acceptance at work that enable them to do their work effectively (Al-Qutop & Harrim, 2011; Stutzer, 2012). Factors that can raise employee stress levels include, for example, limited home contact, overtime, the employers' expectation of commitment (Avgar et al., 2011). Each person's degree of balance (stress vs. wellbeing) may be different or have a different impact and require different options to gain this individually adjusted WLB (Carlson et al., 2009). The literature suggests that continual pressures affecting a worker who is putting in regular hours with productive output, meeting career structure guidelines, and also participating fully in family life, creates stress that is seen to be harmful (Allan, 1998; Thanacoody et al., 2009). This results in increased sick leave, stress leave, and Work Care considerations, which can decrease the organisation's productivity (Hamilton & Rush, 2006; Grawitch et al., 2006).

Productivity

Work-life balance is a complex process, requiring management to generate an environment that encourages understanding of the conditions required for people to work together, to promote productivity, and an environment flexible enough for the individual worker to "have a sense of contribution and self-worth" (Gresham, 2004 p.26). Organisations must also look at the staff's view of WLB, as that is integral to a worker's health and well-being (Grawitch et al., 2007; Al-Qutop & Harrim, 2011). Workers' experience of a satisfactory degree of healthy programs may reduce stress levels incurred when carrying out their jobs (Grawitch et al., 2007).

Some companies in Australia have introduced forms of WLB benefits and assessed how this has impacted individual workers' wellbeing and the overall productivity of the company (Abbott & De Cieri, 2008). The results of Abbott & De Cieri's (2008) assessment indicated that managers' and workers' perspective on WLB were similar, and that decisions on employee wellbeing by the company's Board of Directors (based in Australia and overseas) had both good and bad effects on workers' environments. They also found that some overseas organisational cultures have impacted on the degree of support for and range of implementation of WLB strategies, and that Australian tax legislation impacted negatively on the WLB provisions. Even when government and organisations consider WLB policy to be successful, there is minimal evidence of the introduction and implementation of any form of WLB environment (Hyman & Summers, 2004). Gresham (2004), has shown, with organisational time and commitment, and management striving for a balanced lifestyle for workers, individual workers may become more consistent within their own 'values' than they had previously. This includes being consistent in their habits and satisfied within themselves, which gives an individual worker more balance and can lead to the so-called "productivity cycle", thus improving productivity within the organisation (Gresham, 2004, p. 25).

The literature outlines the need for organisations to implement WLB policy for the right reasons – namely for the "benefits of improved recruitment, retention, creating a supportive culture and promoting workplace equality" - and to support these policies with the resources to enable managers to implement them effectively (Wise & Bond, 2003, p.22). Managers are caught between WLB policy and required output, with the role of driving and introducing flexible workplaces, but seem to fail from lack of resources, even though the strategic HR focus is WLB (McCarthy et al., 2010; Wise & Bond, 2003). According to Wise and Bond (2003, p.29), "Properly targeted communication of policies and training for line managers in

work-life issues is essential for turning centrally developed policy strategy into effective practice but the challenge for organisations does not end there. Having formal policies which practically cannot be used is counterproductive". Balding (2005, p.355) agrees in that through "a process of education and training for line managers" in the organisations policy, provides the best connection between the vision of the company and the reality of those on the front line of the business. As most WLB documentation still focuses on family, women in paid employment, eldercare, single households and health, there is an opportunity for organisations to look broader across all working groups to better enhance their output. There needs to be a culture of flexibility acceptance and champions within these organisations to enable WLB to gain momentum and be taken up by workers in a positive mindset (McDonald et al., 2005; Wise & Bond, 2003).

Workplace awareness

According to a 2006 survey by Cox (2007, p.1) Australians agreed with the statement "A government's prime objective should be achieving the greatest happiness of the people, not the greatest wealth". Within the group answering the survey happiness was interpreted as family and partners. This suggests an organisational imperative to ensure WLB among employees. Although shareholders may not agree with this concept, Jones and Felps (2013) found the generation of shareholder wealth is only weakly linked to the social welfare maximisation. Organisations require awareness of the need to look at adopting 'family' issues as a core policy, rather than 'soft' policies such as 'women's interests' (Cox, 2007). Introducing family-friendly policies for men and women would make good business sense: evidence shows that a highly flexible environment, with a more family-focused workplace has more direct influence on workers well-being (Lingle, 2004)). As outlined previously Gresham (2004, p.11) suggested that workers' "productivity cycle" displayed the values that flowed through into their work ethic and they became more productive, which reinforced these values in others.

Investigation into work-family policy has demonstrated mixed results. For example, a study in one university that had introduced work-family policies used both utilisation data and employee feedback through interviews to determine the success of the policy (McDonald et al., 2005). Reviews through systematic policy evaluation alone would not be sufficient to assess if they were being achieved, as it would not demonstrate accurately the use and success of the policy, as experienced by workers. The provision of family-friendly practices resulted in increased organisational commitment, job satisfaction, retention, recruitment, decreased

absenteeism and improved morale. However, the personal interviews showed inconsistency in staff opinions of the success of the policy (McDonald et al., 2005). This suggests that without evaluation of the policies implemented, organisations would not be able to gauge any outcomes of the policies by establishing a link between individual workers' conditions and organisational productivity. This could result in poor outcomes and underutilisation of such policies by employees, as the organisation may not be meeting the employees' expectations and thus failing to realise the policy's aims (McDonald et al., 2005).

As outlined, many industries have some formal policy and output driven initiatives in place for worker's needs and requirements. In the next section I will discuss the evidence for WLB in the healthcare industry.

Work-Life balance from a healthcare perspective

Healthcare organisations have experienced different approaches to the flexible working environment, many from single points of view, rather than from an overall approach such as culture change. A (Canadian) Institution for Research on Public Policy (IRPP) study by Chaykowski (2006) shows that WLB has been transformed into work-life conflict and suggests examining this work-life conflict from within healthcare organisations. This will show increased demands on workers' time, and their inability, under work pressure, to allocate time to align family and work demands, which may increase stress on workers, potentially leading to health problems and absenteeism (Chaykowski, 2006). Should employers and governments in general, be more 'policy active' around work and family issues? It would appear from Chaykowski (2006) the Canadian government tends to target specific problems and resolve the issues and conflicts rather than push policy implementation.

With the increasing expectation of staff shortages within healthcare, and the need for retaining skilled staff, an employer with flexible family friendly workplace practices is expected to be better able than other employers to attract and retain such staff (Stutzer, 2012). Hospitals with these arrangements, which include a variety of leave and employment arrangements, are also seen by potential employees as the employer of choice, which internally is reflected in staff loyalty, reduced absenteeism and turnover, and staff ability to cope with the peaks and troughs of variable workloads. Workers generally want to be employed by someone who appreciates their contribution, and employers want to employ the best staff, realising that this improves the 'bottom line', or company profits (Poelmans et al., 2008). This concept has been

accepted and outlined in Victorian government guidelines, which supports the needs of the employee through the implementation of a flexible working environment to enable a better balance between work and home, making the individual worker more efficient (State Service Authority, 2005). Although skill shortages have been a problem for some time in healthcare, and even though some specific shortages have eased over the last few years, there are still skill shortages locally and nationally (Department of Education, Employment and Workplace Relations, 2013). This highlights the importance of organisations changing their outlook in order to attract and accommodate a wider selection of workers than they attract at present. Managers' ability to help introduce policies and develop a culture that promotes such recruitment is imperative, enabling them to support flexible/variable ways to employ and support workers (Maxwell, 2005).

Although these policies and strategies enhance the working lives of internal staff in the organisation, there is a new move towards the global arena to access a different group of staff/services, as specific departments such as Radiology have done this within the hospital, and have looked externally for their workforce skills and outsourced reporting services from overseas, using internet connectivity (Hayes, 2007). Which is the progression and diversification of a (now), much more sophisticated IT technologies, than the historic internal outsourcing of urban (city hospital) Medical Specialists, giving advice/diagnosis to rural or remote doctors via a video link.

The Organisational Perspective

The healthcare literature illustrates the various factors impacting on healthcare organisations. These included: a) Government or Consultants, b) Employee or Union, c) Human Resources or Employer (organisation) and d) Welfare or Community. Each book and journal article relating to WLB in the healthcare industry reviewed for this research was categorised into one of these four groups and into a matrix for easier identification and categorisation. Included in this matrix was additional information covering arguments used, goal, evidence, and strategies used, by each author or researcher.

The value of this matrix for the researcher was to understand the concepts of each of the authors, as used in their arguments. For each group, the format clarified their arguments around their policy of intent, their programs, and what researchers indicate organisations were doing to implement them in the healthcare setting. As proposed earlier, there are many uses or

different interpretations of the term ‘balance’ within the WLB research. The final form of ‘balance’ was determined by the situation of the individual worker and by the solution required to reduce the conflict between the worker’s responsibilities at work, and away from work (Carlson et al. 2009). It is this balance that impacts on middle managers and senior human resource managers in terms of the need to create an environment that is flexible enough to enable their staff to fulfil their responsibilities, or at least to reduce their work-life conflict while providing a service.

It is interesting how the four main groups (identified previously p.14) individually portray WLB, not just on different levels but also at different stages of evolution. This is identified in healthcare as the Victorian government has only documented specific guidelines on how to implement, review and modify work-life environments within the public sector, not enforced the implementation (State Services Authority 2005). In contrast welfare and employee groups appear to understand and insist that present arrangements for WLB have not met the broader family requirements, unlike changes in union EBAs (Chaykowski, 2006; Pocock, 2003, p.214).

Where to?

Whilst there has been increasing interest in work-life balance (WLB) over the last 10 years or so, there has been limited research on the resources available in healthcare organisations, such as hospitals, to assist managers in WLB decisions for their employees. There has been work in Australia that has looked at the effects of WLB on employees, their families and the benefits at the higher levels of the organization (De Cieri et al., 2005; Pocock, 2006, p.12, 53-55). Also, WLB initiatives in healthcare within Australia have been examined by researchers from a Human Resources aspect, assessing modes of employment and effects on employees and on staff retention (De Cieri et al., 2005; State Services Authority, 2005; Poelmans et al., 2008). The Federal Government in 2006 and the State Services Authority of Victoria (2005) have also established guidelines to assist the public sector to implement changes within current workplaces, and establish a more flexible environment within the public sector. However, this work does not show what measures have been taken for creating a flexible workplace and how such measures may affect, and assist, daily decisions regarding WLB decisions that middle managers have to make, in response to staff requests, within Victorian A1 hospitals.

The healthcare workplace environments do not appear to accommodate work-life needs of employees. The literature consistently identifies the need for greater understanding of the needs of employees that could be met with a well designed package of initiatives. However, there was very little robust evaluation of WLB initiatives in hospitals, so there is little evidence to use in planning such initiatives in this environment.

The research undertaken in this study will provide insight into both the resources that are available to middle managers in Victorian A1 hospitals, and the obstacles they encounter when making WLB decisions. Understanding these issues will allow the development of policy/practice changes that could positively affect the WLB of staff, and consequently the ability of the hospitals to better meet the needs of patients.

Chapter 2 Research Methods

Introduction

This chapter contains an account of the research methods used for this study. It includes an outline of the methods used to identify, collect and analyse the data required to examine the research question: How do department managers in A1 hospitals in Victoria make decisions on the work-life balance issues of their staff?

Middle managers are not responsible for setting organisational policy but have a high enough responsibility within the organisation to manage requests that are impacted by any WLB policies or guidelines in place. In addition these managers are in a position of responsibility for making day-to-day operational decisions on their department service workflow but are required to follow the needs of the organisation and align their decisions accordingly. This management group is perceived to be, in the researcher's view, where policy implementation would have a greater impact. The managers' role is to both initiate and implement policy to their staff and manage the outcomes within the resources available to them (Drew & Murtagh, 2005; Maxwell, 2005).

The value of a qualitative approach

A qualitative approach was suitable for observing and understanding the views of middle managers (Miles & Huberman, 2002; Bardoel et al., 2008). Qualitative research methods are useful for developing theories derived from interpretation (Strauss & Corbin, 1998). Data were collected through in-depth interviews with middle managers to explore the kinds of practices followed by middle managers in A1 hospitals, the impact of these practices, and the issues faced by managers when making WLB decisions. A review of the documentation available to middle managers when making WLB decisions was also undertaken.

The sample consisted of A1 hospital middle managers who managed staff working in varied specialties and covering all types of shifts, including some staff working 'shifts over 24 hours each day'. To encapsulate the organisational view, four senior human resource managers were also interviewed, as they are a key group in the hospital structure. A second benefit of interviewing this group was that they also had staff reporting to them, and similar requests would be made to them as were made to middle managers regarding WLB. Individual

interviews were conducted to gain direct insight into middle managers' personal experience relevant to the research topic, and this method of interview allowed the researcher to collect information likely to be more honest and open than if gained through group interviews (Minichiello et al., 2008).

Documentation available to middle managers to assist them, as part of their job, in making WLB decisions, was also reviewed. Many official documents were already in use in A1 hospitals, and since these hospitals had to respond to a range of Department of Health (DoH) policy documents, these were identified through the in-depth interview process and managers were asked how they took them into account when making their decisions (Strachan et al., 2007).

Once the analysis of the interviews documentation was complete, it was compared with Vroom's (1976) decision model to gain an insight into the middle managers' decision making (Strauss & Corbin, 1998; Tuckett, 2005). Vroom's (1976) decision model demonstrates how managers made decisions, influenced by having to follow the philosophy of the organisation, but also needing to take into account the circumstances of their individual employees. Maxwell's (2005) explored the WLB within the tourism and financial sectors looking different perspectives on the development of WLB policy. Maxwell (2005, p.182) found that "managers are pivotal to WLB in practice: employee requests for WLB arrangements:.… the organisational benefits of WLB: ..", these findings support Vroom's (1976) decision model, as it too focuses on the organisations three-way relationship middle managers had to consider in decision making.

Theoretical framework

Vroom's Decision Model

Vroom's Decision Model (1976) was used as a theoretical framework for information data collection and analysis. The model describes the behaviour in response to the attributes of the manager in combination with the attitudes of the employees. These interactions then lead to organisational outcomes from the decisions made. The model framework was used in leadership research programs. This research interest refers to "the determinants and consequences of participants in decision making" (Vroom, 1976, p.1538). The model informed the development of the research questions to highlight the interaction between a three way relationship that includes the managers, organisation and employees. Vroom's

(1976) decision model (Figure 2.1) below is also used extensively in the discussion chapter to draw together the analysis of the data collected. Below is an outline of the relationship of Vroom's model to the findings of the documentary and the thematic analysis of the interviews.

Situational Variables (1)

- Employee
    - Why staff want leave
    - Type of leave
    - Staff expectations
- Department / Organisation
    - Staff skills mix
    - Service requirements

Personal Attributes of managers or staff (2)

- Experience
- Education

Leader Behaviour (3 - manager)

- Flexibility – use self to decide/staff and self to decide/their manager and self to decide

Organisation Outcomes (4)

- Nature of decisions made
- Using organisation policies

Situation Variables (1a)

- Government legislation e.g., Fair Work Act
- Enterprise Bargaining Agreement

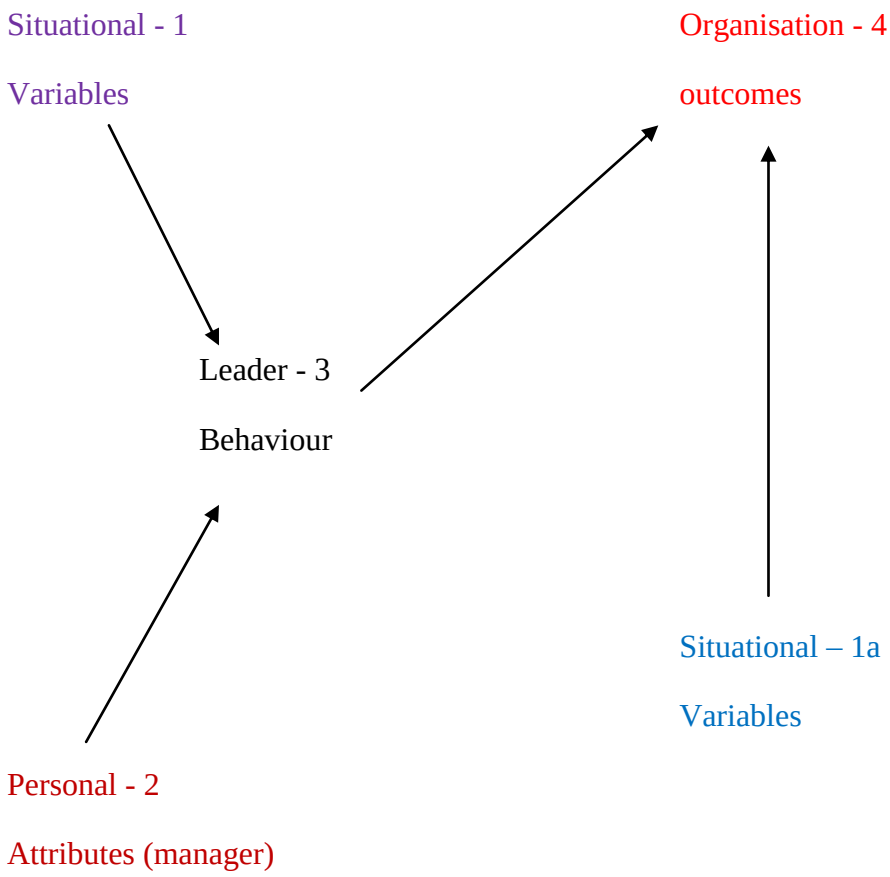

Figure 2.1 **VROOM's Decision Model, 1976, p. 1537** (schematic representation of variables used in leadership research)

With the Vroom model in mind, the interview questions to middle managers had to focus on what information was available to them, and their perceptions of any obstacles that affected their ability to make WLB decisions. It was also important to explore managers' understanding of the organisation's requirements regarding WLB decisions, including their perception of their staff members' understanding of these requirements. Therefore the focus of this research explored the interpretation of what staff understood from a middle manager's view, and included their experiences and perceptions from the outcomes of the decisions they made. The interview questions also encompassed whether there was the need for middle managers to engage the hospital Human Resources Department for assistance or confirm the organisations position on possible outcomes of these decisions.

Interviews

Semi-structured in-depth interviews are a valuable qualitative method for exploring complex processes through a conversation that is considerably more detailed than a structured

interview (Sturges, 2008). Semi-structured interviews allow participants to express their beliefs, experiences, feelings and interactions to become part of the conversational process (Strauss & Corbin, 1998 p28).

Features identified in the literature and utilised by the researcher, about individual in-depth interviews included:

- Conversational and engaging, to illustrate the skill and experience of the interviewer.
- Allows a new understanding and theories of the subject to be developed.
- Questions (usually) are not known by the interviewees before interview.
- Participants' responses are less influenced by the presence of peers, as in the case of group interviews.
- Time taken can be from half an hour up to two and a half hours a session.
- With a set of questions, the interviewer should start with 10 structured questions, as more will be likely for 'follow up'.

Many of the A1 hospitals were likely to have both general and specific resources available to managers, an additional reason why individual interviews were likely to be more productive for eliciting information than focus groups (Minichiello et al., 2008): focus groups would tend to inhibit discussion of the methods individual managers used, that is, if they did not use formal policy, or if their method was perceived to be 'wrong' by superiors, or as not following hospital policy. Group composition could reduce or negate managers' free-flowing conversation and inhibit interaction (Minichiello et al., 2008), especially as the study required the participants to feel unrestricted or uninhibited, away from other managers, so the maximum amount of useful data could be collected (Liamputtong & Ezzy, 1999, p72).

Selection of participants

The primary group selected for interview were middle managers within the five A1 hospitals in Victoria. The researcher used purposive sampling, based on the need to meet certain criteria (list below), the expectation of a willingness to participate and have the knowledge to contribute appropriate data in terms of relevance and depth. Each A1 hospital is conditioned by the same factors both internal and external: government oversight and regulation, funding resources, overarching policies, service delivery responsibilities, and each were competing for the same skilled labour. These managers had direct face-to-face interactions with staff, they

control daily operations, they had to accommodate the mix of staff within their departments, and deal with all forms of employment; a variety of shifts, organising staff on-call, deciding on office hours, and coping with staff who may be full-time, part-time or casual. It was important to include consideration of a broad range of staff that had different needs, skills, and working conditions.

In addition to the middle managers, it was also important to gain a wider organisational view of any issues, or current problems, regarding the management of WLB. Hence, senior human resources managers were also interviewed, though as a secondary group, they were likely to have insight into what was available in regard to WLB, how polices or guidelines were distributed in the organisation, or what future plans faced staff management. The senior human resources managers also had direct reports, and therefore were aware of middle managers' concerns when making decisions and requiring staff to understand and deal with the outcomes of decisions made.

The criteria that the participants were required to meet included:

- managers were accessible to the interviewer, and willing to be interviewed;
- responsible for direct reports to line superiors for unit performance;
- responsible for their service's effective operation;
- in charge of a combination of staff with various skill types and levels, that is, groups of staff at similar levels of seniority and of comparable composition;
- responsible for a mix of staff over a 24-hour period;
- working within a similar Human Resource services structure.

It was important to select middle managers with no medical responsibilities, as having medical responsibilities limited their responsibility for the service provided. These managers also had to have either direct or indirect access to the Human Resources Department or to a senior human resources manager. This would facilitate research access to the full suite of organisational resources, especially policies and guidelines concerned with WLB. After emailing all A1 hospital Chief Executive Officers (CEOs) requesting written approval of my research to be carried out within their hospitals, and only after approval was given by the CEOs, 12 identified middle managers and four senior human resource managers were contacted by e-mail. The e-mail outlined the approval process to contact them, the study to be

undertaken, copy of the ethics approval, copy of the consent form and a request for them to participate in the study by being interviewed. All managers accepted the offer with only one having to withdraw due to accessibility and their second in charge was interviewed in their place.

The data gathered at the interviews needed to include resources used/available/known by each middle manager, and their explanations of or the information and methods they used to make WLB decisions.

Ethics Approval

As outlined in the ethics application, the particular research topic required interviews from a large enough subset of middle managers and senior human resource managers from all participating Victorian A1 hospitals to ensure the data collected accurately represented the views of these groups of managers. The middle managers were selected because their departments covered the varied mix of employment options; 24hours 7days a week, day shift, night shift, overtime, on-call, 24 hour shift roster, and Monday to Friday day shift employees. The middle managers were employed in the state's major large teaching hospitals responsible to the DoH for funding and service requirements.

To assist in the ethics documentation of the recruitment method, the researcher sent an initial e-mail to the CEO of each A1 hospital selected, to request their hospital's participation in the research and to seek approval to directly contact managers, to request their participation in an interview. Included in this e-mail was a template letter saying that, subject to the Chief Executive agreement to participate, the CEOs could choose to print and sign, or modify and sign, and return the signed agreement to the researcher.

Once the La Trobe University Human Research Ethics Committee gave approval (which took four months) the researcher began to select the participants within the A1 hospitals. Five Chief Executive Officers responded, one refusing to allow the organisation or its managers to participate, as they were 'too busy'. Two signed and returned the template letter agreeing to participate, and two referred the request to their Research Departments. With the two consenting hospitals, I approached the senior human resource managers and the middle managers of the selected departments that covered the employment options described above, to request their participation in the research and their individual consent to a one-on-one

interview, enclosing a research proposal information summary (Appendix 1) and consent form (Appendix 2). Once their acceptance was received, individual interviews were organised at each manager's convenience, at which they would be shown the ethics approval letter, would be asked to sign the consent form, and have the process explained, including their right to withdraw their consent at any time.

With the two A1 hospitals that had referred the initial request to their Research Departments, the first Research Department requested an ethics submission specific to that organisation, to be reviewed by its ethics committee. The submission had to include the written agreement of each middle manager to participate, followed by the approval of each manager's immediate supervisor. Once this was agreed to, the Research Department had to see all the e-mails relevant to the university ethics submission, including the La Trobe University Human Research Ethics Committee's approval letter. This additional hospital ethics approval process took a further five months, and the research was deemed to be 'low risk'.

The second A1 hospital's Research Department requested a completed ethics application similar to that of the Department of Health, though only one section had to be completed for review. After approximately one month the Research Department requested an additional section to be completed. The hospital's Human Resource Director had final approval, which took some time, as documents were lost and had to be resubmitted twice, before final approval to proceed was granted, 10 months from the initial submission – again, the project was deemed to be 'low risk'.

With ethics approval received from the two A1 hospitals that had referred the request to their research departments, the researcher was then able to organise interviews with the participants at these last two hospitals. Each received an information summary and consent form, as with the interviewees from the first two A1 hospitals.

The researcher is known to one of the participant groups being interviewed and is known to another participant in a second participant group. This raised the possibility of certain participants being affected by a relationship with researcher, with the potential to influence some outcomes, depending upon how personal the relationship was. However, it also gave the researcher a relatively close understanding of the various topics discussed.

In line with the ethical guidelines all electronic copies of interview documents and transcriptions are stored in an electronic password-protected folder in the researcher's office.

As the research was conducted with humans, approval was required from the La Trobe University Human Research Ethics Committee, to conduct the interviews. This approval was granted on the 15th of June 2009.

Data Collection

The Interview Schedule

The design of the questions for the interviews was crucial, so that the interviewees would readily disclose the required information. The interview theme was decided upon beforehand, so that the conversation could be initiated through set, open-ended questions (Liamputtong & Ezzy, 1999, p62). Initially, the researcher compiled an inventory of important topics, identified earlier through the literature review as it related to the researcher's question. Notes were also used to identify questions arising from the researcher's inventory of central topics to assist interviewees to reflect on 'their' story, and help the flow of the conversation to elicit the data required.

Wording of the interview questions was important, to extend the researcher's genuine interest to participants, avoiding an impression of 'testing knowledge' or 'technical phrases'. The interview had to show participants an understanding of what information was wanted, while appreciating also their experience and knowledge.

The conversation had to 'flow', yet be full of detailed information, with 'open-ended' questions, to avoid 'yes' or 'no' answers (Minichiello et al., 2008). The questions had to be slightly different for the middle managers, compared with those for senior human resource managers, to draw slightly different data from the latter in relation to the organisation, and to ascertain a 'whole-organisational' perspective, as opposed to the perspective of an individual department manager concentrating on a narrower range of responsibilities specific to a particular unit and staffing group.

The interview questionnaire contained a set of 14 standard questions for the middle managers (Appendix 3) and 14 for the senior human resource managers (Appendix 4), though only nine of the 14 were the same for both groups. Similar questions were used to extract data about the

interactions between managers and their employees, while those for the middle managers allowed them to reflect on the organisation and how they interacted with senior managers and the Human Resources Department. Questions for the senior human resource managers sought their account of the way the organisation generated information (policies, guidelines, for example) and its implementation. Therefore the format of the question was able to reflect the relationship demonstrated in Vroom's model (1976) between managers their staff and the requirements of the organisation.

Interview process

With approval given and interviews organised, the final schedule of 16 interviews were completed in the following sequence:

- Seven of eight interviews completed within three months of La Trobe ethics approval at the first two A1 hospitals at which the Chief Executive Officers had given permission.
- The last of the initial eight interviews, with a deputy manager, was completed within two weeks of their agreement to take part, 10 months after La Trobe ethics approval.
- Four of the last eight interviews were completed within three weeks of the first A1 hospital (additional) ethics approval (six months after La Trobe ethics approval).
- The last four interviews were completed within two weeks of the second A1 hospital (additional) ethics approval (12 months after La Trobe ethics approval).

Once the researcher had organised the interviews with each manager at their convenience (at a time and place agreed to, usually the participant's office), each interview started with a review of the information that had been sent out in the pre-interview e-mail. The participants were then given a hard copy information sheet and asked if they required any more detail or had any questions about the research or the pending interview. It was explained to the participants that the interview would be recorded, transcribed, and emailed back to interviewees for checking on accuracy and completeness, with the researcher possibly following up to request any clarification. The researcher stressed to each participant that the recording and transcribed notes would be kept in a secure electronic folder in his office. Once participants said everything was clear and understood, including any questions answered, they were each asked to sign a consent form, and shown a 'Withdrawal of consent' form that could be submitted at any time throughout the data collection and review process.

The researcher expected that the preliminary chat, and any further discussion relating to the participant's information sheet, before the first question, would help relax the participant and set up a comfortable interview environment. Both lists of questions started with a broad question to identify the participant's understanding of WLB and steer the conversation to the topic under discussion, asking what WLB meant to that manager. The managers' responses varied in length and in the way they met the researcher's expectations, but they assisted the interviewees to focus on the topic, and relate their comments on their work-life experiences to the particular conditions of their work environment.

Questions two to four drew the interviewees back to considering their work environment and assisted them with "props" (the prop was a list of leave options, staff may request), to focus and build on in their answers. Positive verbal feedback was given to the interviewees' throughout the interviews to help maintain a good rapport between interviewer and the participant. They were encouraged that the answers were interesting and worthwhile by using simple terms and body language such as: terms like - interesting, can you expand on that, and also included nodding, leaning in, engaging in eye contact and smiling.

Questions five and six asked the managers what resources were available to them to assist in their decision making, and also covered their knowledge of other resources that were available but which they did not use in decision making. It was at this stage (question seven) that the questions differed between those for the middle managers and those for the senior human resources managers.

For the middle manager, questions seven and eight sought to establish if they referred some issues (leave without pay, working from home, work school hours, for example), being created by staff requests to other managers, or asked for advice, and if available documentation was consulted before they made decisions. Question nine then asked whether there were any obstacles that obstructed or affected their decision making, which then led to further questions covering the basis on which they then made actual decisions, and the impact of these decisions. The interviews closed with a general question about anything not covered that the participants thought relevant, or any other issues/problems they would like to discuss.

For senior human resource managers, question seven was modified and related to whether the organisation had specialist HR managers who covered the WLB portfolio. They were then

asked for examples of any WLB decisions made, and if these were discussed at that manager's level before other middle managers were given advice. Questions 11 and 12 related to how staff performance affected decisions made. Question 13 covered any topics/subjects that had not been discussed, and each interview ended with the interviewee being asked about any organisational work-life documents, either internal or external.

During the questions it was important to use some types of prompts for the participants, so that they could expand or elaborate on their answers (give more detail), such as prompts to continue ('go on' or 'what happened then?'), clarify (to resolve ambiguity, e.g. 'what do you mean by that?') or even to show the interviewer's interest and attention ('that's really interesting').

Interviews took approximately 45 to 80 minutes. As part of the interviews, participants were asked about documentation on WLB within their organisation, and if it was possible to give the interviewer a copy. As a result, the researcher received documentation from three of the hospitals – the fourth had none. The same request was made to the participants before document analysis, and again approximately 12 months post interview. Additional information was received from the A1 hospital that initially had no WLB initiatives (or documentation).

The interview process used, with a set number of questions, allowed better control by the researcher, over the interviews conducted (Minichiello et al., 2008). The interviews also enabled the researcher to explore the different priorities of the managers' staff members, and what managers also saw as necessary for their own WLB.

Although the questions used were slightly different for senior human resource managers, as distinct from middle managers, they were all designed to focus the interview around internal processes of the hospital, and how WLB decisions were made. The questions could also be viewed as directional, to focus the interview in a certain way, a method which met the needs of the novice interviewer, and the scope of the study question.

This interview technique allowed the researcher in this case, to collect all the data before doing any coding, analysis, or theorising, and although there may have been theories

emerging during the collection of the data, there was no modification of the standard set of questions, or of the method of data collection, throughout the interview process.

The use of a structured format for interviews allowed the interviewer to stay focused and follow the chosen format (Minichiello et al., 2008). Using a formal process of interview preparation the interviews were very successful. This formal process included: assigning set questions, interview practice, common format, recording the responses and concluding the interview on a 'good note' (Strauss & Corbin, 1998). The use of structured questions facilitated the researcher to remain focused on the topic, preventing any 'drift' away from the main topic (Minichiello et al., 2008).

The quality of each participant's contribution came down to the credibility of the researcher, the rapport achieved with the subject, which included:

- interviewer establishing trust, and maintaining control over interview data;
- interviewer and subject had set boundaries;
- subject having given informed consent;
- suitable surrounding conditions (e.g., no interruptions);
- participants feeling comfortable in his/her own environment.

Document Collection

The researcher collected documents by asking interviewees and hospitals about the documents they used; these also included the broader policy documents, such as policies and guidelines from the DoH. These documents used within A1 Hospitals, and the external documents that managers had to respond to, revealed that middle managers had additional factors, which affected their decisions about staff WLB requests.

The documentation reviewed included journal articles, State and Federal Acts, local organisation guidelines and policies. Local documentation included draft policies and/or guidelines that outlined the introduction of, or outcomes of WLB. These local documents provided examples of identified needs, including what had already been implemented within the particular hospital. The contents of these documents were compared to the current literature to help build an understanding of a hospital's progress in achieving WLB for employees, and what stage the A1 hospitals had reached in introducing this policy.

Data Analysis

Inductive Thematic Analysis

'Inductive Thematic Analysis' uses data to formulate or develop a theory 'linked' to, or arising from, the data collected (Braun & Clarke, 2006). The theory entails completing the data collection in full prior to any data analysis, through a set process of in-depth interviews. The data collected through these interviews is analysed collectively as a single data set. This data set is a true reflection on the middle managers experiences, meanings and realities were from within the environments they work. Through the process of thematic analysis themes are identified that reflect the entire data set, providing a "rich description of the data" (Braun & Clarke, 2006, p.83). A 'bottom up' approach was used to drive themes from the data and "this form of thematic analysis bears some similarity to grounded theory" (Braun and Clarke 2006, p.83).

This particular qualitative method outlined above allowed the researcher to determine beforehand exactly the volume of data that would be collected, that could be reviewed, coded, and analysed in detail. As explained above, data was collected through in-depth personal interviews, with middle managers at A1 hospitals, and for a whole-hospital perspective, with senior human resource managers. By interviewing managers from different healthcare groups and disciplines, a range of employment criteria was covered, which are described earlier in the chapter (p.27). Using these criteria, differences between the groups of staff became clear, and it was possible to gain an understanding of a wide range of WLB requirements for healthcare sector staff.

In the coding and analysis process, in addition to Braun and Clarke's (2006) method of Inductive Thematic Analysis the researcher also reviewed similar thematic methods used by Strauss and Corbin's (1998), which assisted the researcher in processing and analysing the data to produce a detailed list of categories and sub-categories. Through this process of analysis the categories were shaped from common themes, into collections of similar themes, until they became solidly grouped categories (Braun & Clarke, 2006).

Again, qualitative method in the form of Grounded Theory (Strauss & Corbin, 1998) guided the interview process, in the hope that both middle managers and senior human resource

managers would describe what particular factors affected their decisions. From the data collected, theories and categories developed, to give the researcher insight into how these decisions were made within the Vroom's (1976), three way relationship.

Thematic analysis – coding and generating themes

All the interviews were electronically recorded for accuracy, and then transcribed by an independent audio typist verbatim. The transcription identified both the interviewer and interviewee by a different colour text, which made reviewing and editing errors much easier. The researcher reviewed the transcribed text against the recording to check for accuracy, and to aid familiarisation with the data.

These transcriptions were then sent to participants, asking them to check the interview notes for 'correctness and completeness', and to return the corrected document within two weeks. If interviewees had not returned the document within two weeks, it was agreed that they believed it reflected the interview accurately. Some interviewees gave no answer, others sent e-mails to say they were happy with the record, and others returned documents with corrections and minor modifications.

Once all the transcriptions of the interviews were finalised they were then printed out in preparation for coding, and coded using 'thematic analysis' (Strauss & Corbin, 1998; Braun & Clarke, 2006; Tuckett, 2005).

Using Braun and Clarke's (2006) inductive thematic analysis process, with its 6 stages, gave an integral understanding and a precise method of producing detailed themes and categories. Incorporating Strauss and Corbin's (1998) grounded theory analysis process using their three stages of thematic analysis; these are 1) Open, 2) Axial, and 3) Selective, enhanced the researchers understanding and improved the process.

Braun and Clarke (2006) outline six stages in their process of thematic analysis. The first stage involves familiarisation with the data. This involved re-reading the transcripts of the interviews and making notes of ideas. The second stage involves generating initial codes. Codes are similar ideas and were generated by coding interesting features across the entire data. The third stage entailed Searching for themes, by collating codes into potential themes and gathering all data relevant to each theme. The fourth stage was a significant amount of work that required the researcher to review the themes and repeatedly checking themes in

relation to coded data throughout the data set and generating a thematic 'map' of the analysis. The fifth stage was a combination of defining and naming themes. This included refining specific themes and generating clear definitions for each theme identified. The final sixth stage was collating and producing a report, selecting extracts as examples, and relating these back to the analysis of the research question and the literature.

The method entailed reading each line of text and allocating a theme or idea that it described. This process was integral to the allocation of different idea(s) ('threads') throughout the data. Re-reading the data, coding, writing and theorising improved the researcher's ability to recognise and categorise the data accurately (Tuckett, 2005). Themes were important messages from within the data that emerged from material being examined to generate categories within the analysis. The initial process of reviewing the data and identifying ideas was the main focus, the frequency of these ideas was not as important as the 'position of the idea' within the narrative (Liamputtong & Ezzy, 1999). The ideas lead to themes, which lead to categories, through a detailed allocation process of grouping similar concepts.

Once a transcription had been read and reviewed to identify patterns of ideas and themes, the themes were grouped and collated (Braun & Clarke, 2006). Each line was coded as an idea and then grouped into similar idea groups or themes. More reviewing led to these themes becoming grouped into multiple categories. These categories were reviewed and analysed again and were grouped into fewer more common categories with a broader scope to include more related themes. A few of the minor codes appeared singly and if each represented only a single idea, unsupported by data from other interviews, it was not used (Tuckett, 2005).

Each emerging idea and theme was both colour coded and numbered for easy identification. The number related to the specific category and sub-category, and the colour code was related to the main text of the interview documents, so that each line or idea could be related back to the original interview, if necessary. For example:

> Most of the requests that I get are usually based around leave (5.1) and changes in rosters to suit an individual's needs. (5.2) These needs are not always personal but relate to kids, older family as well as individual health issues. (5.7)
>
> I try to meet all submitted requests if other factors such as rosters, time of notice, specifics of request……all line up together and I can manage to allocate the resources to approve the request. (3.3)

Document analysis

A content analysis of the documents collected was undertaken using theories and models found in systems supporting health policy analysis, according to Krippendorff (2004).

An analysis of the literature was undertaken primarily to identify what the broader population had identified as issues/problems within the subject of WLB. A secondary process was used to classify these documents into 'groups' based on the subjects identified through the literature review of similar information and views. The defined groups are listed below:

1. Employer/Human Resources
2. Employee/Union
3. Government/Consultants
4. Welfare or Community viewpoint.

The literature was separated into one of these four groups using a template, as shown in Table 2.1 below. This table also outlines information about the content of documents during the article/document review process. These questions were: What were the particular items in the articles/documents under headings of Argument(s), Goals, Evidence, and Strategies?

Article Ref. No.	**Subdivision**	**Argument**	**Goals**	**Evidence**	**Strategies**
Article reference number	Article group either - Human Resources, Welfare, Government or Employee.	What is the article/paper's fundamental argument?	What is the goal, or suggestion made?	Is there enough evidence to support the argument?	What strategies are offered or possible solutions given, in the article/paper?

Table 2.1 - Defining document grouping

Summary

To answer the research question it was necessary to look at a three-way relationship between middle managers, their staff and the organisation (the human resources department of the hospital), (Maxwell, 2005). This relationship, and how each of the three parts interact when middle managers are making decisions, is best demonstrated by Vroom's decision model (1976). This model demonstrates the interaction of these three groups (see figure 2.1), and

their interdependency, when a decision is being made, and what conditions are likely to influence each decision and its outcome (Vroom, 1976). This relationship was fundamental in the development of the interview questions used for the thematic analysis and subsequent coding of themes and categories.

Carrying out an appropriate document analysis for A1 hospitals required integration of the categories identified through the Thematic Analysis of the interviews. The grouping or categories that were identified through the document analysis are listed below. These subjects were significant to those interviewed, and which in turn influenced daily operational decisions.

Grouping of documentation available in A1 hospitals:

- Leave Policies
- Government (policy & regulations)
- Enterprise bargaining agreements & awards
- Other hospital policies, i.e. Information Technology & Communication, staff programs, employee assistance program
- Hospital department rosters
- Staff health and wellbeing
- Promotional brochures (for leave & WLB)
- Employee workflow guidelines

Chapter 3 Work-Life Balance Document Analysis within A1 Hospitals

This chapter contains an account of the findings of the analysis of the policy documents and guidelines governing activities in the Victorian A1 hospitals included in the study. There are two sections: first, an examination of the official documentation that is used to assist managers in implementing WLB decisions; and second, discussion of the gaps and shortcomings in the official documentation.

The A1 hospitals' many policies and guidelines are based on, or relate to, the relevant union, state and federal government documents. All documents collected were placed into selected 'groups' of those with similar views and arguments (as described in Chapter 2). These selected groups enabled the researcher to compare and illustrate the various issues and problems that influenced and led to particular work-life balance decisions.

With the available documents (policies and guidelines) reviewed, the researcher found that there appeared to be a gap in the necessary resources available to the managers. That is, specific work-life balance documentation relating to staff issues, which managers were likely to encounter, was lacking.

Current Documentation in A1 Hospitals

Formal documentation for middle managers that related to work-life balance within the A1 hospitals varied considerably and consisted mainly of hospital leave management policies and guidelines, EBAs and workplace awards, and other local departmental guidelines generated by middle managers. There were only a small number of specific work-life balance and staff wellness documents, and these were also collected and grouped. Government documents from both state and federal governments that impacted on work-life balance decisions were also included. All the collected documents are summarised in Table 3.1.

Documents	Hospital A	Hospital B	Hospital C	Hospital D
Government & Legislative policy and regulations	X	X	X	X
Other hospital policies • Information Technology & Communication • Staff programs – discounts • Employee Assistance Program	 X X X	 X X X	 X X X	 X X X
Enterprise Bargaining Agreements & Awards • Administration • Nursing • Allied Health • Scientist • Medical	 X X X X X	 X X X X X	 X X X X X	 X X X X X
Leave Policies • Annual leave • Sick leave • Special leave • Long Service Leave • Leave without pay	 X X X X X	 X X X X X	 X X X X X	 X X X X X
Local Department Rosters	X	X	X	X
Health and Wellbeing • Policy • Guidelines	 X X		 X X	
Promotional Brochures of WLB		X		
Work Life Balance Surveys • Data for managers • Staff surveys	 X X			

Table 3.1 – Documents relevant to work-life balance in the A1 hospitals studied. Note: X indicates documents in place.

Each category of document is discussed below.

Government & Legislative policy and regulations

There are many Federal Government Acts that have general requirements for A1 hospitals to uphold and that have to be integrated into any A1 hospital policies affecting health workers' conditions, including their work-life balance requests. These include:

- Charter of Human Rights and Responsibilities Act 2006 (Victorian)
- Delegation of Authority
- Fair Work Act 2009
- Defence Reserve (service protection) Act 2001 (Commonwealth)
- Enterprise Bargaining Agreements (Nursing, Administration, Allied Health – 2004-2011
- Workplace Relations Act 1996 (Commonwealth)
- Equal Employment Opportunity Act 1995 (Victorian)

There are also state government documents, such as the Charter of Human Rights and Responsibilities Act and Equal Employment Opportunity documents.

The Fair Work Act 2009 covers the rights of employees and how they must be treated within a workplace. The Equal Employment Opportunity Act 1995 outlines the right of all people to be equal and the imperative to eliminate any discrimination or sexual harassment. These documents allow employees to make requests to their managers with the expectation that their subsequent treatment, and decisions, will be fairly administered.

The *Fair Work Act* (2009, pp 5) has many purposes. It "(a) provides for terms and conditions of employment (Chapter 2); and (b) sets out rights and responsibilities of employees, employers and organisations in relation to that employment (Chapter 3); and (c) provides for compliance with, and enforcement of, this Act". In fact it describes the essence of employees' work–life balance, saying that employers must be:

> … assisting employees to balance their work and family by providing for flexible working arrangements. (p. 4)

This statement shows that the government's intention is that employers should try to meet staff expectations of work-life balance, and allow for them as far as possible.

Interestingly, other documents, such as the Code of Conduct for Victorian Public Sector Employees (2007, p. 24-25) encouraged employers (middle managers) to "provide a safe, encouraging and supportive work environment that recognises and values diversity, abilities and contributions," to treat workers "fairly and consistently" when making decisions, to adhere to both "industrial and legal obligations", and to "encourage work arrangements that enable their employees to achieve a work-life balance". This echoes the *Charter of Human Rights and Responsibilities Act 2006* by relating the Code of Conduct to the family unit, as Section 17 of the Charter states "that families are the fundamental group or unit of society and are entitled to be protected by society and the State".

A federal government paper, 'Work and Family Issues', in 2006 gave examples of such issues to assist public sector agencies, such as hospitals, to incorporate more flexibility into their arrangements for employees and to assist them in implementing many types of leave – parental and personal/carer's leave, for example. This paper included lists of merit awards being given in recognition of "outstanding leadership and innovation from business in the promotion of a better balance between work and family", thus demonstrating government support for workplace initiatives (The Hon. Kevin Andrews MP, 2006, p. 16).

Hospital policies

A1 hospitals' policy documents used a wide range of legislative and Department of Health (DoH) documents, which included those policies and regulations general to all workplaces. In response to the federal government paper A1 hospitals produced leave management policies and guidelines relating to all areas within the workplace. The leave management policies analysed in this study referred to many government documents that have been referred to above and that need to be considered when making decisions in each hospitals' departments. These documents outline part of a work-life balance framework that middle managers had to consider.

These policy documents lay down the philosophies that the A1 hospitals have to consider when implementing their own policies, with the welfare of the employee 'paramount', including an expectation, as outlined in the legislation, that all decisions with regard to staff requests need to be fair, consistent and without bias. A1 hospitals have Boards of Management in Victoria and through the DoH they receive policies and guidelines, as well as funding, on which they base their own policies, rules and regulations. However, there is no

formal government policy setting out how employers are to manage work-life balance in A1 hospitals, to which middle managers could refer in managing their employees' work-life balance issues in the workplace.

In addition to the HR policies and agreements used for decision-making there were numerous policies and guidelines available to both staff and managers that had been generated by other departments, such as the Information Technology (IT) Department for example. These other departmental policies could influence or even negate a middle manager's decisions when staff requests cross departmental boundaries.

Staff requests relating to working from home or off site, possibly because of current personal circumstances, were a specific example where IT policies were concerned, because IT policies limit access to the necessary systems because hospitals have an obligation to protect the patient, the organisation, and individual staff member's personal information or data, thus restricting the manager's ability to approve such requests. Managers have to be aware that these IT and HR policies apply generally, and that decisions have to satisfy both compliance with government legislation and hospital-specific security and access requirements, such as in-house data management systems. Following these policies could therefore limit managers' ability to grant staff requests related to work-life balance needs.

Managers now have available to them a list of broad HR leave policies to oversee local department need and help cater to these requests. However, the circumstances affecting a staff member can go beyond the need for 'leave', and the A1 hospitals included in this study all had programs such as the Employee Assistance Program (EAP), initiated to help staff and managers in work situations and with non-work issues.

Such programs and policies created a positive environment for all employees, which could influence staff requests. The organisation was creating a constructive relationship between staff and management by providing these amenities for staff.

Enterprise Bargaining Agreements and Awards

Enterprise Bargaining Agreements (EBAs) and Awards are a formal agreement between a professional body/union and the state or federal government, for a fixed period of time. At the conclusion of this period they are then renegotiated, usually between the government, Unions and the hospitals' representative that varies for different professional groups; for medical staff

the Victorian Managed Insurance Authority (VMIA) is used. These documents outline a range of agreed employee entitlements or benefits. While different craft groups can be covered by different EBAs, the detail of their entitlements may differ only slightly between different agreements.

The wording in these EBAs varies within the documents, though if an entitlement is mandatory, the statement has '*shall be'* or '*will',* referring to leave, for example – Registered Nurse Divisions 1 and 5 *shall be* granted 190 hours of annual leave (Nursing EBA 2007-2011). Other entitlements are worded so that the entitlement is clear, but a variety of words show which is not a mandatory item, such as, '*may be'*, '*may grant'*, '*entitled to'*, '*deemed to be'*, or '*by agreement'*.

Other items included in these EBAs were financial penalties for staff working out of normal 6:30 am to 6:00 pm hours. If staff were required to work outside normal working hours they had numerous 'offsets', including higher hourly rates, meal allowances, many different shift allowances, or minimum number of hours pay for recall to duty, etc. Also included within the Health Services Union Australia (HSUA) 2004-07 EBA was a 10 hour break between recall and duty shifts, extra leave for working more than a specific number of weekends, days in lieu of public holidays on weekends, and 'time in lieu' instead of financial payment. Managers thus have to keep within budget constraints despite an increased costs of entitlements and a need for additional EFT staff to maintain services, since staff are needed to fill the 10 hours between the imposed 10-hour break allowance for standard and overtime shifts and recalled staff ending one shift and starting their next (HSU 3 Allied Health Award 2009).

There were of course benefits for managers in these EBAs, such as the formal acceptance of 'modes of employment', which include job-share, part-time, bank or casual. Having staff employed under some of these provisions, outlined how middle managers could improve their department employment outlook, serviceability and flexibility (Nursing EBAs 2007-2011). The nursing enterprise EBA also included staff ratios for numbers of patients that improved patient care and reduced stress within the workplace (Nursing EBAs 2007-2011).

One recent change in EBAs was the inclusion of '*Salary Packaging'*, which is now available to all staff as a financial benefit, though employees have to be informed if and when this facility is no longer beneficial for them. The definition of a benefit is not included in the

EBAs, but the relevant clause does include a reference to seeking financial advice before this entitlement is in operation. Staff could perceive salary packaging as an aid to balancing their finances between work and home needs, since items that could be covered by salary packaging include, but is not limited to, mortgages, loans, rent, and amenities.

Leave Policies

All the A1 hospitals participating in the present study had an individual Leave Management Policy, which included additional hospital-specific guidelines that the organisation required employees to adhere to.

> As stated: "These guidelines are provided to give guidance to Managers and employees in regard to leave entitlements and responsibilities…… These guidelines have been developed to coincide with requirements under relevant legislation. Should any conflict arise with these guidelines subsequent to changes in enterprise bargaining agreements (EBA's), the EBA requirements will take precedence" (leave policy, A1 Hospital C).

The presence of these general policies enables the hospitals to facilitate and implement the entitlements fairly and appropriately. These 'master' documents list all the other types of leave, or associated leave, that both managers and staff need to be aware of, and use in conjunction with hospital-specific guidelines when staff request any type of leave, and use also in conjunction with any current EBAs and awards.

The intent of a general leave management policy is to transfer the responsibility to manage the absences of employees, both from an operational and a staff welfare perspective, to middle managers. The middle managers have to balance the needs of the organisation and the requirements of the Enterprise Bargaining Agreements and Awards while making decisions. One example of this is the balancing of leave, as an entitlement for staff is to be allocated annual leave each year, as outlined in the EBAs, but staff are not entitled to stockpile leave. The purpose of annual leave is to help staff maintain their work-life balance, and hence is allocated annually. The manager has to implement the organisation's leave policy for all staff, while avoiding 'leave liability,' so storing leave can occur only under special circumstances, with management approval; if a staff member does not take that leave within a certain time, negotiations between manager and employee should lead to enforced leave.

General leave management policy became more detailed and hospital-specific when applied to items such as 'the amount of leave' an employee may accumulate before reaching an excess amount, necessitating a plan to take leave as soon as possible. The hospitals had their own organisational policies to make all managers aware of these entitlements, and how they should be implemented, so managers could assist staff to plan for their leave in the organisation's interest, without staff losing their entitlements.

In addition to the routine leave requests discussed by managers such as, annual leave, sick leave, conference leave and long service leave, there was also personal leave, which has been included in the list of available leave, in leave guidelines. Many organisations have had to become flexible in accommodating personal leave, as the scope of such leave has broadened to include taking care of aged parents, including time for finding aged care accommodation – useful where a growing proportion of the population is over 65. Parental leave has also been expanded to include additional paid maternity leave, paternity leave, and adoption leave. Personal leave is another term being used in awards and agreements to cover types of other leave such as sick leave, carer's leave and compassionate leave (Nursing Enterprise Agreement 2007-2011). Employees needed to note that each award and agreement included different provisions and they should take advice on actual entitlements before utilising them.

Personal leave also includes limited unpaid leave (special leave), which can be provided at the discretion of the hospital executive for circumstances not covered by any other type of leave (for example, if all paid leave entitlements have been used).

Local Department Rosters

The staff rosters for different specialised units vary in what types of shifts and skills are included, across the departments that participated, but similar across the same staff disciplines. Departments have specific workflow requirements such as: operating hours, responsibilities/positions to be covered by staff, requirements for skill maintenance to ensure service provision, and leave plans, and each roster had to be easy for all staff to access.

Each roster also incorporates a number of hospital policy, as well as EBA, requirements. Mandatory EBA items on rosters include: accrued day off cover (for fulltime staff), annual leave cover, allocated shift codes, and allowing for staff to take the required breaks before returning to work. These rosters also include other items that are not mandatory, such as long service leave cover, cover for recall or overtime, and maintaining the required mix of staff

skills. Rosters have to be available to staff between four to eight weeks in advance, and in many formats, including printed, digitally on Excel, HTML, or Word, and on payroll systems.

Staff are allowed to make agreed changes to the rosters in some departments as long as they meet certain rules, or maintain particular requirements, to maintain a functioning service. This flexibility is a feature of most department rosters. The major positions on the roster have to be filled with the appropriately skilled staff so that the service is maintained, but staff are also encouraged to change shifts and swap 'on call' or accrued days off, and even to negotiate changes in annual leave allocation. Changes to rosters requested outside of these accepted rules (documented guidelines) have to be submitted to the staff member's immediate supervisor, who is responsible for the generation of the roster. If the request is complex, or setting a precedent, the request is always referred to the middle manager of the department.

Although these 'rosters' accommodated many changes associated with the type of leave (annual leave, accrued day off, other leave, etc.) and work type (fulltime, casual, etc), the rosters main function is to ensure daily service provision, though only one of many available tools assisting middle managers making decisions about staff requests. Rosters are modified periodically to reflect any changes in the decisions made by managers and/or changes in staff entitlements.

Health and Wellbeing

Out of all A1 hospitals studied, only two had formal draft (not endorsed by hospital executive) health and wellbeing policy documentation for managers and staff to refer to. Within the 18 months of collating and analysing the data, only one hospital had introduced formal health and wellbeing guidelines for their staff. Another hospital had introduced them after testing staff views by means of surveys, which led to a document outlining the hospital view of wellness, and management's expectations of the staff's agreement.

Objectives and strategies incorporated in these two hospital health and well being policy guidelines reflected the importance and benefits of work-life balance for all staff, and also offered a range of flexible work practices, which encouraged staff support for achieving a balance in their work and life responsibilities. In conjunction with wellbeing, one hospital's policy stated, "Additionally, these strategies and practices further aim to create an engaged workforce, as well as to attract and retain new staff and graduates" (leave policy, A1 Hospital A).

These wellness policy documents, written by the Human Resources Department, included what the health service called ‘Healthy Options’ that staff had available to them. Below is a list of hospital programs and hospital facilities identified in the interviews, such as:

- Newsagent
- Post office
- Intranet for Staff Notices
- Gym, Swimming Pool
- Pharmacy
- Breastfeeding facility.

Additional programs include:

- Employee Assistance Program
- Weight management
- Memberships
- Discounts – i.e. gym, private health cover
- Free worker health checks
- Quit programs

These policy documents also included an expectation that managers would facilitate flexible start and finish options in rosters, to improve hospital responses to meet external events, reduce pressure on individual staff and avoid stress on staff, which could hamper the organisation’s ability to retain them. Improvements through the use of these flexible work practices would allow staff and managers to develop effective ways of completing workloads, which again would increase flexibility and assist in meeting staff current or future personal needs.

Promotional Brochures and Work-Life Balance Surveys

As noted in the previous section, some hospitals had draft documentation, though not formally adopted policy, encompassing staff wellness programs. One A1 hospital included in its material available to managers and staff an online organisational brochure, a simple one page ‘brief’ promoting work-life balance, and the need for staff to make full use of their leave, even giving examples of the types of holidays employees could take, and promoting a ‘No Leave, No Life’ slogan. The introduction of the online brochure, with its ‘Health and Wellbeing Strategy’, clearly showed that the organisation supported the concept of wellness and work-life balance for staff.

Another hospital (B) had conducted a formal staff survey (through an external consultancy), with focus groups, to gain information about staff views on the work-life balance issues included in the draft guidelines. The survey questions were focused on the staff and their interpretation of wellness and work-life balance, to gauge the "future impact on employee engagement, retention and service delivery, from both the managers' and other staffs point of view" (Middle manager, hospital C). The hospital executives used the collated information to formulate a proposed work-life balance policy that reflected the organisational outlook. The policy details were then incorporated within the organisation's wellness promotion, wellness guidelines, and work-life balance policy.

The information within this survey reflected staff needs in multiple matters such as flexibility (shifts, hours, location, etc.), staff work-life priorities, and workload. The CEO of hospital C also used this information in highlighting opportunities for staff retention, planning and change in organisational culture. According to the survey report:

> 70% said that their Manager/Supervisor tries to be flexible when helping staff who have a work/life conflict and 67% overall agreed/strongly agreed that they felt comfortable talking to their immediate Manager/Supervisor if they have a work/life issue (hospital C survey, p. 5)

Documentation shortfall

The list of policies and regulations that A1 hospitals use, i.e. EBAs, Awards, legislation, routine and extended/broader range of leave policies, falls short of information that managers' require to assist them in making decisions. This list is disappointing, when looking at those WLB policies actually operating, compared to those in some industries, and even in some interstate hospitals – Greenslopes in Queensland, for example (Business Council Australia, 2007). Victorian A1 hospitals were still defining the constituents of employee needs through surveys and 'motherhood statements', and even with some policies, guidelines and draft WLB policy documents available, the information available falls well short of sound solid policy for appropriate use in decision making. Without clear and direct HR WLB policy, it could be expected that middle managers' would adopt and utilise their own solutions.

Chapter 4 Interview Analysis of A1 Hospital Middle Managers and Senior HR Managers

In this chapter I present the thematic analysis of the interviews with three middle managers and a senior human resources manager in each of the four participating Victorian A1 hospitals. The interviews focussed on what types of requests managers received relating to work-life balance, the resources available to them to respond to requests, and what decisions were made.

The managers that were selected to participate in the study 'sit' within the middle management level of the A1 hospital organisation hierarchy. Each manager reported to the Director of his or her particular Clinical Specialist Unit (CSU) or Department, who in turn reported to the hospital Executive responsible for that area. Each clinical middle manager was clinically qualified in the area they were responsible for, and the senior human resources managers all had a background in Human Resources (HR) training. Additional training of these managers varied from attending a hospital in-house workshop to post graduate qualification in management.

Five categories were identified in the thematic analysis and were organised as follows: first, the degree of experience of the manager in his or her position; second, the ability of the middle managers to be flexible; third, the types of requests staff made to managers; fourth, the kinds of constraints imposed on the manager's ability to make a decision; and finally, the impact of hospital policy on any conditions favouring WLB (listed in detail below). The managers' interview responses are discussed in relation to each of these five categories.

1. Experience gained in a management position.
    1.1. Management structure
    1.2. Time in the management position
    1.3. Previous decisions
    1.4. Skills with managing staff, such as staff retention and allocation of staff skills
    1.5. Management structure
    1.6. Other resources
    1.7. Manager education

2. Flexibility (workflow system flexibility)
    2.1. Middle Managers' ability to decide on staff requests
    2.2. Policy and Enterprise Bargaining Agreements
    2.3. Rosters
    2.4. Staff expectations

3. Types of staff requests
    3.1. Leave
    3.2. Change to roster
    3.3. Workplace location
    3.4. Connectivity to the hospital off site
    3.5. Promotion request
    3.6. Staff national Culture requests
    3.7. Time out from work (regroup oneself)

4. Constraints (affecting a manager's ability to grant requests)
    4.1. Leave policies
    4.2. Enterprise Bargaining Agreement
    4.3. Staff skills range
    4.4. Decision has to be co-approved by manager's superior
    4.5. Performance of staff member

5. Work-Life Balance – Policy
    5.1. Inadequate or incoherent information
    5.2. Human resources departmental support – positive or negative
    5.3. Senior management support

Experience gained in management

The middle managers interviewed emphasised that their past experience in carrying out their job was a significant component in making many of their decisions. The experience gained over many years (which ranged between 3 to 12 years) derived from a range of outcomes from many different decisions in response to staff requests. The managers had taken the time to understand the content of documents, such as staff EBAs, and the hospital policies, which added to their knowledge when making decisions.

Management structure

Senior human resources managers' believed that strong leadership from the Hospital Executive was essential to support middle managers. This leadership was needed to set values, generate trust, encourage staff openness, and have confidence in the middle managers' decision process. This support allowed middle managers the freedom to manage their department relatively autonomously, and combined with a deliberate delegation structure, enabled them to be confident and productive when making decisions. In contrast though, some middle managers perceived the leadership structure as restrictive, as it could limit their decision making process.

Middle managers believed that many layers of staff within the delegation structure was sometimes a major stumbling block when quick and decisive actions were necessary, or when managers were trying to be creative in resolving complex requests. In some instances, middle managers tended to 'manage up the structure', to educate new Directors in the customary management procedures. Managers said they did this 'as I may need their authority' or 'I have had numerous Directors in a short period of time'. The more senior the middle managers, the more they relied upon their experience: as one middle manager (middle manager, hospital B) said, "I suppose I've become more experienced …… I would use [my manager] less".

Middle managers agreed that being well-informed was critical within their management structure. Information had to pass freely between Executive Directors and managers, so that managers were aware of any decisions made that would affect their own staff, and Executive Directors became aware of current issues affecting staff. Several middle managers had strong links with managers in other areas of the hospital, and frequently 'bounced ideas off' these colleagues, especially when they had differing points of view. A senior human resource

manager actually reported: ‘I find EBAs limiting, so getting fresh ideas from other human resource managers is valuable’.

Time in management

It was evident from the middle managers and the senior human resources managers that the time they had held their positions was one of their most important assets when deciding on staff requests. They were aware of the relevant hospital policies and could name several policies that they used. During their time in the position they had developed some guidelines themselves, including departmental guidelines that reflected department processes and expectations covering most staff requests. These local department documents generated over time were a quick and accurate reference for staff, without being restrictive, enabling both staff and managers to reach the desired result.

It was important that the middle managers’ decisions resolved the immediate issue of a request, but further discussion could help them recognise any issues behind the initial request, not necessarily related to the specific request itself. Senior human resources managers supported this approach, as any underlying problems discovered could highlight the need for staff members to have a break from their workload. In some cases, staff had asked for a block of time off to complete a non-work task, though such requests were not limited to non-work, but applied also to requests to have dedicated time at work to complete projects or set tasks difficult to complete within the normal time allocated.

It was also evident that middle managers, in some cases, had to make a decision on a staff request quickly. On these occasions, managers stated that their past experience and ability to ‘think on their feet’ allowed them to do this. One manager said. ”You know that you believe you become self sufficient over time when handling the same problem over and over again”.

Middle managers had become relatively autonomous, and tended to seek help only when they thought they needed it – this was demonstrated repeatedly in the interviews with the middle managers who had spent most time on the job, and who found that their decisions related particularly to their experience, rather than to the result of referring a decision up to their superior manager. Most managers said they only reviewed hospital policies periodically to note any new drafts of an EBA, or a new/revised general hospital policy. Even though middle managers said they looked for minimal assistance from Human Resources or from their Directors, they did seek opinions from other managers or peers to help them gain support for

their decisions, believing that this method preserved their control over their 'local departmental' decisions.

Managers' development and use of their own guiding principles created, they believed, improved staff rapport and consistent staff expectations, as decision were usually made quickly, thus not allowing for speculation or any 'what if' questions. Knowing the benefits of creating a flexible workforce, this consistency enabled middle managers to provide the required service, as staff were usually aware of the likely outcome of a request, which in most cases averted a conflict in the roster. These known outcomes also reduced the manager's constant juggle to maintain a complex and skill-based service in departments with high numbers of professional staff. Although some managers appreciated that some of the rules could appear inflexible, their past experience told them that their decisions were correct.

Senior human resources managers agreed that experience in their role improved decision outcomes; they also indicated that managing staff, in a smaller specialised industry (such as HR), made it easier to make decisions, with less impact on their department as a whole.

Previous decisions

Middle managers believed that being fair and consistent by giving one answer for the same request was fundamental to the development of a basic rapport with staff. Even so, both middle and senior human resource managers stated it was also important that each request was assessed on its merit every time, as it was not just the decision that staff were interested in but also the 'why'. Therefore, when staff did put forward a request, both the circumstances surrounding the request and the known outcome of past decisions together created certain expectations, applicable to the outcomes of many decisions.

Managers believed that these expectations of particular outcomes over time had created improved morale, a team approach, and the basis for rules/guidelines within a department. For routine decisions, when the precedent had been set it was hard to argue for a change in the expected outcome – in fact a different outcome had a detrimental effect on staff, even when managers, after a change in hospital policy, made a decision that appeared to modify a previous one. Managers said staff perceived this as 'bending the rules', and some middle managers believed that they had to offer an explanation in these cases and discuss the decision openly with all staff in a detailed conversation, as either the previous decisions had been made in error, or the manager now felt justified in changing the routine outcome. Not all decisions

could be discussed openly, however, because of privacy requirements, so knowing how to have this conversation was a skill learned over time.

Staff skills – staff retention

Managers believed that the retention of staff, once employed, had become more difficult than in the past. The range and level of skills required by some staff had become more specialised in some technical specialties, but also the range of skills most staff needed had broadened over time. Two middle managers (hospital A and D) said that the gap between individual skills in the group made it hard to cover specialised services, while others found rostering easier than in previous years, as their staff group had maintained the skills required to provide an ongoing service, even in times of difficult recruitment. Middle managers had also experienced a change in staff expectations of when they wanted to work (no night shift), rather than when they 'had' to (required to cover any shift in a 24 hour period). Managers' use of rosters as a tool had succeeded in overcoming most of the difficulties of the planning processes for these changes, but could not compensate completely for changes in staff skills.

Managers having continually to meet staff requests had both short and long term effects on supplying an efficient and comprehensive service, especially in more highly skilled work. The loss of skilled staff, even for one shift, impacted on service provision, and could constrain the middle manager's decision. Maintaining the service reduced the manager's flexibility in agreeing to a staff request, but managers were aware that they also needed to retain the staff expertise, so in some cases they had to lose an expert staff member for a period of leave to keep that staff member long-term. Disgruntled staff could leave or transfer if their expectations were not regularly met, so for managers it was a matter of balancing the recruitment of appropriately skilled staff with managing staff requests and thus reduce the need to recruit extra staff.

Both the senior human resource and middle managers found that it was hard to make staff realise that a hospital needed to function continually on a clinical level (which is high cost, due to being labour-intensive) and that most of the clinical services provided were face-to-face. New graduates, managers found, have a different perspective on work, apparently believing that work comes second to their own social lives. Routine requests from such staff, made in high-skilled sections came with the expectation of an automatic 'yes' from the manager. One middle manager (hospital C) said "I just say 'yes' to all requests and modify the roster accordingly, it's better to manage the expected leave than the unexpected leave".

This reaction was supported by several middle managers interviewed, and although there were other problems with it, they felt that having part-time staff enabled them to cope with those problems.

Some managers had staff requesting to work from home, because of a need for childcare, a wish to reduce working hours, or to care for a parent. Managers considered that if the work could be completed at home, the request should be supported, though not all staff requests were just accepted: they were reviewed on merit, and if agreed to, then a range of IT and department workflow questions had to be resolved before home based work was supported. Such support allowed the organisation to retain staff that would otherwise leave or significantly reduce their working hours. If supported, this type of 'niche' work arrangement tended to suit both parties, but managers said they routinely reviewed the resulting outcomes by monitoring the performance of these workers.

Other resources

There are resources available to managers in hospitals today, and these resources were referred to throughout these interviews. These resources include: workforce planning, recruitment, technology, policies, government documents, awards and EBAs, as a few examples. Although these resources appeared not to be widely used by middle managers in making decisions this is possibly because these middle managers developed their own decision making 'tool kit' over time. The interviewees described this "tool kit" as mainly including their personal experience along with local department rules, which together dealt with many of the routine decisions. Other middle managers, including one of the senior human resource managers, had incorporated some technological resources for basic administration functions, i.e., IT functionality from home, using Citrix (software designed to facilitate secure access to applications and content), for access to the hospital systems.

Most middle managers were aware of resources such as workforce planning and recruitment, networks of peers (internal and external), Occupational Health and Safety (OH&S) guidelines, Employee Assistance Program (EAP), Human Resources Business partners and internal training programs. Many also mentioned the organisation's physical facilities to help support staff, such as childcare, a gym, a staff clinic, elder care, and programs such as salary packaging or wellness programs.

These other programs available to all staff did not necessarily have a direct impact on requests being made or decided, though these programs were designed to increase staff well-being. Some were for physical health, including exercise programs, and others were personal, such as Quit smoking, health insurance, weight loss. Improvements to staff amenities included a staff gym (and/or memberships), childcare, bike rack/storage, and shop facilities.

Middle managers believed that availability of data, and improvement in the detail, had improved over the last few years. Such data had been instrumental in providing 'feedback' to middle managers to assist them in monitoring the varied types of leave, which enabled them to more accurately plan leave requests (of all types) with individual staff members when required.

Manager education

Middle managers interviewed noted there were in-house educational training programs for managers available (encompassing a leadership theme), but not many of them could actually recall being specifically trained for their work, or receiving any specific in-house management training. Senior human resources managers, however, could outline several educational courses that the hospital had indeed opened up to middle management personnel, although they were not sure how many middle managers had enrolled in and completed these courses. Some middle managers had regularly attended seminars for training in how to negotiate with staff about hospital policies and their implementation, and staff expectations.

Managers also referred to recent training programs that had been implemented in a few of the A1 hospitals. These programs incorporated advice on what the middle managers should look for in staff behaviour, such as clusters of sick leave or unscheduled absences without notice. Skills included in these training courses were, for example, the ability to initiate discussion of any unscheduled absences with a staff member, and to discover possible problems associated with these absences. This would enable managers to then develop solutions to assist the individual staff member to resolve such problems, or plan future ways of dealing with them.

Both groups of managers interviewed were aware of the importance of succession planning in the event of skills shortages, either short or long term. No official training existed for this, but middle managers tended to receive support and guidance from other hospital managers, and from their peers.

One A1 hospital had organised sessions for middle managers with speakers on WLB, and master classes teaching managers to look after staff health and wellbeing. The senior human resources manager believed this type of education was critical within the organisation but needed to be driven both from the 'bottom up' and 'top down' to achieve a common understanding of what it meant, and to generate this 'staff welfare' culture within the organisation.

Flexibility (workflow system flexibility)

Middle managers reported that they received many requests to make adjustments to working arrangements, based on staff members' need to adjust their work and non-work balance, and that, as managers, they required a flexible working environment to respond to these requests. Senior human resources managers reported the need to show more flexibility than reported by middle managers, specifically with regard to changing work arrangements, and even to *rethinking* aspects of work arrangements, so that they could meet staff work-life balance needs. Flexibility was constrained by the expectations of staff that leave would be approved with little or no notice; that workflow rosters would be covered by the remaining workforce available; and that award regulations were to be automatically adhered to, without manager opposition.

Middle Managers' ability to decide on staff requests

The middle managers and senior human resource managers stated that it was sometimes difficult to find solutions to problems staff raised in regard to their work-life balance issues. Managers' discussions demonstrated categories of concern raised by staff and also highlighted specific issues related to staff views and policies of the organization.

Solutions were required for problems with annual leave, time in lieu, reduced shift times, and to some degree sick leave. Although the process of deciding on a solution was perceived to be simple by the individual staff member, it became more complex in the context of other processes affected, such as rosters, EBAs, staff skills availability, and staff personalities. In most instances the answer to the staff request was to approve it and then make additional adjustments to the flow-on effects on the weekly roster, which included changing other staff days off or rostered day off, to cover the shortfall.

Staff requests made with very little notice was regularly accommodated, but they had a greater impact on the workflow in the middle manager's department than those made with adequate notice. For departments providing a 24-hour service, maintaining the appropriate level of skills in areas affected by approval of 'short notice' requests, was identified as the most critical issue, as staff-patient ratios as prescribed in the relevant award had to be maintained for proper patient care. Therefore, approving one 'short notice' request could reduce the manager's ability to approve subsequent requests, and staff understandably saw this as the manager's inability to approve the simplest of requests. Typically, managers dealt with the problem of short notice requests by repeatedly asking staff to plan all absences, so that the requests could, as far as possible, be readily met (and essential skills covered).

Policy/Enterprise Bargaining Agreements

Many of the managers believed that staff differed considerably in their level of understanding of what was in the EBAs and in the various hospital policies. Some staff would come forward with a request and inform a manager, erroneously, that this was an award condition and should therefore be approved without discussion, or that a hospital policy allowed a 'statutory declaration' as proof of sick leave. On occasions staff had to have the leave policy, or other policies, explained to them in detail before they understood the manager's decision.
Another issue that arose for managers with these EBAs related both to the entitlement and to whether it was mandatory or not. Middle managers and senior human resource managers needed to know what entitlements were in the documents and if the employee had a right to them, or only at the employer's discretion, or if circumstances allowed the granting of a particular entitlement.

Managers stated that when new to the job they would rely on checking the different hospital policies and even different discipline EBAs, while as experienced managers they were less likely to do this, as they had built up a repertoire of responses to the most common requests. Most requests covered by entitlements were routine, and there were established ways of maintaining workflow during periods of absence. In some instances, departments had a flexible revenue stream that enabled the manager to employ bank, agency or casual staff in order to meet predictable leave entitlements. Problems arose with staff from various disciplines having differing entitlements in their EBAs, creating a possible interdisciplinary conflict because decisions made for staff in one discipline were not reflected in similar requests made by staff in others – the difference in decisions often seen as one group having an additional benefit over another, for example with professional development leave (Nursing

EBA 2007-2011). So, when making decisions on some staff requests, middle managers were unable to make a common decision, as it would meet only one discipline's entitlement condition.

Written hospital policies from the HR Department (e.g., annual leave, OH&S, sick leave, etc), along with industry awards, were valuable because managers could direct staff to them in order to clarify the organisation's expectations of its staff, and staff in turn would 'know where they stood' before making requests. Managers agreed that staff members' understanding was the starting point for any request. Some managers had additional 'department-specific' guidelines available to staff which were derived from years of precedent-setting requests and decisions. These sorts of guidelines incorporate many minor and sometimes major decisions, so that only subtle variations require discussion before being approved or not approved by supervisors. Although the hospitals themselves had these guidelines, managers' decisions and options were still at times restricted because some items – for example, shift length, staff patient ratios and wages/allowances – were mandated within the relevant EBAs.

Not all changes to staff awards had a negative impact: for example, the introduction of mandatory 10-hour breaks between shifts, or providing replacements where nursing staff were on sick leave, had led to modification or adjustment of some hospital policies, thus assisting managers to meet subsequent difficult or awkward requests. Additional changes in EBAs over time had also allowed middle managers (and hospitals in general) to: employ more part-time and casual staff; meet workflow needs more easily; introduce 48/52 annual leave (an extra 4 weeks annual leave per annum, that is paid 48 weeks pay over 52 weeks); alter shift lengths (10 hr and 12 hr shifts); and to allow paternity leave and carer's leave. Such options and decisions had become relatively routine because staff were now regularly making these requests. Thus managers had to become personally aware of working conditions outlined in all staff EBAs in order to develop a consistent approach to decision making.

Rosters

Departments' that provide a service on behalf of the hospital are known as a 'service department'. Service department personnel usually allocate staff resources using a roster, which can be any document (hard copy and/or electronic) that shows where staff members are scheduled to work at a particular time, usually directing them to either an area (defined by a

required skill) or piece of equipment. In the hospitals studied some departments' allocated staff only to daily shifts while other departments had to allocate staff to daily shifts, multiple shifts (i.e. rostered shift then a shift of 'on-call' and shifts over a 24-hour period. In addition, a more general roster could allocate a group of staff to a location (casualty), not necessarily to specific tasks.

The middle managers used rosters to cover the allocation of individual skilled and specialised staff to daily shifts, but then used the roster for out of hour's rostering for groups of staff with a variety of special skills. Some rosters covered weekday activities, with no weekend requirements, while others had rosters covering shifts around the clock. The human resources senior managers, however, did not use rosters but allocated their staff to specific positions matching their particular expertise.

Rosters, although usually covering the basic, essential department functions, were impacted by the many rules and requirements 'built in' to them by the middle managers. These rules were to ensure that departments could still provide the required service even when modified either by staff (when allowed) or by managers. In the four 1A hospitals, these rosters had both general rules – e.g. one person rostered per day to one specialist area (hospital B) between 9 am and 5 pm – and specific rules requiring certain skills to be available to the organisation 24 hours a day – either on site or available to come in when required (hospital C). Specific rules around certain skills required for working in certain areas, to maintain the service, created problems for managers trying to find ways of meeting staff requests *versus* service needs. Staff could view rosters displaying the manager's current decisions, thus providing up-to-date information and enabling them to plan for future leave, rostered days off, training, etc.

Some departmental managers allowed staff to co-ordinate roster changes themselves, even those changes affecting the maintenance of a specific skill mix; "with rostered days off, they would just swap, and they would just organise it and let me know" (middle manger hospital C). These staff-initiated changes were only allowed, however, if the service was not left short of the required skill mix at the altered times. In other departments, by contrast, rigid roster rules allowed changes only to accommodate annual leave, rostered days off, and sick leave, so a permanent roster change required staff to follow a formal process of negotiation. Other departments used a rotational process to allow a change of environment for staff, or to accommodate staff training in different sections of the department. This training and

broadening of staff skills allowed further flexibility in maintaining services when unplanned absences occurred, as more staff members could be transferred to cover the work.

In fact, rosters seemed to give stability to staffing arrangements, providing a framework within which managers could make adjustments to support staff requests for leave, and meet staff expectations, while still covering service needs. However, managers observed that changes in the makeup of the workforce had impacted on their ability to set rosters. Most middle managers interviewed reported that the composition of the workforce has shifted from largely fulltime staff to a mix that includes a greater proportion of part-time and casual employees. This increase in part-time staff gave rise to improved flexibility in allowing leave, as staff were more readily available to work an extra day, or change their work days at short notice, providing better coverage when staff had planned leave and rostered days off. However greater numbers of part-time staff increased the managers' need to improve staff resourcing, and added another level of complexity in rostering and training. As one middle manager said:

> I have 60% of our workforce here is part time and 40% is full time, and it's really nice to give people flexible work arrangements but all of a sudden you've got 2 or 3 people doing the one job you've got a lot more things you've got to manage to make sure that job gets done properly. (Middle manager, hospital A)

Managers observed that roster frameworks had been established with a fulltime workforce in mind, so with many more part time and casual workers a new set of problems arose. Managers now had to juggle additional variables in skills and preferred times of work in order to meet service requirements. For example, middle managers stated that not all staff complemented each other's skills and at times they were not available, resulting in managers struggling to create a staff mix able to provide a comprehensive service. Other managers found that part-time staff filled niches in their rosters that required only a few days work.

Managers were also concerned with ongoing staff training and education. With the numbers of staff rising it was increasingly difficult to train (and update) staff skills to maintain a level of skill required for specialty services within certain sections of the departments – if appropriately skilled staff were not available at specific times, the rosters could not be filled. Thus either the service was not provided, or staff were stretched to cover the missing positions, or to supervise less competent staff doing the work. Some middle managers said

that the more part-time staff they employed the more flexible they had to become both in rostering and decision-making. Although managers stated the presence of part-time staff was an advantage and assisted in filling 'niche jobs', it could be concluded that this was the case only if managers could develop the training and the required flexibility in deploying them.

Staff expectations

Once managers made decisions with regard to a staff request, whether based on changes to rosters, implementation of an award, or hospital policies, the process gave rise to a pattern that both the manager and staff then tended to follow. These patterns became the basis for developing 'routine outcomes' for staff requests; these outcomes were the result of understandings that the manager and employees had gained from being either part of a previous decision, or from simply observing one. Through this process of decision-making, based on precedent, it was important from the manager's point of view that these patterns created particular staff expectations, so that a certain class of decisions became relatively streamlined, saving managers time and effort.

One important task for managers, including senior human resources managers, was to educate their staff: first, in planning for leave, then to extend this routine pattern of request decision-making to include all types of requests, including changes of duties, work to be covered, or shifts. Managers valued highly their consistency in decision making for similar requests, enabling them to gain credibility and staff trust: "… it promotes a more honest approach to coming and talking about what their issues are ……." (Middle manager hospital A).

This consistency in decision outcomes was built up through constant dialogue between managers and staff that involved discussion of the reasons for particular outcomes in response to requests. The more routine the request was, the easier the expected outcome was to achieve, though problems did occur when staff had expectations that were not met. This created ongoing difficulties with that person, and on occasions had 'flow-on' effects to other staff. For example, when a staff member expected a favourable decision disappointment could shake their loyalty, even when experience demonstrated that other hospital criterion (such as service delivery) were also essential in decision making. An important part of staff education about their expectations was for managers to explain clearly the Human Resources department's requirements for continuity of service, which underpinned all decisions made, so that some service demands to the hospital may outweigh requests from individual staff.

Managers understood that staff differed in their expectations of the same issue, which created problems with granting requests. Managers identified that it is hard to be consistent and fair in decision making when the individual perceptions differ – for example, a staff member might believe that his/her specific conditions or circumstances were different from those of other staff members, and therefore merited a different outcome to a request that the majority of staff would expect:

> Sometimes expectations are different, so I guess you need to ensure that both sides are aware of the policies, the guidelines, and the issues that are involved, because often requests may not be realistic, [staff's] expectations may be unable to be met because of all the issues that you have in front of you. (Middle manager C)

To be truly consistent in decision-making, and consolidate uniform staff expectations, managers needed to use the same reasoning and language to all staff, whether communicating to groups of staff, or to single employees.

Managers considered their younger workers ('generation Y') to be much more focused on what they wanted and needed in life in general than older staff: "Just about everything they come to with this about work-life balance, especially generation Y, ……they are very focused on work-life balance" (Middle manager C). Yet in many cases the expectations of these workers were different from the expectations of their workplace. The boundary between work and play of these younger workers was blurred, and their expectation of managers was that work would not outweigh 'play', and that managers therefore should accommodate this new thinking/approach. The real threat for managers is the pressure these young workers create on management. It seems that managers believe that if Generation Y does not have their requests granted, they have the option to resign and work elsewhere.

Types of staff requests

There were many types of staff requests made to middle managers in the course of a day. Not all requests were for leave; instead they included flexibility of work arrangements in a particular specialised workplace, working with specific staff, and preferred shift hours. Middle managers had to understand both the reason for the request and the likely impact of their decision. In addition to the many types of staff leave requests, middle managers had to be aware of any increase in other types of leave requests, as these also had an impact on the ability to provide or maintain a flexible work environment.

Leave

Middle managers stated that leave planning was all about how flexible a department structure was in its ability to grant the leave request – the more flexible a department was the easier it seemed it was to retain staff. Some managers had actually taken the initiative to plan 12 months allocation of staff rostered days off, giving staff a projected view of the roster, so that they could plan or swap these days with other staff.

Middle managers stated it was difficult to get individuals to be responsible for planning any type of leave. Because this process was poorly followed managers tried their best to accommodate all requests. Yet no matter how simple the guidelines, managers needed to make final adjustments, as each request had a slightly different impact. Some kinds of leave required approval before being planned, usually including study leave, professional development days, staff training, and conference leave – all of which had to be included in the mix with other types of leave requests.

Changes in awards had taken away some control from the manager's ability to have any influence on decision outcomes. Maternity leave, for example, can now be taken for between six weeks and 104 weeks, of which 10 are now paid. Planning for a 12 months' absence or for two years have a different impact on the manager's ability to appoint staff (temporarily) into these positions, affecting their ability to provide the required service. Paid maternity leave had an additional budget impact, reducing the funds for filling the created vacancy. Long service leave could be taken for double the time, at half pay, again making it hard to fund the replacement staff. Changes in annual leave options such as 48/52 leave allows staff to request an additional 4 weeks leave and incorporates a reduction of their salary to 48 weeks per annum paid over 52 weeks. This type of option had improved planning in staff leave (such as carer's/parent leave) and could actually reduce unplanned leave.

Change of roster

All middle managers concurred in their interviews that most changes to rosters were no longer mainly in regard to annual leave. Reduction in hours, change in work practices, staff complaints (such as 'doesn't suit my life style', or, 'no evening or night shifts'), or easing into retirement, were additional requests. Staff liked a flexible roster and preferred rules around it that allowed them to make their own changes, and middle managers had worked over time to create a roster flexible enough to reflect this need.

Changes from part time to full time, and then back to part time, have challenged the fundamental ability to maintain skills and service. The impact of roster changes arising from lifestyle and leave requests had increased the use of casual or agency staff, with a considerable effect on budgets. Some organisations have set up their own staff 'bank' or have negotiated 'set prices' for use of extra specialty skilled staff, for high use periods such as 'winter' as this time of year peaked for sick leave.

Location

Middle managers described most staff as reluctant to move organisations, as they lived near their current place of work. However, one manager stated that staff had become more reluctant to move over the last few years, shown in the minimal staff turnover. One manager had staff that were quite happy sitting in their cars for 90 minutes travelling to work and 90 minutes home again.

Most staff preferred working on one campus (in the case of multi-campus hospitals) but would work across campuses if it was part of their roster and employment agreement. One middle manager had some staff training problems, and asked staff to work at different campuses for set periods of time to improve their skill sets, as a particular site had a more acute patient workload than others.

Connectivity

Some of the senior human resources and middle managers interviewed had staff working from home if the work allowed, for reasons such as having no access to childcare, but also demonstrating increased output efficiency for work. One middle manager (hospital C), described working from home one day a week as follows: "I have access to absolutely everything at home to what I have access to in the office, and it's got, I think the advantages of it are far greater, because you don't have meetings booked". Other departments had typists working from home, covering hours 6:30 am to 11:00 pm, being available via phone or e-mail to type routine work as well as urgent reports, to fit in with overnight and evening medical staff rosters. Some departments had staff 'on-call' from home to complete IT system repairs or re-initiate 'IT controlled' systems when they go off-line, without the need to come in to physically do the same thing.

Middle managers commented that, as systems within the hospital enable a move towards 'paperless' workflow, more staff would be able to complete tasks at home. IT departments had improved the connections from home, allowing this to be an option. Managers believed that "Connectivity is great, as many administrations activities can be done any time of the day" (Middle manager, hospital C).

Even with improved access and increased efficiency some middle managers were concerned about the loss of social interaction with these staff members, and one manager disliked staff working from home, from the socialisation point of view, believing staff needed the social interaction with colleagues at work or they might lose the feeling of being part of a team. Staff, managers believed, also have to be disciplined to do their set tasks within the appropriate time. Working from home is not always practical for hospital staff, managers commented, given their many essential physical activities within the organisational departments linked to patient care. A couple of the senior human resource managers stated that organisations will have to be aware of the advantages and disadvantages of staff working from home, because this would be a fundamental issue as the needs of the hospital grew over the next 10-30 years.

Promotion

All the managers interviewed indicated that staff requests for pay rises or promotion were uncommon. Most issues around promotion were linked to job satisfaction and job classification. Pay increases were usually part of a routine process for filling vacant positions, or within the awards or EBA negotiations, but were not the main reason staff had for coming to work, though one middle manager had in fact demoted two staff members: one was not coping with the workload, and the other wanted a modification, which reduced that member's ability to fulfil the current supervisory position.

Culture

The middle managers reported that the number of requests had arisen that related to a staff member's culture, as there was more religious diversity among staff, connected to numerous differences in culture. For example, a staff member may need leave to take care of a parent's medical appointment, or look for an aged care facility, but now some staff had the responsibility of overseeing all aspects of their parents' welfare, as this was part of their culture, even, as in one case, where parents lived overseas.

There were also more requests now for religious holidays or special events, and an increasing staff expectation that managers would grant these requests. Middle managers needed to create a culture of open communication about what the organisation could offer in responding to such requests, and ensure that the employee understood the basic rules for these types of requests.

Time out

Another new request that both senior human resources and middle managers commented on was a request for a break from work. Reasons for these requests included: 'I want to get away for 6 months'; 'I have had enough'; 'I want time to reflect on what I want to do next'. Sometimes the request was because of an important outside problem which the staff member needed time to sort out, with a manager understanding that the staff member's mind was on the home problem, which could have a negative impact on patient care.

In addition, a staff member could be ill and need considerable time away from the work environment to have treatment and recuperate, or to assist a family member going through this process. Some staff members needed time to attend to their emotional needs, or to consider family needs that were not being met, and the extra time would be essential to resolve these problems. One hospital had introduced a form of 'time in lieu' for executives, as they did not have rostered days off but still needed some personal time away from work pressures.

Constraints (ability to meet requests)

The impression given by the middle managers was that there were many constraints affecting their decision-making, which stemmed mainly from general changes to hospital policies and EBAs. The improved benefits for staff that these changes brought had created difficulties for middle managers' ability to provide an ongoing service, without the ability to increase resources. The changes to hospital policy and EBAs included additional staff, funding for higher allowances, longer shifts and longer breaks between shifts. This increased the pressure on managers to ask for additional funding to support these changes.

Leave policies

Hospitals had many policies covering the many types of leave available to all staff, most of which were managed and reviewed by the Human Resources Department (overseen by the Directors). Middle managers were aware of these policies, but seemed restricted in the way

they used them when making their own decisions. The types of leave listed below each had different guidelines for their operation and implementation.

- Leave without pay (LWOP)
- Sick leave
- Annual Leave
- Long service leave (LSL)
- Carer's leave
- Maternity leave
- Paternity leave
- Rostered day off
- Compassionate leave
- Study leave
- Professional Development
- Extra Annual Leave (weekends worked, on-call)
- Emergency service workers' leave
- 10 hour break between shifts.
- Time in Lieu
- Others.

This list is extensive and, for a middle manager, quite daunting, when many staff were requesting different forms of leave at the same time.

Enterprise Bargaining Agreement

Senior human resources managers were critical of EBAs, stating that they were an 'industrial instrument for mainly full time employees that did not add value to WLB, not the solution we are looking for' (Middle manager, hospital D). They saw EBAs as barriers rather than a means to a solution or improvement for staff, though they also acknowledged that if the EBA was followed to the letter it did assist in protecting employees from situations such as a lack of work safety, or not being paid according to the correct classification.

Now that the work force in a couple of the A1 hospitals was composed of more part-time than full-time staff, middle managers had to become more flexible than the EBAs have allowed them to be. Managers stated that adding part-time and casual staff, and a growing range of shifts to fulfil the philosophy of 'one size fit all', meant EBAs did not work. They considered an EBA was something left over from the post-war era and Human Resources staff were struggling to educate Hospital Executives that there was a need for alternative solutions. Managers believed EBAs were designed more for full time employees, and lacked the flexibility needed for the newer workforce that managers were now responsible for. Some

middle managers had more than one discipline group to manage and therefore had to tailor staff decisions due to different EBAs.

Staff Skills

In many departments, providing the full range of desirable staff skills was one of the most difficult problems middle managers faced when providing an ongoing service, especially given the many restrictive practices (registration) and multiple EFT required for the same shift. Middle managers drew attention to the same problems whether they were supervising 'high-end' emergency care or low impact outpatient care. Given these difficulties, a reduction in unplanned absences led to an improved ability to provide appropriate staffing, and thus enabled maintenance of the required skill base for the care needed. It also led to improved morale, which, over time, managers had seen improve both attendance and retention of staff. This improvement, they believed, was due to using staff entitlements within rosters, in regard to staff-patient ratios, allocated time between shifts and on-call and appropriately skilled staff for specific duties, to enhance the work environment and workflow efficiency.

Middle managers did find it difficult to 'backfill' staff positions, that is, either using another employee with overtime, or if available casual or agency staff, depending on the skills required (although doing so usually cost significantly more). The senior management preferred middle managers to use part-time staff, which tended to be easier as those staff had more flexibility in their working arrangements, although some could lack some of the required skills. Further, while middle managers saw the advantage of flexibility in employing part-time staff, this again could change staff members' roster and workload expectations – and workload expectations were particularly complex with a relatively high number of part-time employees. Employing part-time staff also increased the difficulty of maintaining staff skills training as these staff, only being available 'part-time', created the need for additional training sessions to improve attendance, and also an increased availability of trainers thereby increasing cost. Most managers considered that workloads in evening shifts were now the same as in normal day shifts, and therefore the need for skilled staff to cover evening shifts had increased. One middle manager stated she had to roster staff across different hospital campuses in order to maintain their staff's skill acuity levels so that they could continue to perform the duties expected of them.

What was evident, managers thought, from observing staff new to the hospital workforce, was that they worked for a few years, helped by training in the workplace, then many tended to

leave to travel. This continuous turnover had a deleterious effect on the skills base of other staff as a whole, leaving the core group with depleted resources of skills. One middle manager (hospital C), when dealing with multiple requests from the more junior staff, had a fixed focus on just meeting all requests – "I just need to line up all the requirements, skills, EBAs, rosters, and see which staff member is left to fall in the slot". If the loss of an individual staff member left a gap in the range of skills required to maintain the service, then the request had to be refused. Once the decision was made then explaining it became the most important part of this process.

This loss of skills across the organisation was magnified by female staff routinely coming back from maternity leave, and changing from full-time employment to part-time. This created the need for more part-time staff to fill the gaps, both in staff numbers and required skills. In all the interviews, only one manager had experienced one new mother returning to work full-time in recent years. It would seem more appropriate then, from the information given by managers, to expect and plan for all those returning from maternity leave to return on a part-time basis.

Decision has to be co-approved by manager's boss

In all the organisations, it was clear that if any staff member requested leave without pay this had to be authorised by the Executive Director, and the staff member had to have no annual leave or RDOs due before such leave would be considered. In the case of most long service leave requests, while they could be approved locally for short periods (two weeks), if staff asked for an extended period, again Executive level approval was essential. Some middle managers felt that this rule hindered their creativity in managing their sections.

Performance

All middle managers agreed that staff performance, good and bad, was influenced by whether leave requests were approved or not. Good behaviour was characterised as staff carrying out their work adequately, or with some increased productivity. Poor behaviour was more noticeable, and ranged from low throughput, i.e. not all patients being collected for their diagnostic test, patients not registered in the time allocated, or staff calling in sick on the day they had requested leave. Individual staff in these cases were counselled and reminded of the impact of their performance on the quality of the service. All managers interviewed reported that all decisions affected staff, and they needed to know how staff would react, as this sometimes influenced the actual decision, as well as other staff working in the same area.

Managers gave the following as an example. Some staff had requested to work from home. If these individual staff members could perform their duties better at home it was an advantage for the organisation, so managers would meet the desired staff request, understanding that it was important to maintain a high level of trust in staff, and to organise the right work for them to complete in their homes.

Work-Life Balance – Policy

Middle managers stated in the interviews that there was no formal policy document that specifically contained a policy for WLB. They acknowledged that there needed to be a balance between work and recreation, and that an organisational policy outlining this would be helpful. They also acknowledged that, as managers, they had to manage the lack of policy by creating their own concept of what staff needed, and deciding what they could do to assist in meeting these needs within their available policies and rules.

Haphazard information

Senior human resource managers were well aware of the need for official work-life balance policy documents. One hospital had documents available that outlined management's position, but only in a draft form. Another hospital's management had carried out significant research, including staff surveys, to find out what was needed, and the resourcing required. This hospital had also appointed a 'wellness' manager to oversee this initial and ongoing process. Other human resource managers were doing the background research, but were still well short of where they wanted the organisation to be, since they believed the question was central to their organisational principles. These managers also appeared to consider the WLB question to be a more complex one than they had thought, so that it remained a 'work in progress'.

Middle managers found it hard to develop a culture that incorporated work-life balance through staff engagement, with no formal organisation philosophies (or policies) to support what they were trying to achieve. Senior human resource managers agreed with the middle managers, but added that internal support from the Hospital Executive was not enough, as there was no clear direction from the Victorian government, no sharing of information across health services in general, or sharing of 'Key Performance Indicators' (KPI's) to measure staff performance. Managers felt that the organisation lacked a uniform, agreed set of

standards that could be measured, and which should then move hospital managements towards thinking about 'best practice' in their WLB policies. This lack of direction and funding toward the generation of policy was paramount in the comments from senior human resource managers, which they identified as the cause for the poor state of WLB policy.

Human Resources Support – positive and negative

Senior human resource managers said they were looking at the WLB question from an organisational perspective, considering what programs they could use to teach employees and managers how to manage the issues in general. Solutions included training in implementing organisational policies such as leave, OH&S and leadership. Some senior human resource managers had engaged and allocated specifically selected HR staff to departments (HR business partners) to give specialised advice or assistance in HR processes for staff groups/departments/Clinical Specialist Units. They had also encouraged middle managers to use other facilities available to assist them and their staff, programs such as employee assistance program (EAP). These programs had increased the options available to staff to assist them to use an alternative avenue to improve their circumstances, which meant that some staff did not need to make the request to their managers or human resources (Middle manager, hospital B). Senior human resource managers were also becoming aware of a need to be available to managers and staff alike after hours – Human Resources managers usually worked, and dealt with any problems, from 9am to 5pm, but now said that they had to become more aware that the hospital is not 9-5 service, so HR needed to work out what else can we do?

Middle managers tended to ask the Human Resources Department for advice, certainly when they were new in the job, but only when the request was not seen as routine (in the managers' experience), or was borderline, meaning the managers interpretation may not be the 'correct' one. HR had produced other useful information that managers had found helpful, such as different kinds of employee leave reports, used in the monitoring of, for example, sick leave, ADOs and annual leave, to assist implementing hospital policies, such as those governing excess leave.

One middle manager in particular used HR help only for an award issue or for matters such as a visa for an overseas applicant, preferring to rely on experience. Middle managers also found contemporary problems more complex than in the past, but believed that their decisions had been built and tested through their experience.

Senior management support

Middle managers have accepted managing staff requests as part of their work, and looked forward to working toward an organisational culture of staff 'Wellness', while believing it was important that this be supported by the hospital's senior management – it had to be seen as a 'valued system' within the organisation. Managers expected to have the often difficult discussions with staff about unexplained absences or excessive sick leave, and did so, but also required the support of the senior manager. This support, they believed, also had to be there for the 'softer' conversations around staff work-life balance, but without specific hospital policy on this they did not know whether that support was available.

All managers referred to the importance of senior support being shown in physical form. Items listed included bike racks, car parking, showers, gym and gardens. One senior human resource manager stated that such support had to flow from the Chief Executive Officer down, but that not everyone was convinced of this yet.

Conclusion

The requests managers received relating to work-life balance were varied and difficult to always approve. There were conflicting organisational and local requirements to be met with very limited hospital resources available to them. In respond to their staff requests middle managers had used tried and true rosters, core management policy, as well as lessons learned which seems to have blended with improved skills and awareness of what staff want.

Chapter 5 Discussion

Public Hospitals are complex health organisations that have competing internal and external influences, budget restraints, state services to provide, throughput targets to meet, all within set policy guidelines and limited budgets. A1 hospitals that use work-life balance (WLB) in staff ads and internal leave management policy to encourage staff to take leave portray themselves in a similar manner to other organisations, as supporters of WLB (Mescher, et al. 2010). Hospitals construct policy around leave management, employment options (part-time, casual, etc) and socially accepted behaviour; however, this study found that there are no specific policies relating to organisational WLB within the A1 hospitals. The A1 hospitals' main focus as pointed out by their Mission/Vision is around health care for others: "To provide world-class health care for our community" (Hospital A), "Trusted to deliver outstanding care" (Hospital D), "Better health in our community" (Hospital B), "providing compassionate and innovative care" (another A1 Hospital) and "provider of tertiary health services" (Hospital C). There is no direct link to the health of their staff in their Mission/Vision statements.

Although best health provision for A1 hospitals is 'core business', none have internal WLB, wellness or family-friendly policy established. This then fails to assist staff meet their WLB issues. It also fails middle managers' ability to provide an agreed organisation WLB position to staff, while requiring the same staff to provide the expected 'better patient care'. The public health system is known for its culture of health and healthy lifestyles (Anderko, et al. 2012). A1 hospitals did recognise the need for WLB, illustrated through a few carefully worded ads or healthy programs, yet they have been unable to contextualise their staff requirements.

Although not always recognised by senior management, middle managers are appropriately positioned and instrumental in managing services that affect other departments and the overall service provision of the A1 hospitals (Balding, 2005). They create, construct and implement integral services that impact daily on many departments and staff. Throughout this complex process these managers need to take into account the needs of their employees, the resources they have available to support the work-life balance (WLB) of their staff, and their own accountability for providing a service for their organisation. The results of this study illustrate the difficulties facing these middle managers, as well as the lack of resources and support for

ensuring the WLB of their employees. In this chapter, the key findings of this study will be explored and discussed referring to the work of these middle managers, and to recent research. This chapter will also include recommendations for further research into the topic, and important conclusions for A1 hospital management to define, plan and create strategies for their staff's WLB requirements.

The aim of this study was to explore how department managers in A1 hospitals in Victoria make decisions on the work-life balance issues of their staff. To achieve this aim the following issues were investigated:

- Managers' understanding of WLB
- Types of WLB requests staff ask of middle managers and senior human resource managers
- The resources available to middle managers when making WLB decisions, in responding to the requests of their staff
- Other influences on middle managers making and implementing these decisions
- Organisational structures affecting the degree of support for managers
- Managers' bases for their WLB decision-making.

The key findings of this study can be summarised as follows:

- Despite the legislative and regulatory requirements for WLB, such as the state government's *Health Services Act 1988*, the federal government's *Equal Opportunity Act 2010 (Vic),* and the Nursing Enterprise Bargaining Agreement (EBA) 2007-2011, there was little internal human resources policy in these A1 hospitals prescribing how managers should make decisions, and how senior staff should support managers responding to staff WLB requests
- Managers believed that increased pressures on staff at work, and their wish to maintain work and home-life balance, had led to a rise in staff requests for 'time out' away from their job
- Middle managers received similar types of requests, such as:
    - Not working overnight or evening shifts
    - Starting later or finishing earlier
    - Working during 'school hours'
    - Working from home
    - Leave without pay, including breaks from work or 'time-out'

        - 48/52 annual leave, that is, an additional four weeks annual leave in lieu of 4 weeks pay
        - Working at a specific campus location
        - Family/study/conference/extra maternity leave
- In response to the lack of hospital WLB policy and documented practices and procedures, the middle managers in these A1 hospitals demonstrated some common attributes and themes in their management of staff WLB requests. These included the initiation of local rosters and guiding rules for many minor and some major WLB requests
- Managers across the hospitals faced similar difficulties, including a mismatch of resources with the desires of their staff. The expectations of staff in regard to the outcomes of their requests, such as meeting staff timeframes for decisions and meeting award conditions, had become increasingly varied, which considerably strained the resources to maintain services.

The Health Organisation

Organisations including health organisations, are attempting to draft WLB policy with the intention of improving staff attraction (recruitment), retention and succession planning (Chaykowski, 2006; Bardoel et al., 2008; Zwink et al., 2013). Many health institutions overseas have initiated WLB policy for these reasons, which is an indication of the importance of such policy. In some organisations the aim is to improve the health and happiness of their staff, to ultimately improve productivity, work environments and work overload (Rama-Maceiras et al., 2012). These improvements include the introduction of wellness programs, leave management, family friendly workplaces and workplace policy. These programs are then taken up by staff in a varied capacity and for many different reasons. In general staff believe the programs are important, but not all staff utilise them as many keep their private life and work life separate (Robroek et al., 2012).

Wellness programs are now also being integrated into WLB programs. Health organizations promote these programs from a slightly different perspective - in America they are more health/chronic disease oriented (Anderko, et al. 2012), while in Australia the focus is on the balance between work and home lives. However there are some aspects that are common across organizations, including work environment, resiliency, personal development and education needs, support, burnout and peer relationships (Zwink et al., 2013).

Governments have documented the need for WLB policy (State Services Authority 2005). Unfortunately these ideas and policies are slow to be introduced and often take on the form of a complex leave management guidelines/policy (Hospital A) rather than core WLB policy. This highlights that WLB is seen to be needed in hospitals, to meet staff family and some personnel commitments, however the lack of policies limits management support around WLB. Even though this research outlined limited WLB internal policy, organizations should be moving into a more family-friendly direction that incorporates working arrangements, re-entry to workforce (part-time, working from home), parental leave, childcare (holiday, emergency, in-house), elder care (respite, advice, information) and up-keeping of skills (Stutzer, 2012). Stutzer (2012) also states that this assists in creating a hospital culture that increases job satisfaction, productivity and motivation and decreases absenteeism.

The WLB definitions of managers, staff and that of the organizations do not appear from this research to be common or striving for the same outcomes. Due to this fundamental difference the middle manager struggles to link decisions with requests while providing the service required. There appears to be a disconnection between senior management perspective and the organization's WLB needs. The lack of support from HR and specific policy is the reason that middle managers are utilizing old techniques or their own 'limited' experiences. This was voiced by the middle managers in this study – they were not supported appropriately on WLB issues by the resources that are available to them in A1 hospitals.

Managers' understanding of work life balance

Both middle managers and senior human resource managers understood WLB simply as a balance between work and home life. As they worked in a common environment and were exposed to the same issues, this was predictable. Most used similar terms in their description of 'balance' such as: *"equal time"*, *"meet commitments of work and non-work"*, *"work does not impact time at home"*, and *"enough time after work for personal time"*. The WLB definition was simply a comparison of the proportion of time one spent at work and the time spent at home, that is, not at work. If work dominated the total time of the individual worker, then balance was not being achieved. There are many diverse definitions of WLB in the literature, with the simplest definition put forward by De Cieri et al. (2005, p.90): WLB "is the maintenance of a balance between responsibilities at work and at home". This definition is similar to others, such as where Carlson et al. (2009) state that balance is achieved when there

is no work-family (or work-non-work) conflict, or Burke (2000) who views balance as the relationship between work and personal life.

The interview participants did not include the notion of 'quality' time in their definition of WLB. Their definition focused only on the balance between work and non-work. This was unexpected, because quality has been used in the literature to reflect on the relationship between the worker and his/her environment. Al-Qutop and Harrim, (2011) notes that in more recent times the idea of quality has broadened to incorporate the worker's total 'wellness' or 'well-being' (at home and at work), and highlights the need for employers to help sustain workers' well-being without lowering productivity. This notion of well-being encompasses many life tasks or the vision of the 'good life', covering the "physical, intellectual, social, spiritual, emotional and occupational domains" (Al-Qutop & Harrim, 2011, p.197).

The employer definition in the literature is generally employer focused with the aim being to improve motivation, productivity and decrease absenteeism through increased job satisfaction or well-being (Stutzer, 2012; Thanacoody et al., 2009; Gresham, 2004 p.26; Al-Qutop & Harrim, 2011). The alignment of the two views of WLB, staff and employer, need to be shared and discussed so that both groups can be involved in program development. Health HR departments should have focus groups, surveys or workshops with both senior and middle managers. These meetings need to incorporate the views and needs of both parties and should strive to involve staff in the drafting of WLB policy. These programs should be based on healthy workplace programs beyond the standard prevention programs, focusing on wellbeing in terms of both physical and mental health (Grawitch et al., 2007).

Middle Managers' WLB

With regard to their own WLB, some managers mentioned having to be readily accessible via a phone or 'Blackberry' at any time, which made them feel 'out of balance' and attached to the job, even when not at work. The impression from the managers interviewed was that this concept of being 'contactable' while off site was becoming the norm. Cox (2007) comments that in the 24/7 world of the IT explosion of information, the line when work finishes and home starts is now blurred. Being accessible online or by phone allows managers not only to work anywhere but also to be reached from anywhere at any time, which is an increase in demands not allowing managers to 'turn off' (Roberts, 2007). Burchielli et al. (2008), too,

states that managers also struggle in gaining WLB and meeting external commitments, identifying flexibility as being complex.

The managers in this study reported that, as they were often without work-life balance themselves, this was likely to influence their perceptions about their staff WLB conditions. There was a concern that this could affect their responses to staff requests, in that there was a chance that their own experience would influence their understanding of their employee's requests and they might therefore misunderstand the intentions of their staff. Although the routine rules and guidelines around rosters would lessen some of this impact, managers were also challenged by new and sometimes more complex requests. Maxwell's (2005) research found there may be a three-way tension in the manager's group between providing more flexibility for staff, planning to meet their own WLB needs, and providing the service required. Hence, managers act as both an agent for the organisation and independently (Newman et al., 2012). Even with this additional tension, managers are integral to WLB policy generation and implementation. While managers themselves work long hours, they receive employee requests for WLB, make arrangements, and influence the benefits organisations derive from these practices (Maxwell, 2005). While these managers saw WLB as a simple balance between time at work and time not working, they considered that WLB is not only a workplace concern for their staff, but has personal implications for them as well. Consistent with previous studies, these managers identified the inherent tension between their accountability for high quality service delivery and the WLB needs of themselves and their staff.

Types of work-life balance requests asked of middle managers

Leave requests

Managing requests for leave is a routine human resource management function for managers. A major component of this includes the negotiation between a staff member wanting to take leave and a manager needing to ensure the provision of services. The managers participating in this study were asked to describe the types of WLB requests made by staff, whether these requests had changed over time, and how these changes had affected these managers' decisions. All the participating managers reported that decision-making had become more complex within the last 10 years, due to the changing nature of requests and rising staff expectations. They concurred with Lingle (2004) that leave is no longer taken only for a

holiday or if a worker is sick, but now has a much broader scope and covers family, social, personal, compassionate, and cultural leave.

This change in type of leave requested was reflected in comments by participating managers: staff no longer just requested short-term leave from the organisation, such as annual leave, but increasingly asked managers for 'time out' leave, in the form of Long Service Leave (LSL), sabbatical or leave without pay (LWOP). These types of leave are prevalent in other industries and it has been suggested that the health industry needs to adapt and make these types of leave available for all groups of workers (Vincola & Farren, 1999). The findings showed that managers believed that increased pressures at work for staff, and their wish to maintain work and home-life balance, had led to the rise in requests for 'time out'. This is a view shared by Avgar et al. (2011) and Thanacoody et al. (2009) that the most persistent challenge in health is a rise in pressures and stress at work for frontline employees, leading to high levels of 'burnout' and turnover.

Growth in technology had created the expectation that staff needed to learn new and diverse skills, which appeared, from the managers' point of view, to signal a shift in staff mindset from previous practice within their departments, and formed part of the current growth in more complex procedures. In effect, staff felt the pressure to respond to the growth in patient numbers, increasing complexity of work and new technology by up-grading their skills and intensification of their work. Thanacoody (2009) defines this process of intensification as a desire to maintain a higher level of service with reduced costs, hence a reduction of labour input in relation to the relative output.

This intensification was also apparent at department and organisational level, with these managers regularly being asked to 'do more with less', in some cases causing staff to review critically their roles within their departments. As work intensification increased, staff faced a number of issues. As employee skills grow, so does the number of tasks for each individual staff member. This increases each person's responsibility, potentially leading to the need for staff to provide service over longer periods, or at odd hours, which can reduce the number of staff breaks (Roberts, 2007). This intensification of work has not always generated an efficient outcome and in fact may account for staff requesting 'time-out' because of the growth in work and the management expectation that staff can just absorb this intensification. Allan (1998) stresses that intensification of work does not enhance employer efficiency or improve staff health and well-being, though it is expected by management.

In many industries, workers have been for some time taking personal ‘sabbaticals’ to re-evaluate career and life choices (Vincola & Farren, 1999). In the health industry sabbatical leave is usually restricted to medical staff for education and research. Two middle managers cited examples of staff requesting time out to review major issues in their lives: one related to family problems, and another to a loss of direction in the staff member’s career. Both these staff needed time to re-evaluate some aspect of their lives. Although it could appear that this form of request is becoming more popular, managers did not see these ‘time out’ requests as routine, as requests of this type had to be endorsed locally and then referred on to the hospital executive for final approval. As Abbott and De Cieri (2008) found, senior management are slow to react in response to some issues, including WLB. Managers believed that in practice this decision making process could occur quickly and be implemented at departmental level, whereas the slower process at the executive level reduced the rapport between them and their staff. Executives thus need to be either more active and quicker with LSL and LWOP decision making processes, or hand back such decision making to individual department managers, enabling them to decide on and implement these requests in a timely fashion, and thus look after the WLB of their staff comprehensively.

Middle managers stated that requests for family leave had also grown, possibly as more staff are now caring for both children and older people, such as parents and grandparents (Kaplan-Leiserson, 2003; Belliveau, 2004; Crooker, et al., 2002). Requests for family leave also included requests for carer’s leave for longer periods of unpaid time. Flexibility for staff is needed not just in time off, but for staff to pick children up from childcare, or attend ‘required’ appointments with parents, hence a need for flexibility in hours to allow for these changes in out-of-work responsibilities (Kaplan-Leiserson, 2003). Requests for new forms of leave had also been experienced, with staff requesting cultural leave for holidays, celebrations, and for religious reasons. All these new leave requests added to the list of staff wants (perceived needs) that managers had to be aware of, and also added to the complexity of what was once a simple decision. Simple leave requests for holidays and sick leave have been engulfed in broader needs, including social interaction, education, shared family responsibilities, community needs, lifestyle, and personal growth.

Requests related to working conditions

The proportion of staff employed within A1 hospitals includes a large component of part time and casual staff (senior human resource managers, hospitals A and C; de Ruyter and Burgess,

2000). Participants in this study reflected that this change appeared to be employee-driven, aimed to meet workers' personal requirements outside work. An increased proportion of part time and casual staff has both positive and negative aspects: part time employees improve functionality within a department for meeting both roster cover and workload demands (Working Families Charity, 2005), but the negative side, in the view of middle managers, has been the consequent inability to appropriately train and maintain skills across a broad group of staff. As the numbers of part time staff increase, the numbers of staff requiring training rises, but their available time falls, as they are at work less often. As a result, at times there is no staff member with the required training available to work in specialist areas. This also diminishes the overall staff skill base, limiting the manager's ability to provide comprehensive services out-of-hours and on-call. With a lower skill base, staff with a higher skill set must work more overtime to provide an out-of-hours service, and this rise in out-of-hours and on-call work adds to time spent at work and has an unfavourable impact on their WLB.

The organisational, as well as the departmental, working environment has had to change and be modified to align with current workload trends and social needs (Maxwell, 2005). These changes were reflected in the interviews, with the managers stating that they needed to provide;

- Flexibility in hours worked
- Flexibility in where their staff worked
- Shorter timeframes for approval of leave, and
- Breaks from work.

Further, employers now need to compete in a global market to attract and employ workers, and, as pointed out previously, workers' expectations have changed in regard to what they expect from a 'normal' working/organisational environment (Lingle, 2004). The middle managers saw the workforce shortages leading to this expanding employment pool as increasing competition between organisations for staff, and suggested that their organisations needed to create an improved environment for their workers by developing improved options or benefits relating to staff WLB. This they expected would not only assist them as managers in retaining their staff, but would also assist in attracting new staff from local and possibly international markets. This is strongly supported by studies in which the positive relationship between WLB and individual and organisational outcomes was mediated by an organisational

culture that supported WLB (Cegarra-Leiva et al., 2012; E. Stutzer, 2012; L. Jerg-Bretzke & Limbrecht, 2012).

The A1 hospital managers stated that the introduction of efficient IT systems and other technology over the last 10 years has assisted employees to be externally connected to the organisation, which employees saw as facilitating a variety of working conditions. While this external connection has become commonplace in other industries to gain maximum return on technology (Roberts, 2007), in health most services are carried out face-to-face with patients, with those requiring specialised technology carried out on site. Possibly some administrative work could be carried out remotely either off-site or on other hospital sites, but in order for this to occur, managers would need to ensure that the sites met departmental policy requirements, such as IT security and OH&S requirements. This could be difficult due to hospital information security, management of equipment used, and requirements of third party IT systems to link with the organisation that could lead to open access to internal hospital programs. Therefore the middle managers approved and implemented only a limited number of 'work from home' requests. Other industries have used this type of change to employ specific skills that are provided off site, so this possibility should not be overlooked in the future as a way to improve flexibility in the current WLB environment (Hayes, 2007).

Other staff requests identified in the interviews related to changes in shifts, such as reducing the number of evening and night shifts, and altering start and finish times. Most of these requests revolved around family matters, such as the need for off-site childcare or school pickups, and meeting other family (and social) commitments outside work. Only a few requests suggested the need for an improved list of facilities on site, which included requests for a post office, a staff gym, and childcare. Each A1 hospital offered different facilities that senior staff believed 'matched' what would be required by their current and potential staff. On reflection, it may be that the facilities these hospitals offered were not readily available in their immediate area, hence the expected need for the employees to have access to them.

The managers stated that their hospitals had two forms of support to help achieve a high level of staff retention. The first was in the form of physical benefits, such as bike racks, car parking, showers, and gardens. The second was in the form of programs, such as Weight Watchers, Quit, and discounts on products and memberships. The managers said that although they believed these programs to be worthwhile, they did not have a noticeable influence on retention of staff with specific skills. Poelmans et al. (2008) agree that even the provision of

improved working conditions, including WLB policies, does not necessarily guarantee attracting and retaining staff, possibly due to staff differentiation between 'intrinsic' or expected programs, such as salary packaging, staff clinic, immunization, or smoke-free environment, *versus* 'extrinsic' or extra programs such as weight watchers, health cover, gym or meditation classes. It seemed that these workplace benefits appeared to only cover basic functions, not necessarily providing an added bonus of working at that particular hospital, or a drawcard for new workers. The only item described as a direct benefit was the availability of childcare on-site, which for some managers increased the number of applicants, but childcare places were limited, and no particular positions ensured being allocated a childcare 'spot'. Managers considered that once staff were employed then a stable environment with consistent decisions and predictable outcomes led to retention of reliable staff numbers and suitable skill mix, a view supported by Parkes and Langford (2008). Staff commitment and intention to stay occur through manager support, job autonomy, learning opportunities, and involvement in decision-making (Parkes & Langford, 2008).

The general current trends in requests received by middle managers are more complex than those managers used to receive and affect service provision. This is consistent with research literature findings, and many industries are working on WLB policy and its implementation to improve staff conditions (Poelmans et al., 2008; Maxwell, 2005). The implication in response to these requests for hospital middle managers is that there has been little support from their organisations for WLB policy development and implementation to assist them in finding ways to improve conditions for their own staff.

The resources available to middle managers for making decisions

To explore the resources used to make decisions regarding WLB, managers were asked to describe the policies, regulations or processes that were available to them from within the organisation, and what they utilised in their own decision making. The common theme evident throughout the interviews was that all relied mainly on their experience, gained from occupying their positions over a period of time (an average of eight years), and on their continuing responsibility for making decisions on both old and new WLB requests. They all impressed on the researcher that they were still self-sufficient when handling the new problems, using the same methods repeatedly. They reported a limited focus on WLB within the organisation as a whole, reflected in the lack of policy and of employer awareness of the real issues within managers' areas of responsibility. This conclusion was also reflected in the

research by the Society for Human Resource Management (SHRM) and the Australian Human Resources Institute (AHRI) that Australian managers perform relatively poorly on WLB policy and on promoting flexible working environments (Global Index of Workplace Performance and Flexibility, 2010). As reflected in the study done by Todd and Binns (2013) managers are 'managing' WLB in a limited way, and largely in an individualised manner, at a level that does not disrupt the usual way of organising work and employment in the organisation.

Another concerning aspect of the WLB discourse is that as organisations have moved from a family friendly to a WLB focus, the policy has become quite deliberately gender neutral or grounded in flexibility (Lewis and Humbert, 2010; Smithson and Stokoe, 2005). Family – Friendly policy is still more directed at female carers of children and the family with increased flexibility to meet these needs. Bergman and Gardiner (2007) state, in relation to organisational individual or gender neutral policy, which it focuses "on seeking equilibrium between two apparently separate and equal entities: work and family or work and "life", which can be combined harmoniously". This concern has not yet impacted on A1 hospitals because leave policy is still more family-focused flexibility with specifics relating more to maternity leave and return to work initiatives for mothers, than WLB holistically

Local resources

Middle managers explained that they had built up a repertoire of responses to the most common requests from each group of staff, and had integrated that repertoire as a set of rules into their individual rosters. They generated these rosters based on their experience, reflecting the distribution of resources of staff and equipment available to provide varied services to the clients of the organisation, and to meet the fluctuating demands of service delivery, as well as the usual staff requests, such as length of shift, rotations of staff, and accrued day off (ADO) timetable, for example. These roster templates were based on the decisions they had previously made in response to similar requests. As a result of the increasing complexity of rosters and the current service requirements of the organisation, some of the middle managers had dedicated staff overseeing the generation and maintenance of rosters and staff operations, where before they had performed these functions themselves. Managers concurred that if rosters did not incorporate guidelines, streamlining many minor and sometimes major decisions (so that only subtle variations had to be discussed and approved/not approved each time), each and every request would need to be reviewed individually; a task they perceived to be unmanageable.

Yet, in spite of these difficulties in dealing with requests, these managers did not have an alternative method for building their department rosters, and hospital policy makers were not generating any new ideas to assist managers facing this changing environment. With no future strategy apparent, a couple of middle managers reported that they tended to say 'yes' to most requests, dealing themselves with the 'flow-on' effects, such as utilising Bank or Agency staff to fill vacant shifts, or using junior staff and restricting services, or approving overtime to staff with the required skills to maintain the service. Other managers indicated that they used the 'predictability of service' demands likely across any given day. That is, they understood the service demand trends which allowed them more flexibility to negotiate with staff if required, as with any difficult-to-manage request. The roster appeared to be the only major resource used to offer flexibility, but it showed no potential to allow managers to initiate and implement any significant policy or procedure changes in light of the growing number of staff WLB requests.

Managers are required to ensure the entitlements outlined in the EBAs are followed – and in some cases these entitlements make it difficult to ensure high quality service delivery. As a reflection of this, a number of these types of entitlements had been included as generic rules within the staff roster template. Depending on the group covered, these entitlements varied around the number of weeks of annual leave, leave for professional development, study and conference attendance, and time requirements between shifts depending upon the type of shifts worked. Middle managers overcame most of these entitlement inconsistencies by having separate roster templates for different working groups (or for different staff disciplines).

This initiative allowed staff to plan their workload, as long as each decision met the requirements of the roster 'rules', which also incorporated a number of EBA and hospital leave management requirements. Staff could not take a day off unless they found another person to supply equivalent skills, a process implemented by middle managers in response to a need to share the workload and create staff work and non-work equity, which was not being provided by the organisation. As the managers pointed out, the A1 hospitals had no written policy laying down the organisation's common expectations of managers in regard to WLB issues. As Bowen and Ostroff (2004) comment, there is an expectation that, when policy is produced, HR takes on the job of integrating it into the employee's knowledge and practice,

an integrative process characterised by four features: visibility, understandability, legitimacy of authority, and relevance, since a strong HR system uses these characteristics to assist employees to meet organisational demands. The A1 hospitals had failed to connect what the middle managers were implementing at a department level to the expected HR co-ordination and implementation of a WLB policy system, due to the absence of suitable organisation policy and practice. It is the responsibility of senior managers to set operational priorities, and therefore policy (which needs to include WLB), but are not exercising their power to do so through the HR departments. This leaves middle managers with the responsibility of providing for staff WLB requests (Todd and Binns, 2013).

These managers believed that, as professional workers, their staff felt empowered by the way they interacted with their roster, so that workflow efficiencies improved. Staff became instantly responsible for maintaining the service and for maintaining the correct combination of rostered skills required when initiating the changes they wanted. However, managers of the *administrative* rosters had extra flexibility, due to the less complex nature of their staff tasks and workloads, compared with the clinical tasks and rosters of their *professional* staff. The introduction of this form of self-empowered staff roster was seen by managers as a positive action, demonstrating their attitude toward flexibility. As Drew and Murtagh (2005) state, the implementation of any policy or set of guidelines relates closely to the experience and attitudes of the managers implementing them, suggesting that if the organisation had well-constructed and valued WLB policies, their implementation would have positive effects given the flexibility demonstrated by these managers. One manager stated, however, that senior hospital executives had to support and value an organisational culture of staff WLB or 'wellness' for it to be accepted by employees. To be effective, WLB and staff wellness policies need a culture of leadership rather than just commitment (Poelmans et al., 2008) and with some evidence of the importance of the WLB culture as a mediator (Cegarra-Leiva et al., 2012).

Assistance from peer managers also occurred regularly, but not as part of any formal procedure. One senior human resources manager found EBAs limiting and looked for fresh ideas and support from peers. Middle managers also reported speaking to peers at external forums about their decisions, but commented that no matter what kind of organisational structure prevailed, or what decisions were made within the department, all decisions were ultimately reviewed and assessed as good or bad by the employees. When they made a

favourable assessment, managers considered this a fundamental step towards an efficient workplace and towards building positive rapport with staff.

Managers' loss of flexibility

The interviews suggest that the interaction between EBAs, hospital service obligations and the local department roster was paramount in each middle manager's view; and that these three interactions were linked through the written rules and format of their rosters. If the EBA or hospital services changed, managers had to rethink aspects of the roster, and then try to adjust work arrangements for staff in order to meet these new changes. From the interview discussions it appeared that many modifications were introduced into department rosters over time enabling managers to maintain local flexibility within their own departments, but over time this flexibility has declined. Staff EBAs are negotiated outside the workplace with trade unions and are designed to improve employee benefits, thereby improving WLB (Roberts, 2007). Middle managers believe that through this process they are losing their 'local' flexibility and their ability to meet staff requests and ultimately to help staff meet their WLB needs. It is however through this process, that middle managers "play a crucial role in framing the nature of the problem in WLB. Most commonly the problem is represented as one of individual circumstances and choice. Solutions revolve around developing specific human resource (HR) policies" that help provide options (Todd and Binns, 2013 p221).
Interestingly, each manager interviewed seemed to be doing their own thing, with no form of assistance or formal co-ordination from the organisation's senior executives. So while the nature of staff expectations was one of demanding more flexibility, these managers expressed concern that their systems and processes were, in fact, decreasing their ability to be flexible in responding to staff WLB requests (Wise & Bond, 2003).

Staff expectations formed another complex layer over the top of the legislation and EBAs to which the managers had become accustomed. Although managers were used to legislation and agreements, staff expectations had changed as benefits included in these EBAs had broadened over time, which made it more difficult to be flexible and meet all staff requests. For example, two managers commented that younger staff members expected that leave would be approved with little objection, or without their needing to consult the manager, or even to follow the rostering rules. The impression the researcher gained from the interviewees was that the staffs understanding of what was in the EBAs, and in the hospital policies, differed between staff members and the A1 hospitals. Also, those staff members' understanding was not always aligned with the content of the EBAs, with hospital policy, or with their particular department

roster, making it especially difficult for managers to make decisions that would result in meeting the requirements of all three. Both Vroom's (1976) decision model and Maxwell's (2005) discussion of linkages between organisation, manager and employee, outline the difficulty that middle managers face each time they need to make decisions that impact on the service their department has to provide. These decisions are interlinked and critical to the needs of the organisation, whether they are approving staff leave and requests, rostering specialist staff in particular areas, or initiating a training schedule for using new technology. This is also supported by Todd and Binns (2013, p229) "complexity of implementing WLB practices due to firstly, conflicting priorities between operational practices and employees' WLB interests and secondly, the broader political, social and economical context in which management decisions and actions regarding WLB take place"

Middle managers reported that there was little WLB policy support from their organisations, so they relied almost exclusively on their rostering process to assist in their decision making about WLB requests. They reported that over time, with the increasing expectations from staff and the requirements of the EBAs, these rosters had become more complex and difficult to manage, with less satisfaction for both the managers and their staff. Therefore, with both complexity in service and staff expectations expanding, without new tools or skills managers could expect to fail to meet their obligations in service provision, in addition to retaining or attracting staff.

Aligning the needs of the organisation and that of staff is complex; however, it is imperative that A1 hospital senior manages engage both line managers and workers to identify the perceived WLB gap. This work has to be a balance of bottom up and top down processes to not just agree on what the definition and strategies should be, but to forge an organisation wide culture of WLB need and acceptance.

Organisational resources

Most middle managers considered that support from their direct management supervisors in allowing them autonomy was important, as it showed these executives had confidence in them and in the work they were performing. This confidence, coupled with access to those hospital policies on leave management and delegation structure that were available, with the regulations and EBAs, enabled them to keep informed about the organisational view when making routine decisions. It was a different story with complex WLB decisions and the managers indicated that there was insufficient support in these instances. In some cases,

middle managers perceived that the organisational structure with which the delegation of authority and policy information flowed was restrictive. They believed that, although organisational structure could assist managers with complex decisions when these arose, it appeared unnecessarily restrictive when it came to the LSL and LWOP decisions, as the final outcome of LSL and LWOP decisions would affect only the particular staff member's department.

Vroom's (1976) decision model states that when making decisions managers are expected to align the expected results of each decision with the organisation's policy point of view. That is, managers had to take into account the requests they received from staff, and the likely situations arising from granting such requests, and then had to meet the organisation's requirements, as outlined in its policies, and provide the services required. When discussing their decision-making around staff requests, the middle managers did not comment on the specific views of the hospital executives in relation to WLB, nor was it explored further by the researcher. The researcher believed there may be some disagreement between the managers' views and values on WLB and those of senior executives, as it appeared that senior executives expected that managers would convey and work to the official position. This difference in attitude was identified by Todd and Binns (2013) when flexible working arrangements were put in place within their organisation, some mangers still showed resistance in implementing these new policies. As a show of good management, the Victorian Building Commission (2005) presented awards to any employee displaying the corporate values of his/her workplace in an exemplary manner and only rewards those that are able to toe the company line. The managers' autonomy described above could be viewed as the A1 Hospital example, as they only exercise it as long as they follow the official organisational policies. In fact Maxwell (2005) describes these managers as 'pivotal', not only in policy generation but in the implementation of the organisation's WLB policies, and in their generation of various practices under the umbrella of these policies. Human Resources management should initiate the education and practices that the organisation requires to be put in place, under the changing organisation environment, rather than leave it up to the middle managers to set 'local' culture based on their own interpretation. This outcome is strengthened by the interaction they have depending upon who the managers interact with in HR, as the messages developed can be confusing or inconsistent (Bowen & Ostroff, 2004).

In some instances, middle managers tended to 'manage up the structure', that is, to educate new executive directors about their customary practice. One manager stated that he did this, as "I may need their authority and I have had numerous Directors in a short period of time", so it was important for this manager to maintain a constant view for his staff, which he had to relate to his new manager each time (Middle manager, Hospital A). Middle managers reported that their use of their own managers in making decisions occurred only when they believed it necessary, or if the policy on delegation dictated that they needed to. Another middle manager commented, *"*I believe that most decisions are made from my experience that I have gained while in this role*"*, and therefore, had the ability to implement decisions made from staff requests (middle manager, hospital C). These comments were supported in the interviews in general as middle managers reflected that they consulted their manager less and less over time as their experience grew. This reduction in consultation with senior executives would impact on why the hospital executive had a disconnect from the reality of current HR practice/outcomes (Leggat et al. (2011).

Senior human resources managers had issues that were similar to those of middle managers, as they too had staff reporting to them and making requests. Senior human resources managers, however, appeared to be more aware than middle managers of the need for all managers throughout the organisation to have appropriate resources available to them in making staff-related WLB decisions. It was interesting that the managers in HR did not identify the need for them to 'push' WLB policies up to their hospital executives, if they believed they were needed. Of the two hospitals further along in the WLB policy process, the senior human resource manager at hospital D pointed out that Human Resources staff, and CEOs, needed to sponsor WLB policy, and that the hospital needed improvement through developing new WLB policy and guidelines, but noted that CEOs generally were not yet ready to support this process fully. As outlined in the document analysis, A1 hospitals are behind other industries in this regard, as other industries have WLB policies, or have modified policy to incorporate WLB, in order to attract and retain staff, improve the environment, raise performance levels, and introduce broader flexibility to meet employee out-of-work needs (Beauregard & Henry, 2009). Such new policies, however, were always going to be hard to 'sell' because of the size of the project and the expected high cost: Leggat et al. (2011) found that CEOs in the Victorian health system were blind to the HR situation, as they considered it better than it actually was because there was no direct link or correlation between executives, HR and management, outlined by the middle managers interviewed in this study. This could

also explain the lack of attention to and investment in policy and practice related to WLB found in this study.

Health is no different from other industries in the need to retain staff and provide customer service, but health appears to be well behind in WLB implementation as compared to other industries, as stated by one senior Human Resource manager (Hospital C). Hospital HR staff are split into front end generalists that deal with staff relations and backend specialists that deal with enterprise programs, which gives rise to a disconnect for staff (Kates, 2006). HR staff need to improve their management of policy development, and the education and skills of managers to oversee staff issues. They also need to look at alternative (external) methods that managers can use to cope with the growing numbers of WLB requests, as there is at present only limited internal policy for managers to refer to and use. Although only two of the A1 hospitals had some documentation relating to WLB, it is becoming common to see the words 'work-life balance' appearing in daily information sources, including hospital advertisements, giving the impression that the hospitals are already open to a WLB culture and have appropriate WLB policy. The dissonance between hospitals' self-promotion and the real situation is probably a frequent source of confusion among members of the public and prospective staff. Bowen and Ostroff (2004) note the need for visibility and consistency that was found lacking in this study. The connection required between policy, culture, and the implementation of WLB policy should be central to the performance of the managers and of the HR department personnel, so that they proceed to identify the organisation's needs, set up a method of policy implementation and promote the process of change (Bowen & Ostroff, 2004).

Other influences on middle managers making and implementing these decisions

Getting the balance right between the diverse needs of the employees and what the organisation requires is not always easy or acceptable to everyone concerned (De Cieri et al, 2005). Through the interviews for this study it emerged that managers believed that staff did not fully understand how their requests could influence hospital service requirements, even when initiating simple changes to the roster. Staff, they alleged, failed to see the flow-on effects their leave could have on service delivery. To dispel this lack of understanding, middle managers explained regularly to the staff why and how decisions affected rosters and different services and in some cases managers had implemented roster committees to help generate insight on the part of both managers and employees, with a view to improving their

understanding. Even with improved understanding, however, some simple decisions still became complex, as not all staff complemented or replaced each other's skills, or were available when needed. This resulted in managers constantly struggling to create the required skill mix of staff to ensure a comprehensive service. The health staff of the middle managers interviewed required specialist skills and specific training to perform essential tasks that are both not readily available in the general community, but also not transferrable between disciplines, i.e. a nurse cannot take an x-ray or a radiographer cannot administer drugs.

Despite this, the decisions the managers made in response to requests from staff in one group were usually accepted by staff of the same group, as these decisions were group-orientated and tended to set group precedents. In some cases though, non-clinical groups, such as the clerical staff, thought that decisions made for one group appeared to allocate a benefit to that group over another, in matters of, for example, professional leave. Such perceptions, occurring within the hierarchy of staff in the hospital showed that, although all groups or distinct disciplines of staff members share a joint commitment to their work, the members of each group carry out their own specific tasks in doing so, which creates this difference in their view of themselves compared to those in other groups (Degeling and Maxwell, 2004).

Current Generation Y staff members have added a new layer of complexity to the tasks of managers when making departmental decisions. These employees have different lifestyle expectations and increasingly diverse priorities outside of work (McNulty, 2006), with new thinking and strategies to incorporate into department functionality. These different lifestyle requests have become more common, but also more individually orientated, than those preceding them, and are not always aligned with departmental requirements for supporting the hospital's services. The interviews suggested that Generation Y staff tended to focus on themselves and see work as a means to an end, or indeed have different values and views indicating their attitude could be a sign of fierce independence (Kehrli and Sopp, 2006; Lander, 2006). As they had not been part of previous decisions, they did not see that their own expected outcomes should be similar to those of other comparable workers, so they tended to consider previous decisions did not necessarily apply to them, and they therefore expected a different response. Even though it seemed difficult to accommodate these new requests, managers have had to cope with them because these workers are now a part of the cohort of staff working within their departments. Kehrli and Sopp (2006) believe Generation Y should

be accepted as they are, given space and the means to complete tasks, which will improve their performance, as they are educated, enthusiastic and compassionate.

Organisational structures/support for managers

The results of this study correlate with findings from other studies about the need for increased organisational flexibility towards WLB (Capowski, 1996; Bambra et al., 2008; Crooker et al., 2002; Eikhof et al., 2007; Jerg-Bretzke & Limbrecht, 2012). This flexibility, as discussed by this study's participants, appeared to be confined within the department, and was facilitated by the use of the set of rules outlined previously, including the roster, EBA and hospital policy. The findings suggest that while there was some flexibility within the department, built up over years of decision-making, there were limitations to the manager's ability to introduce new initiatives. In addition, the departmental focus prevented the development of links in dealing with WLB within the rest of the hospital structure as an integrated workplace. For most of this group of managers, continuity of decision-making and practice seemed to be their overarching goal.

Apparent throughout the interviews was the lack of training provided to equip managers with the skills required for dealing with the changing environment and the need for greater flexibility in dealing with staff. Only one hospital had organised sessions for middle managers with WLB experts as speakers, and master classes for managers to examine issues such as staff wellness, although one senior human resources manager considered that this type of education was needed within the whole organisation. Such education should be organised from both the bottom up and the top down to gain a common understanding of what WLB means among managers and staff, in line with Thompson's (2006) recommendation to develop a common culture within the organisation. Ramo-Maceiras et al. (2012) also promoted the need for communication to be in a "bi-directional way to foster trust and mutual understanding and good relationships and align goals of workers and organisations", and to create better team-work and leadership. Hospital C completed a survey to find out what staff believed wellness to be, and to determine WLB needs and requirements. Some training programs have been instigated as a result of this survey, directed at both incumbent and newly-appointed middle managers and supervisors with direct responsibility for staff. These two A1 hospitals should be congratulated for being proactive in promoting WLB; however, there was little evidence of similar programs in the other hospitals.

A1 hospitals' executives appear not to have devised clearly defined links between an organisational culture of flexibility and the organisation's strategic goals, as noticed in the lack of middle manager training in this subject, and the absence of an active WLB policy. This absence of balance creates a tension between work and family life for staff but also a growing tension between middle managers and hospital management (Avgar, 2011; Todd and Binn, 2013). This tension turns middle managers' attention away from their primary role to recognise their staffs WLB needs and supporting them in attaining job satisfaction. What is warranted, as outlined by Ramo-Maceiras et al. (2012), is an organisation that educates and promotes resource management, communication, conflict and crisis resolution, decision-making, team work and leadership.

Two of the senior human resource managers said their hospitals had begun the process of producing draft WLB policies, but that these policies were far short of active implementation, yet this matter was becoming central to managers' daily practice as well as to their beliefs. Developing WLB policy appeared to be a more complex process than human resource managers had thought, so it was still a 'work in progress'. A 2003 Business Council of Australia (BCA) survey concluded that:

> The findings of the BCA Work/Family Survey highlight a significant and strategic response by many of Australia's largest Companies to the challenges of work/family balance. Companies are adopting policies that assist their workers to balance their work and family commitments and they are benefiting from improved retention, morale, productivity and staff loyalty. Those with comprehensive and supportive work/family strategies are finding it easier to attract and retain quality staff. At the same time, it is important to acknowledge that no single Company has all the answers, nor can any one approach suits all Companies or all employees of a given Company (BCA 2003, p.15).

Managers require new skills and tools to manage the changing workplace, and to manage their staff, now and further into the 21st century (Nicholson & Nairn, 2006). What appears to be missing in the A1 hospitals studied was the creativity at senior levels to generate an environment of improved flexibility in staff conditions, and in staff performance, to ensure the hospitals could meet current and future needs. To assist managers with their many face-to-face interactions with staff and patients within this unique health environment it is essential for them, more than for managers in other industries, to have a high level of support/direction from HR, hospital Boards and executives, to help manage this process tension. Middle

managers are well positioned to assist hospitals develop practical WLB and wellness policy and formulate common implementation strategies, including an organisation-wide 'accepting' culture (Walsh, 2013). Middle managers are the direct link and influence on the workers/staff that these WLB policies impact on the most. The flow of communication as to why and the how policy is implemented on a daily basis is imperative from both the organisation and managers ability to implement any new policy. As pointed out before a common organisation culture is better controlled than many locally isolated or separately generated department cultures. As demonstrated in Todd and Binns' (2013) study, this lack of organisation WLB practices creates additional tension between management and the middle managers 'need' to implement WLB more effectively to meet the WLB requirements of their staff.

Basis for decision making

The findings of this study have demonstrated important topics for managers to take into consideration when making decisions about staff requests related to WLB. Identified throughout the study were topics that included: understanding staff requests and their expected outcomes; the manager's own WLB and capabilities, including experience; resources available such as rosters; options for flexibility in work requirements; and decision outcomes, that is, managers' decisions in accordance with department guidelines and organisational policy. These findings are consistent with recommendations from the literature, which stress the interdependency of staff expectations, managers' capabilities and decision impact when making a decision (Vroom, 1976; Maxwell, 2005). Although the data supported the topics outlined above, the managers interviewed considered that for them, with direct daily staff contact, the main relationship between WLB and the provision of care was especially important.

The expectations of staff were integral to the manager's judgement when making any decision, and to how the decision was viewed against the eventual outcome. Staff were expected to show added responsibility through 'self-management' using rosters, in turn reinforcing the decision outcomes when staff followed these rules. Managers also had to seek to understand employees' situations, needs and wants, and their expectations of having a balance between work and non-work life. From the interviews, it was the researcher's observation that the number of managers who were in the position to achieve such a balance between work and home for employees (or even for themselves) was low, even though the researcher believed they were trying to understand, adapt and assist this process within the

boundaries of meeting mandatory organisational management policy, and workplace requirements.

From those interviewed, it appeared that managers' decisions were being made within a historic structure, i.e. rosters - a structure that seems to be failing to develop enough to cope with the changes in staff expectations, in skills required, and in service growth. As discussed previously, managers relied heavily on rosters, fundamental leave management policies, changes in EBAs, and the experience they had each accumulated over their time in health, to make decisions on staff requests. These decision structures had been operating for a long time, had served the organisation, managers and staff well in the past, but it appeared from the interview data collected, and literature reviewed, that a fundamental shift in the way staff are managed is now required. With growing demands for a balance for staff between time spent in work and non-work, health organisations need improved methods of flexible staff management, methods that are integrated effectively into their multifaceted and expanding activities (Kaplan-Leiserson, 2003; Bambra et al., 2008).

This outline of current practice stems from a self-selected sample of middle and senior human resource managers in Victorian A1 hospitals. However, the data provided does reflect common issues and points of view across multiple disciplines and departments in these organisations. Based on that evidence, other public hospitals, structured similarly to A1s and following the same DoH funding and policy guidelines would be expected to encounter similar WLB issues and decision-making processes.

Interestingly, the findings above show that the managers interviewed were unsupported in two aspects: (1) they are working in "an antiquated work organisation" (in the Victorian health system) with inadequate systems for policy-to-practice strategies, as Leggat, et al. (2011) have documented; and (2) they suffer from a fundamental lack of understanding and of in-house policy around WLB issues. Recognising this, managers have needed to increase their HR responsibilities over a number of years, including both recruitment and retention of staff, but do not have enough organisation support or help (documentation) to assist them in this task. They also asserted that they can manage on their own, as demonstrated by their organisation of departmental roster requirements, which included types of employees and their shifts worked, coupled with local decisions and rules on WLB requests that were initiated to best meet both individual staff members' needs and departmental service imperatives.

Further research could include more information from staff to see what the current influences are on WLB, and what directions and inclusions should be considered for the future. Once these are better understood, all three parties - staff, managers, and senior executives - could potentially promote an organisation-wide culture that could improve the process of incorporating and securely establishing WLB practices in these hospitals.

Limitations

Although this research was carefully prepared, there were some limitations. While the sample size was small, the consistency in the interview findings among the middle management staff in these A1 hospitals suggested that the sample was sufficient to uncover the essential aspects of WLB in these hospitals. The interview methodology explored balance in WLB but did not specifically explore the quality of that balance. This is important because individual employees' perception of balance could be influenced by 'quality' of time spent away from work, rather than on the actual 'time' spent away from work. This could modify the definition of an employee's WLB but does not impact on the question being explored in the research.

Another limitation was the researcher did not find out if the hospital executives' views reflected a true indication of the resources available to middle managers when making WLB decisions. This would be interesting to know as it would reflect on how the middle managers and executives interacted, but did not impact from the managers' position on the decisions they routinely made on staff requests. Although these two points are valid and would certainly improve the discussion, the requirement of quality of time away from work would not necessarily impact on the resources available to middle managers. The executives' views would be worth knowing as this could impact on the longer-term provision of resources and/or organisational strategy for WLB; however, the information received from middle managers was sufficient, and outlined the relationship particularly from the manager's perspective. Further study on this relationship could be completed to detail the specific views of the executives to possible draw comparisons to their views and impact on WLB strategy in their organisations. Finally, the focus of this study was on A1 hospitals in Victoria. The results may not be generalisable to other hospitals in other jurisdictions and further study is required. These points could be expanded upon with future research, broadening the scope to include the impact on quality non-work time and the effect on work, or the specific role of executives in supporting hospital resources within health institutions.

Conclusion

There are a number of conclusions that have been drawn from this research. First, despite the legislative and regulatory requirements for WLB there was little internal human resources policy or the requirement for education on prescribing how managers in these A1 hospitals were to manage staff WLB needs and still meet organisational responsibilities. Managers without such training and policy are left to their own devices creating pockets of different cultures and accepted practices that may not meet or align with those of the organisation. This will create unsustainable inequities and varied outcomes for workers.

Second, in response to the lack of hospital WLB policy or documented practices and procedures, the middle managers in the A1 hospitals had implemented common strategies in staff employment and use of rosters in their management of WLB requests of staff. With no policy and organisation WLB definitions it was difficult for managers to visualise staff needs, as they had no local comparison on which to base their actions and decision. These middle managers had resorted to antiquated homemade solutions that were suboptimal to deal with the more complex issues and expectations of staff. If support in the form of new alternative solutions is not forthcoming from the organisations, managers will be stranded with little choice. Consequently managers may need to start restricting staff requests, which may increase absenteeism or possibly lead to a loss of staff.

Third, managers believed that increased pressures on staff at work and an increase in family responsibilities (both young and older family), and their wish to maintain work and home-life balance, had led to an increase in staff requests for ‘time out’ and ‘time away’ from their job. These scenarios were becoming more common and created tension for middle managers due to their reduced ability to provide services and meet their staff needs. This WLB focus from staff had also led to an increase in more part time and casual staff within the A1 organisations, which from the middle managers’ view seemed to increase the complexity rather than negate it.

Fourth, managers faced common difficulties, including a fundamental mismatch of hospital policy and HR department WLB resources with the desires of their staff. The expectations of staff about the results of their requests had become increasingly varied from lack of organisational direction, putting considerable pressure on the resources to maintain services.

Finally, there was a considered lack of support for a hospital-wide WLB culture. There was a missing link between staff, management and executives' perspective on organisational WLB needs. There needed to be a consistent and coherent understanding of the end goal, and the form of strategy, training or co-operation that has to be in place to drive the generation, culture and implementation of these WLB policies. As stated previously this could be achieved by executives, managers and staff working together to identify common ground to formulate WLB promotion to benefit both the workers and the organisation.

Middle managers in this research reported that complex staff WLB issues had become commonplace, and resources provided by the organisation to assist in the decision-making process were inadequate, leaving managers to their own devices, using antiquated methods which were falling short of meeting staff demands over time. It is imperative that A1 hospital executives engage with middle managers and staff through HR to connect with them and develop, through meaningful discussions, WLB policy and workflow flexibility. A1 organisations need to generate guidelines and training, for the implementation by managers, based on hospital operational strategies, staff needs, actual experiences, and future expectations. This process may be difficult, encounter barriers and require significant bi-directional communication to achieve a satisfactory WLB environment. It is essential that A1 hospitals move forward to resolve WLB policy requirements. If this does not happen there will be significant implications on the provision of patient care. Hospitals need a plan to maintain their happy and healthy staff and assist managers that are under constant pressure and tension to provide basic daily services.

Appendix 1

Participant Information Sheet

La Trobe University

Participant Information Sheet

Project Title:
WHAT ARE THE WORK-LIFE BALANCE ISSUES ENCOUNTERED BY DEPARTMENTAL MANAGERS IN A1 HOSPITALS IN VICTORIA?

Researcher:

Name: Colin Baker
School: La Trobe School of Public Health
Course: Professional Doctorate
E-mail:c.baker@latrobe.edu.au

Supervisor: Associate Professor Rae Walker
E-mail:r.walker@latrobe.edu.au

Ethics Approval:

This project has been given the approval, through the La Trobe University Faculty of Health Sciences – ref: FHEC09 / 60

Research Aim:

The aim of this study is to identify Work-Life Balance (WLB) issues that are encountered by middle managers in Victorian A1 Hospitals and the resources that are in place to assist them in resolving them.

I am interested in reviewing how A1 hospital managers are managing work-life-balance (WLB) issues and what the organizations' are doing in relation to creating a better environment for their workers by creating options relating to a different work-life–balance (WLB) needs.

To be able to understand the WLB within a hospital organisational system it is necessary to investigate the issues that arise within the working environment. It is important to see how management and employees interact with each other in relation to: WLB requests and expectations, departmental support, organisational support, and impact of agreed outcomes. What also needs to be recognised is that the internal environment is affected by the external environment to the extent that there may be set rules within which the hospital must make its decisions – e.g. legal rulings, DHS policy, etc.

Through individual interviews an insight will be gained into WLB issues encountered by managers in an A1 hospital, how these issues are negotiated, including exploration as to how managers manage and implement solutions to the problems.

Funding:

This research project is unfunded.

Research Procedures:

I have requested and gained support from your CEO to engage the organization and approval to ask for your participation in this research project. The project consists of individual interviews of several department managers in a number of organizations.

This data will be collected using a taped interview that will be approximately one hour in duration. The interview will cover a series of questions on work-life balance to highlight the issues encountered by specific department managers within an A1 hospital.

The interview will then be transcribed and returned to the interviewee in hard copy for review of its accuracy and completeness prior to it being analysed.

Risks:

It is anticipated that this research will not cause any risks, discomforts or harms which may result from participation in the project. Any personal details are kept separate from transcriptions and each participant will be assigned a code that will be used to identify their materials as an additional security measure.

Use of Data collected:

The data collected within the interviews will be utilized in the following manner:

(a) The data collected on tapes and in hard format will be stored in a locked cabinet during the development of the thesis. Any data in electronic format will be kept in

files that have pass word protection to ensure security and confidentiality of data;

(b) Confidentiality of the participant will be maintained through the use of codes to identify both organizations and individuals;
(c) Normal tape recorders will be used for all interviews and will be converted to hard copy and electronic transcripts. The hard copy transcripts will be used by the participants for review and editing.
(d) Participant may request a copy of their personal data collected in the course of the research including their allocated code name;
(e) Participants will be provided with an opportunity to review transcript(s) of their interview(s) prior to data analysis;
(f) All data collected is for the thesis stated above only. Papers may be derived from the thesis and submitted to journals for publication. The data will not be used for any other future projects;
(g) Data will be preserved within the School of Public Health at La Trobe University research archive for possible future review if required, and only by the appropriate authority for review of my study;
(h) The raw data will be disposed of in the appropriate manner after the required storage period of 5 years.

Benefits of the project to the participant:

The structured exploration of participant's experience of managing WLB issues is likely to enhance their understanding of the issues and hence their capacity to manage the issues when they arise.

Note for Participants:

It should be noted that there are no disadvantages, penalties or adverse consequences for not participating or for withdrawing prematurely from the research.

Any questions regarding this project may be directed to the Investigator(s) Colin Baker, School of Public Health on telephone number (03) 9496 3277 or Associate professor Rae Walker on telephone number 9479 5875.

"You have the right to withdraw from active participation in this project at anytime and, further, to demand that data arising from your participation are not used in the research project provided that this right is exercised within four weeks of the completion of your participation in the project. ***You are asked to complete the "Withdrawal of Consent Form" or to notify the investigator by e-mail or telephone that you wish to withdraw your consent for your data to be used in this research project.****"*

Complaints/query:

If you have any complaints or queries that the investigator has not been able to answer to your satisfaction, you may contact the Secretary, Faculty Human Ethics Committee, Faculty of Health Sciences, La Trobe University, Victoria, 3086, (ph: (03) 9479 3573), e-mail: Natalie Humphries n.humphries@latrobe.edu.au

Appendix 2

Consent Form

La Trobe University

Participant Consent Form

Title of Project

WHAT ARE THE WORK-LIFE BALANCE ISSUES ENCOUNTERED BY MANAGERS AT DEPARTMENTAL LEVEL IN A1 HOSPITALS IN VICTORIA?

Researcher:

Name: Colin Baker

School: La Trobe School of Public Health

Course: Professional Doctorate

E-mail:c.baker@latrobe.edu.au

Supervisor: Associate Professor Rae Walker

E-mail:r.walker@latrobe.edu.au

Statement of agreement to participate:

"I …….. have read and understood the ***participant information sheet and consent form****, and any questions I have asked have been answered to my satisfaction. I agree to participate in the project, realising that I may physically withdraw from the study at any time and may request that no data arising from my participation are used, up to four weeks following the completion of my participation in the research. I agree that research data provided by me or with my permission during the project may be included in a thesis, presented at conferences and published in journals on the condition that neither my name nor any other identifying information is used."*

Name of Participant ……

Signature: *Date*

Name of Investigator **Colin Baker**

Signature: *Date*

Appendix 3

Interview Questions for Middle Managers

Head of Department

1. The core of this interview is the idea of work life balance (WLB). What does this term mean to you?

2. Within your department/area – what type of requests do you receive from staff in relation to the work place?
    - Leave
        - Sick
        - Annual
        - ADO
        - Carers
        - Study
        - Conference
        - LSL
        - LWOP
    - Hours of Work
        - Fulltime
        - Part time
        - Casual
        - Shift
        - Increase
        - Reduce
        - W/day or W/E
    - Place of work
    - Connectivity to work
    - Pay increase
    - Transfer
    - Promotion / Demotion
    - Any other matters

3. Would you consider any of these items above, as pertaining to work-life-balance? If so, which ones? (a list of the above items will be given to the interviewees for assistance in recall)

4. Are there any other requests not mentioned so far that you would consider reflects WLB issues? How would you group these – i.e. family, lifestyle or personal…?

5. When you have a request from a staff member on a WLB issue, what resources do you utilise to assist you in making the decision?

6. I relation to the last question - what other resources are available to assist you in deciding on an action to one of your staffs requests; i.e. physical (IT, hours of operation), policy/EBA, previous decisions or yours / others experience.

7. Are there any other managers who you may consult with if you need additional information, assistance or sounding board? This could be in relation to gathering more information, or what the hospital allows you to do in certain circumstances, or hoe your decision could impact on agreements in place – EBA etc.

8. Are there any policies (local organisation) you follow when making these decisions, if so what are they?

9. Are there any obstacles, organisational, departmental or personnel, to be overcome when making decisions that might help resolve a WLB problem? Does your organization support decisions to resolve WLB problems?

10. On what grounds / reasons do you make these decisions, what are they based on?

    - policy
    - experience
    - guidelines
    - expectation
    - skill retention
    - peer discussion
    - what resources available
    - previous decisions
    - other

11. What impact have the WLB decisions you have made to this time had on your staff? Is the impact different depending upon whether a request has been approved / rejected?

12. Do your responses to WLB related requests, affect staff performance?

13. Are there any issues in relation to your WLB decisions that we haven't covered?

14. Are you aware of any published documents on WLB, i.e. Local/org/Govt/Industry, if so what are they?

Appendix 4

Interview Questions for Senior HR Managers

Senior HR managers

1. The core of this interview is the idea of Work-Life Balance (WLB). What does this term mean to you?

2. Within your department/area – what type of requests do you receive from managers/staff in relation to the work place?
    a. Leave
        - Sick
        - Annual
        - ADO
        - Carers
        - Study
        - Conference
        - LSL
        - LWOP
    b. Hours of Work
        - Fulltime
        - Part time
        - Casual
        - Shift
        - Increase
        - Reduce
        - W/day or W/E
    c. Place of work
    d. Connectivity to work
    e. Pay increase
    f. Transfer
    g. Promotion / Demotion
    h. Any other matters

3. Would you consider any of the items above as pertaining to work-life balance? If so, which ones? (a list of the above items will be given to the interviewees for assistance in recall)

4. Are there any other requests not mentioned so far that you would consider reflects WLB issues? How would you group these – i.e. family, lifestyle or personal…?

5. Does your organisation have a written policy on work-life balance?

6. What resources are available to assist you or other hospital managers in deciding on an action to one of your staff's requests; i.e. physical (IT, hours of operation), policy/EBA, previous decisions or yours / others experience.

7. Are there any policies or information for managers to refer to when required to make decision on staff requests?

8. Do you have any HR specialists that are referred to (or that you refer to) for WLB issues or manager guidance?

9. What guidance are hospital managers given by the hospital or by any other person or organisation in regard to WLB?

10. Have you any examples of items requested and decisions made in relation to WLB? Are these decisions discussed at the Health Service level before being handed down to managers?

11. What impact do these decisions have on managers/staff? Are they different depending upon whether a request has been approved/rejected?

12. Do these decisions affect staff performance?

13. Are there any issues in relation to your WLB decisions that we haven't covered?

14. Are you aware of any published documents on WLB, i.e. Local/Organisation/Govt/Industry, if so what?

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