# Trade Union Involvement in Digitalisation in Norway and the UK: Changing Admin and Clerical Work in Public Hospitals

***Caroline Lloyd, Jonathan Payne and Secki Jose***

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## The Research Team

**De Montfort University, UK**

Professor Jonathan Payne

jpayne@dmu.ac.uk

Tel: +44 (0)116 257 7236

Dr Secki Jose

secki.pjose@uwe.ac.uk

**Cardiff University, UK**

Professor Caroline Lloyd

Lloydc4@cardiff.ac.uk

Tel: +44 (0)292 087 0397

## 1. Research Aims

This report is based on findings drawn from a broader project, funded by the UK Leverhulme Trust, which explores the role and influence of trade unions in shaping digital technology and its outcomes in four sectors in Norway and the UK. The project sought to address two central questions. First, what involvement and influence do unions have in the implementation and use of digital technologies? Second, what factors affect unions' ability to shape better outcomes for workers? The project focused on lower and intermediate-level jobs, specifically:

- shop-floor workers in grocery retail;
- production operatives in food and drink processing;
- administrative and clerical workers in banking; and
- administrative and clerical workers in public hospitals

The researchers worked with trade unions in each country to identify key challenges and opportunities, along with the initiatives currently taking place across the sector. This report discusses preliminary findings from the hospital sector, and addresses the following aspects:

- Union approach to digitalisation
- Union involvement in the introduction and implementation of digital technologies.
- Union influence on job losses and role changes
- Union representatives' views on union resourcing and training

## 2. Research Background

Recent years have witnessed increasing debate around the implications of digitalisation for work. While much concern has focused on potential job losses (Frey and Osbourne 2017), there are also important questions around how tasks change and the impact on skill, monitoring and surveillance, and broader job quality. Critical commentators have warned against 'technological determinism', arguing that outcomes are not driven solely by technology, but depend on public policy, institutions, social actors and workplace contestation (Dølvik and Steen 2018, Lloyd and Payne 2019).

Trade unions are important actors in shaping the use and implementation of new technology in support of workers' interests. Previous studies in the 1970s and 1980s, however, suggest that this is an area where unions have often struggled to exert influence (Deutsch 1986). Today, the challenge is even greater in a context of 'neo-liberalisation', financialisaton, restricted public sector budgets, and union decline in many European countries (Visser 2019). The general position taken by trade unions is that digital technology can impact positively or

negatively on workers, and that shaping its use in ways that benefit workers and society depends on collective voice and influence (TUC 2017, STUC 2018, Voss and Rego 2019). Many factors are important in shaping outcomes including national institutions and public policy; the power that unions have at different levels (national policy, sector and workplace); the approaches taken by dominant actors (government, senior managers); and unions' own strategies, resources and capabilities (Lloyd and Payne 2019, Gasparri and Tassinari 2020). We would, therefore, expect to find differences between, as well as within, countries which can help to illuminate factors that enable or constrain unions' influence and the conditions under which they can make a difference.

The few empirical studies of the role that unions are currently playing in shaping technical change at work have focused mainly on 'Industry 4.0' in manufacturing (Haipeter 2020), with a limited number examining private sector services such as retail and banking (Kornelakis et al 2022, Payne et al 2022). In the public services, digitalisation is seen as a way of boosting efficiency and saving money, whilst improving, or at least maintaining, service quality. Workers' and unions' interests overlap with concerns to defend the quality of services from cost-cutting efficiency drives. The public sector is often said to be challenging for implementing new technology. It is claimed to be 'bureaucratic', with complex and slow decision-making processes involving different professional groups who may be resistant to change (Barrett and Stephens 2017). Public healthcare is often cited as a case in point (Coiera 2011).

Norway and the UK were selected for this project as they offer stark contrasts in their institutional environments and the power relations between social actors (see Table 1 for key features of their respective models). In the UK, there are no formal rights for unions or workers to be consulted over technology or for worker representation on company boards. In Norway, the Working Environment Act requires management to inform and involve employee representatives in any changes affecting the workforce, including technology. In both countries, public sector industrial relations are characterised by strong traditions of predominantly centralised collective bargaining.

Studies of the role of public sector unions in digitalisation processes remain scant, despite being an area where they retain high levels of membership and there are often established procedural mechanisms for collective bargaining and consultation in many European countries (Bechter et al 2012). While we might expect greater union involvement in technological change and shaping outcomes in public services, available research paints a rather different picture. In the UK, where public services have experienced austerity since the financial crisis, the union, Prospect, found that three-quarters of civil servants are not confident their employer would involve them in making decisions when new technology is introduced (Voss and Bertossa 2022). Even in the Nordic countries, despite strong unions and collective

agreements, unions also report problems (Voss and Rego, 2019). In Norway, a survey by Fagforbundet found union and worker involvement is often lacking, that many workers do not receive sufficient information before digital technologies are introduced, and that training is inadequate in many cases (Voss and Rego 2019).

**Table 1: Key features of the UK and Norwegian models**

| UK (neo-liberal) | Norway (Nordic welfare state) |
|---|---|
| Union density: 23%<br>Collective bargaining coverage: 41% | Union density: 50%<br>Collective bargaining coverage: 70% |
| Employer organisation: 33% | Employer organisation: 73% |
| No national bargaining, sector bargaining mainly limited to public sector | National & sector bargaining dominate |
| Very limited union involvement in labour market institutions and policy | 'Tripartite' labour market institutions involving the state and 'social partners' |
| Weakly-regulated labour market | Strongly regulated labour market |
| Extensive low wage labour market and high income inequality | High wage economy and low income inequality |
| Relatively weak productivity | Relatively strong productivity |
| No codetermination in law | Statutory codetermination, including working environment committees |
| No legal rights for unions to be informed and consulted about new technology (only redundancies) | Basic Agreement (national-level collective agreement) & Working Environment Act provide for union involvement in new technology. |
| Moderate data protection laws | Strong data protection laws |

Data sources: Nergaard 2022, DBEIS 2022

## 3. Public Hospitals in the UK and Norway

In the UK, the National Health Service (NHS) offers free healthcare from 'cradle to grave' and is managed through separate systems in the devolved nations. Over the past three decades the NHS in England has faced successive reforms, driven by New Public Management (NPM), including the creation of internal markets, performance management systems, the setting up of self-governing Trusts, and the contracting-out of support services. After devolution in 1999, governments in Scotland and Wales disbanded the 'internal market' and reintroduced regional health boards (RHB) to oversee and deliver provision in their area.

The NHS is distinctive in the UK for its formal structures of consultation and negotiation, which are tripartite at national level and management/multi-union at other levels. Collective bargaining takes place at a UK-wide level over the grading system and conditions of employment, although annual pay rises in England and Wales are decided by governments drawing on recommendations from Pay Review Bodies. In Scotland, separate pay negotiations take place. In England, the employers are hospital trusts, and there are normally local joint-union negotiation and consultation committees. In Scotland and Wales, staff are employed by the region. Committees at this level are typically framed in terms of partnership, while RHBs include one elected employee representative.

In the UK, union density is much higher in the public sector at 58.2%, compared to an overall unionisation rate of 22% (DBEIS 2022). The long-standing structures of consultation and negotiation in the NHS changed to some extent from 1998, with the UK Labour government's attempts to introduce forms of social partnership, alongside devolution of health to Scotland and Wales in 1999. Social partnership forums continue at national level in England but were never very widespread in hospitals (Bacon and Samuel 2017). Where partnership was introduced, problems included lack of senior management commitment, limited effective involvement and a distancing of union representatives from members (Bach 2004, Tailby et al 2004). A recent account of those partnerships that have endured is more positive, suggesting unions are involved in decision-making; however, these relationships are currently being undermined by austerity and pressures on budgets and staffing (Guillaume and Kirton 2022). In Scotland and Wales, partnership was taken up more systematically by the devolved governments and is more embedded, particularly in Scotland (Bacon and Samuel 2017). A review of partnership working in NHS Scotland concludes that much of it 'works extremely well', with positive examples outnumbering 'dysfunctional cases' (Findlay et al 2019: 3, 9).

In Norway, health services are paid for at the point of service, though heavily subsidised. The move towards NPM occurred later than in the UK, involving a shift towards 'corporate management' and 'market-type' principles, with activity-based finance (Christensen et al 2006). Hospitals are organised into health trusts which are separate legal entitles under the ownership of four Regional Health Authorities (RHAs), and responsible to the Ministry of Health and Care Services. The result is a decentralised model of regional health enterprises which, it is argued, are 'subject to financial regulation and accounting principles aimed at private-sector companies, mirroring both the board/director structure and the demands for economic results' (Neby, 2015: 1003). A prominent concern has been the shift from local political control over hospitals as previously exercised through the democratically elected Counties to primarily appointed regional and trust boards.

There is a basic agreement between *Spekter* (the employers' association covering the public sector and related companies) and the union confederations, including

*Landsorganisasjonen* (LO), which sets out the rules on industrial relations and substantive issues. The central collective agreement covers a range of social provisions, and there are sub-agreements specifically for hospitals that primarily deal with pay and conditions. The basic agreement specifies that the introduction and use of new technology and digitalisation must be discussed with shop stewards. Individual employees should have 'real influence', including in project groups. There are also mechanisms to deal with employers that fail to follow the collective agreement.

Union density in the government sector (including hospitals) is around 85% (Nergaard 2022). Social dialogue takes place at central, regional and trust levels on a multi-union basis. RHAs and their constituent hospital trusts are overseen by boards of directors which include three elected representatives of hospital employees who are normally drawn from the main doctors' union, nurses' union and Fagforbundet. Research examining the ability of unions to use these mechanisms to influence management decisions remains limited. One study found most shop stewards reported that involvement in change projects often happened too little or too late (Trygstad and Anderson, 2015:29).

## Administration and clerical work

The main groups of workers considered in this report are administrative and clerical workers, comprising health secretaries, medical secretaries, ward clerks, medical records staff, audio typists and receptionists. In both countries, these workers are overwhelmingly women. Concerns have been raised that their work is often invisible, misunderstood and under-valued (Holten-Møller 2018, Hoeyer and Wadmann 2020). In the UK, these workers are generally classified as Band 3 or Band 4 in the pay system, with rates of pay between £21,700 and £26,300 in 2022 for England and Wales, and between £23,900 and £28,100 in Scotland. There are qualifications available in medical administration and medical terminology, but these are not generally required and most workers do not possess them.

In Norway, these admin workers would fall into groups 2 or 3 in the pay structure, where upper secondary education is expected or required. 'Health secretary' – a role that does not exist in the UK – is a registered occupation and requires a three-year diploma from upper secondary education. Those holding such a qualification are able to undertake a dual role of administration and basic medical procedures, such as injections, blood tests and wound care. Minimum pay rates are the same for groups 2 and 3, and are between NOK389,000 and NOK468,000 depending on seniority. In both Norway and the UK (outside of Scotland), pay rates represent around 70 to 80 percent of median full-time basic earnings.

The main technologies impacting on administrative and clerical workers are electronic medical records (EMRs) or *elektronisk pasientjournal* in Norwegian. Widely viewed in policy

documents as representing modern healthcare, they are seen as supporting ‘better, safer, cheaper and more integrated healthcare’ (Håland, 2012:762). The digitalisation process can involve various stages from scanning paper records to creating new ones in digital format. Various digital platforms are available that aim to provide integration between the records system, appointments systems and patient flows. Other digital technologies include speech recognition and transcription software that allows doctors’ dictation to be integrated into the patient record or into letters/emails to a patient. The aim is to replace human transcription, but a common problem is dictation errors with the software. Doctors also complain of being embroiled in data work at the expense of patient care (Håland 2012, Hoeyer and Wadmann 2020).

There have been claims that digitalisation will dispense with most of the work of hospital secretaries and records’ workers. Holten-Møller (2018: 76) notes that in this discussion ‘the future of AI and automation in hospitals seems to have little or no place for clerical work.’ This follows in the wake of a widely-cited prediction that medical secretaries have an 81% chance of their job being automated in the next couple of decades (Frey and Osbourne, 2017:275). As others have cogently argued, however, technology often replaces ‘tasks’ rather than ‘whole occupations’, with workers taking on new tasks in the process (Arntz et al 2016).

The history of implementing digitalisation in hospitals, particularly EMRs, is a troubled one. In the early 2000s, the UK government invested in a highly ambitious national IT project for healthcare in England aimed at data sharing across the country and between services. It was an expensive failure, primarily due to the complexities involved, a lack of engagement with Trusts and healthcare workers, and the extraordinary high costs (NAO, 2011). Nevertheless, there remains a commitment to digitising patient records, with decisions predominantly made at the Trust or regional level. (DHSC 2016). In Norway, a national EMR project also stalled (GarciIa and Crenner 2022) with decisions subsequently shifting to the regional level. With different systems in place, there is a major challenge of ‘interoperability’ between regions and between primary and secondary healthcare (Fragidis and Chatzoglou 2017). Concerns have also been raised that EMRs increase clinicians’ workload, are complex and often suffer hardware malfunctions (Garcia and Crenner 2022).

The expectation is that these various digital platforms are likely to have an impact on the number and the role of admin workers within the hospital setting. Given their relatively low status vis-à-vis clinical professionals, coupled with claims about the ‘invisibility’ of their work, it might be thought that admin workers are less likely to be involved when digitalisation projects are being planned and implemented. Empirical research has yet to address this issue, including the role that unions are playing, whether in Norway, the UK or, indeed, more broadly.

## 4. Research Methods

To compare the role of unions in Norway and the UK, research was undertaken with Fagforbundet in Norway and UNISON in the UK. They were selected as the main representative of administrative and clerical workers in hospitals, although they also have members in a range of other occupations, such as nurses, porters and cleaners. They are the largest unions in their respective countries, predominantly recruiting public sector workers, with UNISON affiliated to the Trades Union Congress (TUC), and Fagforbundet to LO. While UNISON is normally the only union recruiting these workers, in Norway, Delta (an affiliate of YS) also has members in these areas. As UNISON and Fagforbundet often have the most members, their representatives tend to have key positions on joint-union committees and as elected employee reps at board level.

**Table 2: Research Interviews**

| Interviewees | UNISON (UK) | Fagforbundet (Norway) |
|---|---|---|
| **National/regional officers** | UNISON-national-officer1<br>UNISON-national-officer2<br>UNISON-national-officer3<br>UNISON-regional-officer4 | FGF-national-officer1<br>FGF-national-officer2<br>FGF-national-officer3<br>FGF-national-officer4<br>FGF-national-officer5 |
| **Regional representatives** | | FGF-Region1-rep<br>FGF-Region2-rep<br>FGF-Region3-rep |
| **Senior local representative** | E-Trust1-senior-rep<br>E-Trust2-senior-rep<br>E-Trust3-senior-rep<br>S-RHB-senior-rep<br>W-RHB-senior-rep | N-Trust1-senior-rep<br>N-Trust2-senior-rep1<br>N-Trust2-senior-rep2<br>N-Trust3-senior-rep1<br>N-Trust4-senior-rep1<br>N-Trust5-senior-rep1<br>N-Trust5-senior-rep2 |
| **Local rep** | E-Trust1-rep<br>E-Trust2-rep<br>S-RHB-rep<br>W-RHB-rep | N-Trust1-rep<br>N-Trust2-rep |
| **Total** | **13** | **17** |

Senior rep refers to a workplace rep with a full-time union role or with a high-level position, e.g. chair of the joint-union side.

The research primarily involved semi-structured interviews with national union officers, and regional and workplace union representatives (Table 2). In Norway, interviews were undertaken in all four regions, and with workplace representatives in three of these. In the UK,

interviews covered representatives in four Trusts in England, one in Wales and one in Scotland. Interviews were supplemented with secondary data from union web pages, union policy documents and press releases. A total of 25 interviews were conducted on-line between June 2022 and April 2023 with 30 participants. All interviews were audio recorded with the consent of participants and fully transcribed. The names of all interviewees and workplaces are anonymised in the findings.

## 5. Research Findings

The research findings are divided into four sections: first, union strategy around digitalisation; second, union involvement in decisions concerning the introduction and implementation of digital technologies affecting admin and clerical workers in the hospital sector; third, the implications for jobs and roles; and, fourth, union representatives' perspectives on support and training to deal with introduction of digital technologies.

### 5.1 Union strategy and digitalisation

Neither trade union has produced a written strategy on digitalisation; however, both agree digital technologies can bring benefits as well as threats, and stress the importance of union involvement from the beginning. The participation of workers potentially affected by technology is also deemed vital, along with ensuring that employers provide the necessary training required for any change to tasks or roles. These are general approaches and are not just specific to the hospital sector.

A key difference is in relations with government and the importance of the 'tripartite model' in Norway. As well as exerting influence on government policy through LO, Fagforbundet is directly involved in discussions with government over healthcare policy, including the financing and management of the system. It also participates in working groups, which are '*mainly advisory*' (FGF-national-officer4) on various aspects of digitalisation, including a recent commission on the future of the workforce[1]. The return of a Labour government in 2021 has made a significant positive impact in terms of how much union officers feel that they can shape the policy agenda. Political officers talked of weekly meetings where '*we do put a lot pressure through government'*.

A policy officer (FGF-national-officer1) stated that digitalisation is a '*big issue*' for Fagforbundet and in hospitals, especially given the past failures of large-scale projects. Much attention has focused on ensuring that the security of patient data is not compromised in the

[1]https://www.regjeringen.no/en/aktuelt/the-healthcare-personnel-commission-delivers-its-report/id2961748/

wake of previous scandals, most notably two cases in the South Eastern RHA of data breaches in 2017 and 2018, the former involving the outsourcing of IT operations to a US company. Fagforbundet has continued to push for data to be held in Norway and not under the control of MNCs, and for government to *'reduce the scale*' of digitalisation projects, and build them gradually *'stone by stone*' (FGF-national-officer1). Government policy has, over time, moved away from trying to implement national systems for EMRs, allowing regions to make more local decisions. However, there is a concern that RHAs are driving large-scale digitisation projects in alliance with big tech companies and that this severely limits the scope for bottom-up union and worker involvement.

> *I think this consultant-driven process and also the involvement of the IT industry is very detrimental… the consultants are not really familiar with collective bargaining or… [they want] centralised, standardised solutions which do not really fit our health sector. (FGF-national-officer5)*

Fagforbundet is involved in a network with other unions within LO which is organising a discussion forum over digitalisation. A union officer felt that this might provide an opportunity to engage particularly with unions based in IT companies, and to identify *'common ground*', something that had not received sufficient focus in the past (FGF-national-officer5).

In the UK, the UNISON officers interviewed noted that digitalisation has not been a key priority area to date, despite insisting it should be more prominent.

> *I keep arguing that it should be bigger than it is because I think once you begin to look at it, and that's the thing that's hard to get people to do… we would want our activists to have a clearer understanding of threats, benefit of the whole picture and all the risks that they might want to look at and understand as they have technology introduced. (UNISON-national-officer2)*

UNISON have been working with other unions through the TUC to identify ways to upskill activists to understand and deal with digitalisation. National-officer1 emphasised that union involvement was not just about protecting workers but about meeting a 'shared goal' of improving the patient experience and helping to enhance hospital efficiency. A central issue is lack of resources to devote to policy development which have declined over time (discussed in section 5.4). In addition, strategy is primarily developed by the membership for whom digitalisation has not been a major priority. Nevertheless, in 2022 UNISON's health committee for non-clinical workers was asked by the reps' annual meeting to focus on admin staff for the following year. Part of this work includes a members' survey to examine how jobs have changed, levels of digitalisation and training opportunities. Much of its planned work, however, has been overtaken by the recent industrial disputes in the NHS.

Influencing national policy in England is very difficult given the UK Conservative government, and has tended to focus on the issue of NHS data security. NHSX, a government body aimed at leading the digital transformation of health and social care held stakeholder meetings during its three year life. National-officer1 attended and pushed for the involvement of admin workers in the creation of new systems, and the importance of training, but was uncertain as to whether it made a difference. A more positive relationship was said to exist with the Labour government in Wales and the SNP government in Scotland, which was considered to be '*very pro-dialogue… although it doesn't pan out as well as on paper… the intent is there*' (UNISON-national-officer-2).

## 5.2 Influence of unions in technology decisions

### Hospitals in the UK

In Scotland and Wales, hospitals are organised and managed through regional health boards (RHB) that are responsible for healthcare in their areas. There are 14 health boards in Scotland and seven in Wales. Unions, have the opportunity to influence technology decisions through partnership forums at different levels that act as negotiation and consultation bodies, including at national level. There is also an elected employee representative on each health board. In England, hospitals are organised through a fragmented system of 209 hospital Trusts, which have considerable autonomy as suppliers of healthcare, and are the primary decision-makers on digital changes. None of the Trust boards of those in this study included elected employee reps. Despite the existence of regional partnership forums in England, union reps only discussed the influence of unions in relation to negotiation and consultative committees at the level of the Trust.

National officers reported that union involvement in technology at hospital level was variable, depending primarily upon the approach of local senior managers.

> *there'll either be a good relationship or there won't. They'll either be an employer that recognises the benefit of not startling staff by throwing something on them unannounced and that it's a good idea to go through the unions... And there'll be employers who have a very poor relationship. (UNISON-national-officer2)*

Relations were considered better in Scotland and Wales due to the promotion of social partnership by governments at national level. Indeed, the most positive example of involvement was found in Scotland at S-RHB. A senior rep explained how partnership was a process embedded at every level, with the union involved at an early stage, including in working groups on particular projects:

> *Any digital discussions, changes, proposals or anything like that come to a senior area partnership forum… and then filter down to the acute and any other forum*

*that it needs to go to… sometimes I would be on the working group depending on what the digital strategy would be. (S-RHB-senior-rep)*

National proposals are discussed at a Scotland-wide forum.

*if the [national] forum sets up a working group to deliver something, or introduce something, our health committee would look for local reps… who work in that area, who has a knowledge and an understanding of that, for the short life working group. (S-RHB-senior-rep)*

A local admin rep confirmed that there was substantial involvement at hospital level. The hospital director was planning to introduce voice recognition technology for doctors, and the rep would be part of the working group.

S-RHB is strongly unionised, and senior managers were said to have a positive view of unions. Nevertheless, there remains problems with some local managers, who union reps explained either did not understand what was required, particularly if they are new, or simply did not think unions should be involved in technological change (S-RHB-senior-rep, S-RHB-rep). In such cases, the union is able to stop any introduction of technology '*until such times as they work in partnership again*' (S-RHB-rep) by enlisting the support of more senior managers. How widespread this approach is across Scotland is unclear, although the senior rep commented that the '*odd*' health board does not follow the correct procedure. Failure to follow the partnership agreements can be taken up at the Scottish level, and even directly with Government Ministers.

Despite the similarities between the partnership structures in Scotland and Wales, the experience of reps at W-RHB was very different. A senior rep who sat on the Local Partnership Forum could not recall any recent discussion of digitalisation. For organisational changes in general, their experience was one of being *'told'* and '*not always listened to*'. While some managers did involve union reps in local projects that could be around technology, some were described as '*very anti-union*'. In relation to the recent introduction of digital dictation and earlier attempts to digitalise medical records, the two reps were not aware of any union involvement.

*You're sort of told, you're not asked, as a secretary, well, this is going to happen. So you're not asked for a discussion, for your information, for your ideas. (W-RHB-senior-rep)*

*What I've seen… there's not that taking the time to listen to what you actually do… It seems like as admin you don't really have that much clout to go and say anything or have any change. (W-RHB-rep)*

The union rep described a top-down organisational culture and high turnover among managers that made it very difficult to forge positive relationships as a basis for partnership working.

UNISON reps from hospitals in England reported patchy consultation over technology, which in most cases only took place if redundancy or redeployment were being proposed. A regional officer commented that more often than not management will go through the motions of consultation having already made their decision:

> *It's [consultation] quite a weak requirement…what [management] will often do is they'll propose something, we'll give all the reasons why we're opposed… and they will make… a small number of very minor amendments and they will then say 'that's it we've met our obligation to consult'. (UNISON-regional-officer)*

A local rep took a similar view:

> *[senior management] like to think that these partnership committee meetings do what they need to do, but I don't feel as though there's enough… of a relationship… I think it comes down to people just not being given the opportunity to have a voice. (E-Trust1-rep)*

In the two trusts where union reps stated they were involved in digitalisation (E-Trust2 and E-Trust3), this was mainly restricted to dealing with the consequences of digital change for affected staff. There was no evidence of union involvement in decisions over the introduction of digital technologies or participation in working groups or pilots. A senior rep at E-Trust3 explained that they were consulted at the Trust level, but added that management do not '*listen to the people who do the jobs*'. At E-Trust2, there had been some initial engagement with unions and staff looking at different systems for digitalising medical records. As the process proceeded, however, all but very senior managers were excluded, including clinical staff. As chair of the joint-union side, the UNISON branch secretary explained how she had constantly asked for involvement only to be denied:

> *'Why are you not involving us because this impacts on individuals as well as the whole trust? We need to know what's going to affect our members and how it's going to be beneficial for them', but it wasn't heard. (E-Trust2-senior-rep)*

Consultation then only took place over new job roles and grading '*but it was all decided before it went out*' (E-Trust2-rep).

Some reps reported no union involvement whatsoever in certain digital changes. At E-Trust2, the self-service reception system had simply been introduced. At E-Trust1, a new digital patient flow system was being implemented but even a local manager knew little about it, leaving considerable uncertainty for those medical secretaries whose job would be affected:

*The staff obviously aren't happy… that it's being thrust upon them, and they haven't had any input. They've had no training; they don't know what it's going to look like. They don't know how it's going to affect them day to day… how they're going to make it work with their consultants. (E-Trust1-rep)*

The attitudes of senior hospital management were seen as important in explaining variability in union involvement in digital changes in England. At E-Trust3, where there was more consultation at Trust level, the senior rep spoke of a '*positive culture'* that had existed for many years. At E-Trust2 relations were moving in a better direction as the old '*immoveable*' senior team were replaced by those who were more open to union involvement. However, at E-Trust1 the senior rep spoke of a deterioration, with a new senior management team that was less open and visible than the one they had replaced. As in Scotland and Wales, there were frequent complaints from reps in England of problems with some anti-union line and middle managers, and others who lacked the training or support to engage with unions. Unless senior management are committed to union involvement and willing to ensure it happens, it can be difficult to achieve. In England, the unions only have the option of pursuing a grievance or mobilising workers to resist against how or whether technology is introduced. Reps and officers commented that it was hard to pursue collective action around lack of involvement, compared with issues such as pay, workloads and outsourcing.

### Hospitals in Norway

In Norway, decisions regarding large-scale investment in new digital systems reside with the Regional Health Authorities. Interviewees felt it was important to have employee reps on the RHA Boards but recognised the limitations. A national officer noted that '*you can have a big influence'* (FGF-national-officer3) but, with employee reps' in a minority position, such influence relies on winning the support of other board members. Employee reps opposed to a change can have their objections officially recorded. A regional rep commented that decisions were '*adjusted sometimes'* but there was '*not very much dialogue in the board meeting*' itself, which functioned primarily to sign-off pre-prepared cases (FGF-Region1-rep). Others felt that the Board *'listen to what we say. That doesn't mean we win all the time*' (FGF-Region2-rep). A senior rep described the board as the '*final frontier*' where there was a '*last chance*' to stop a project, if the unions had been unsuccessful in influencing management in regional dialogue before it reached this stage (N-Trust5-senior-rep2).

Alongside the boards, the three regional reps interviewed were all involved in social dialogue around digitalisation at regional level, including participating in steering groups concerned with digitalisation projects. These groups cannot generally stop initiatives decided at board level but they could influence implementation and insist on union involvement at

hospital level. The Region2 rep felt the level of involvement was improving and that the union had '*quite a lot of influence in almost every case we work with'*, including a new common digital platform for health records in the region. The developers were said to be taking into account the views of those at hospital-level:

> *they [the developers] listened to users of the system, they listened to the doctors and the nurse and the medical secretary and the other secretary and the technician… they also had a period where they tested it out, and they [the users] could go back and say, 'oh, this is not as good as this' and they went back and tried to sort it out. (FGF-Region2-rep)*

In Region3, there were opportunities to discuss new projects with regional directors before it went to the Board at which point the union could try to stop a system being purchased. The recent decision to upgrade the patient record system was being overseen by a project group with union involvement and was being piloted within specific hospitals, where local union reps and affected workers would be involved.

Some union officers and hospital reps expressed concern about the role of the region and the restrictions it placed on decisions at hospital-level. FGF-national-officer3 commented that '*there are some parts that we are not getting information… they're hiding something*'. Another remarked that '*new digital tools and software are implemented without much feedback from the employees*' (FGF-national-officer5). Some of the hospital reps also reported a lack of knowledge about what happened at the regional level and a lack of communications with reps at that level.

> *It's difficult to get heard on a local level… a lot of the big decisions about what kind of digital tools we're supposed to use comes from [the RHA]… We also have representatives in there, but they are higher up than me and I don't have any communications directly with them. (N-Trust4-senior-rep)*

A senior hospital rep commented that decisions, such as the introduction of a common platform, went '*over our leader* [hospital director]' and '*it's very high level, so I think we aren't having much we can say at our level.… It's the regional level that chooses the system'* (N-Trust2-senior-rep2).

Despite these regional level decisions over large-scale projects, there are still opportunities to influence their implementation or to be involved in more local initiatives. At hospital level, unions can use the collective agreements to ensure that they are consulted and involved in digital change projects. There are formal monthly meetings between the Hospital Trust leadership and the unions, and between union reps and managers at lower levels, alongside employee representatives on the Trust's Board.

National officers considered that the extent of such consultation and involvement varied quite significantly depending primarily on the attitude of the Trust's management but also the approach of local union representatives.

> *We have some management, they really understood that this social dialogue is very important to get things done. But I also think that some leaders they may see that… this really slows down the work. (FGF-national-officer3)*

> *I think some [union reps] of them are scared, they don't know enough about what is going on and maybe not demanding to be involved. (FGF-national-officer1)*

This is confirmed by interviews with regional and local reps. In two cases (N-Trust3 and N-Trust5), hospital reps were very positive about relationships with management, citing close working relationships, strong involvement and a high level of influence in digitalisation:

> *They involve the union in everything they are thinking to do or change. (N-Trust3-senior-rep)*

> *I think the managers have seen us as constructive partners and not the enemy (N-Trust5-senior-rep2)*

They explained these relationships as reflecting particular localities with long traditions of involvement that endured even with changes in senior management and union leaders.

In the other three cases, there was engagement with unions but not to the same degree. In N-Trust4, relationships at the Trust had historically been more difficult but had improved following a change in management, with the rep feeling that '*we are being taken more seriously than we were for years*' (senior-rep). At N-Trust2, despite '*generally having a good relationship*', some smaller technology changes *'just comes*' without unions being involved (senior-rep2). At Norway1, a senior rep explained that the unions are sometimes informed too late, and that relationships with different directors varied: '*sometimes you have leaders that are just doing the things that they want to do*'.

Project groups, involving union reps, workers and managers, are often established to explore how best to implement a technology in a specific work area. In many cases, the union helps decide the composition of such groups. There is evidence that this can work well. At N-Trust3 the local rep was involved from the start in plans to introduce automated patient reception, which included visits to another hospital where a similar system was in place. At N-Trust5, the implementation of the new patient records systems involved the project group meeting every month.

> *we have a meeting about the system and how far we've come and what went wrong, do we have to stop a little bit and think, are we going to do this now or wait for this system to be ready?... it's people from all levels in the hospital, sitting in*

> *that working group... I think they listen quite a lot actually, because they need the employees and the secretaries to do that job and to be really, really good at the job. (N-Trust5-senior-rep2)*

A pilot was undertaken in one clinic over six months, allowing any problems to be sorted out before being extended for testing in two more clinics.

At the other hospitals, there were complaints of local department reps and workers not being involved in digital changes or that they may be involved but not actually influence outcomes. At N-Trust2, referring to the new health platform, the local rep (who was also a medical secretary) commented: *'we don't know what is going to change in our work…we are not getting any information… I think it's just going to drop on our head'*. At N-Trust4, plans to move to a new hospital, including the introduction of new digital tools and a vision of becoming paperless, had seen the union involved *'every step of the way'* (senior-rep). This included participation in various project groups, one of which was looking at the future of clerical work. However, the senior rep was concerned that involvement in previous projects had not led to influence: *'it's already decided and you're just there to waste your time… I guess… you can talk and you can pray that they will listen and take note the next time.'*

At N-Trust1, the senior rep at the hospital level was positive about the unions' ability to influence digital change. However, a local admin rep stated she had not been involved in project groups and that secretaires were '*overlooked most of the time*', the '*worse informed*' and the *'last*' to be involved after the doctors and nurses.

> *When they start a project, they think that everything is fine… Then we see the problems and it's too late… We have to fix them when they're going on. (N-Trust1-rep)*

The rep had asked to be included earlier when the projects started and was frustrated with management's stock response: *'"yes we're going to do that the next time" and the next time comes and it's the same'.*

## 5.3 Impact on workers: job losses and role changes

The main digital technologies being brought in relate to the digitalisation of medical records, patients flows (such as appointment booking), and automated transcription and related letter writing. In both Norway and the UK, senior managers considered they could potentially reduce the number of admin staff required and change their roles. These changes occur against the backdrop of mounting work pressures and shortages of staff. Concerns were often voiced that technology frequently does not deliver on the claims made by tech companies and that many problems remain when it comes to embedding technology successfully within a particular work

process. A frequent comment in many of the interviews goes along the lines of 'if only they had listened to the workers who will be using this technology.' This section examines the extent to which the unions have been able to shape the employment effects of digitalisation.

## UK Hospitals

In the UK, UNISON officers expressed concerns about potential job losses affecting admin and clerical workers, although it was felt more likely that digitalisation would change job tasks rather than lead to redundancies. One noted that medical secretaries did feel '*quite vulnerable*' but '*I don't think it's job losses… it's more our members being concerned about down banding [grading*]' if there is less requirement for specialist knowledge (UNISON-national-officer1). However, in two cases in England, trusts had tried to use digitalisation to cut jobs and make cost savings, only to learn in the process they still needed these workers. At E-Trust3, for example, management had predicted significant job losses with the introduction of EPRs, and had agreed a '*change management process*' with the unions. This involved the freezing of posts and the use of temporary contracts for new recruits to avoid redundancies. However, the expected level of job losses did not materialise, and the union was now seeking to shift those on temporary contracts to permanent jobs. Similarly, at E-Trust2 threats of job losses had culminated only in a handful of redundancies, far fewer than originally anticipated.

Unions are required by law to be consulted over redundancies, and there are also collective agreements over rights to redeployment. There was variation in the extent of union involvement in the process. At E-Trust1 the union was involved in ensuring that workers were supported in the process of finding and applying for new jobs. In another English trust, the rep commented that redeployment occurred with little substantive consultation and had negative consequences for those affected: '*they didn't listen to us, you're going to be forcing people into jobs that they're not happy with*' (E-Trust2-senior-rep). Another rep explained that managers did not understand what medical secretaries actually did as part of their jobs and thought '*all we [medical secretaries] did was letters*'. Digitalisation had led management to add more tasks to the job, causing many to leave and the remainder facing '*extra work*' and '*stress'* (E-Trust2-rep).

At the case in Wales, there was no concern about redundancies because, as a senior rep explained, '*we don't do that*' and were it to happen '*it would just mean another job would have to be found somewhere else*' (W-RHB-senior-rep). The process of digitalising paper records had stalled in recent years, but there was concern about some workers who still spent most of their time typing. The senior rep commented: '*what we would like to see then is for them to be upskilled to enable them to do other roles*.'

It is only in Scotland, however, where there is a policy commitment across the public sector to no compulsory redundancies. At S-RHB, where digitalisation displaced workers, this was dealt with gradually by not replacing workers who leave or retire, while keeping an '*eye on the management team to make sure that they're not cutting the staff right down to the minimum, or below minimum level required to run the service, simply because they've got technology*' (S-RHB-senior-rep). Here too there was a concern about admin workers, such as audio typists, with a narrow set of job tasks who were *'worried*' that '*if voice technology comes in, that's going to take our job away from us*' (S-RHB-rep).

In the UK, considerable union time is spent dealing with issues around pay banding (i.e., job grading linked to job evaluation) which can be disrupted by changes to tasks and roles wrought by digitalisation. In Norway, collective agreements mean hospital admin workers are typically on the same grade, with pay increasing within the grade based on experience and qualifications. In the UK, these workers are allocated primarily to band 3 or 4 depending on their actual tasks and responsibilities. Changes to tasks can potentially involve an upgrade or downgrade with implications for pay. National officers identified examples of workers being 'down-banded' as a result of digitalisation, or acquiring more complex tasks without being 'up-banded'.

The interviews did not uncover any examples of 'down-banding' related to digitalisation. However, there was a case of management attempting to shift more complex tasks on to lower banded workers. The union had sought to have these workers up-banded but management had refused, preferring to remove the new tasks in order to avoid paying them more:

> *what they've done is, they've taken those roles away, or most areas of those roles away, so that they didn't have to re-band them. (E-Trust2-rep)*

While the NHS Job Evaluation Scheme allows for some flexibility in role design, UNISON-national-officer1 argues that poor local implementation means workers are often discouraged or prevented from having their role reviewed. It also lacks the fluidity of the Norwegian system where admin workers are normally on the same grade regardless of their responsibilities.

More generally, digitalisation often brought to the fore issues around lack of training, increased work pressures and job grading in the UK. Only at S-RHB was training on new digital technologies described as '*good'*, having improved in recent years. The region had also developed with the unions a progression framework for admin workers linked into training provision. Elsewhere (E-Trust1, E-Trust2 and W-RHB), training was either non-existent or very limited, with workers having to learn by themselves or by supporting each other. In one instance, it was described as '*a six-minute YouTube video*' (W-RHB-rep). The senior rep at E-Trust1 noted: *'If you specifically ask for some training you can go and get it but you need to know what you need to ask for'*. Part of the union role was to support workers in ensuring that

line managers allowed them time and access to training, which sometimes meant having to '*escalate*' the issue to higher levels of management.

Working out how to use new systems which can fail on a daily basis and present workers with frustrating technical problems also adds to the increasing work pressures many admin and clerical workers are already experiencing. Financial pressures and expanding service provision were leading managers to cut costs through not replacing staff or trying to do more with less. Unfilled vacancies and sickness due to work-related stress compounded the problem.

### Norway Hospitals

The introduction of new digital systems can be seen as a threat to existing workers. In three cases (N-Trust1, N-Trust2 and N-Trust4), workers were said to be fearful about losing their jobs, even though all reps interviewed thought redundancies would not take place. A hospital rep in N-Trust2 noted that there was concern about job losses among medical records staff as a result of shifting to paperless records. However, management had *'been very clear that we don't lose our jobs, we just get other assignments*' (rep). A rep at N-Trust1 concurred:

> *We have actually today too much to do. So I don't think that's going to be a problem in the future.*

It is not easy to make workers redundant in Norway, particularly in the public sector. Collective agreements require workers to be given the opportunity to retrain for other positions, and employers must demonstrate that such positions do not currently exist before issuing redundancy notices. Rising healthcare demands and staff shortages also mean the threat of job loss is greatly reduced. In hospitals, workers are guaranteed that their pay will not be lowered if they take a different job.

Despite these constraints, in one case (N-Trust4), management had made 70 secretaries redundant following the digitalisation of medical records in 2009, with those affected notified via email '*the day before Christmas*'. However, within three months, those who wanted to return '*got their jobs back*' as management quickly discovered that the digital tools could not replace many of the tasks undertaken by these workers (senior-rep). Unsurprisingly, admin and clerical workers were currently '*very worried*' that the planned move to a new hospital, where further digitalisation was planned and management had indicated that fewer secretaries would be required. The rep said that redundancies would not be *'tolerated'* by the unions this time.

Central to Fagforbundet's approach to dealing with digitalisation is ensuring that workers receive training to deal with digital changes. Reps spoke about their role in ensuring that workers who struggled with these changes were provided with more time to learn the new

systems and, if necessary, find alternative roles within the hospital. Provision for training around digital technology was not considered an issue by reps, although one senior rep (N-Trust1-senior-rep) noted problems in workers finding '*the time to train*', given their workloads. There were more issues raised in relation to other training that was not specific to a digital system and complaints that admin workers were secondary to clinical staff in accessing such opportunities.

> *in our meetings… they are always very positive when we say that we have to prioritise more education courses… but we seldom get them… we have so few people… I don't have the education to be a health secretary, so if I want to take the course to get the authorisation, I would have to take it in my spare time… I think it's easier when you have a nurse job… then you get financially supported. (N-Trust2-rep)*

At N-Trust4, the union was part of a project designed to enhance secretaries' digital skills on a continuous basis, but that '*didn't happen*'. Reps also noted that the union was providing financial support for some medical secretaries who were not formally qualified to gain relevant qualifications. In one case, secretaries were seeking them to help safeguard their job security.

> *they were scared that when we move into the new hospital they will be redundant, and they can prove that they have many skills. (N-Trust4-senior-rep)*

While redundancies are considered unlikely by reps, digitalisation often meant workers being transferred to other roles or acquiring new tasks. Union reps spoke of assisting those workers whose job had disappeared in finding appropriate alternative positions. In some hospitals, union reps had been pushing management to use the skills of secretaries more effectively, particularly health secretaires who are qualified to undertake certain clinical procedures. These local discussions reflect sector-wide concerns about shortages of doctors and nurses. In Norway5, the union reps claimed that their pressure had shifted management's position on using secretaries' skills.

> *because of the union who have been telling them all the time that, 'you're not using the secretaries in the right way actually, you don't see the resource they are… you're just using a part of the education they have'… and so I think that opened their eyes a bit. (N-Trust5-senior-rep1)*

Health secretaries were now assisting with small procedures, while other secretaries were doing '*more interesting work*'.

In two Trusts (N-Trust1 and N-Trust4), health secretaries were reported as being frustrated that they could not use their skills, which added to recruitment and retention problems.

> *so they just put us in front of a computer instead of letting us out to care for patients and assisting doctors in the outpatients… I think it's a lack of knowledge of the qualifications from the top' (N-Trust4-senior-rep).*

The union rep had continually raised these issues with the management and stated that '*we're getting listened to for the first time in years*'.

There was said to be some resistance across the trusts from nurses about healthcare secretaries undertaking some of their tasks, both in terms of their professional status and pay differentials. At national level, Fagforbundet is part of a national commission that is considering changing job roles in the healthcare sector. There have been *'big discussions*' with the nurses' union over many years, with an officer arguing that progress was finally being made as all groups recognised the need to find solutions to staff shortages and workload pressures (FGF-national-officer1).

At two of the Trusts, a big concern of the reps was that digitalisation would simply add to workloads as staffing levels are reduced and more tasks are added to admin jobs, a situation that worsened during the pandemic.

> *It's the work pressure. It's too much. We are… maybe every six months given new tasks but not enough people to do them. So, you're sitting with high shoulders and typing on the computer a lot. We work at home as well, after work. (N-Trust1-rep).*

> *The pressure is continually spiralling upwards… I don't think the tools that we have at hand are the correct ones… and there's of course the fact that there's not enough employees. (N-Trust4-senior-rep)*

While these reps identified lack of doctors as affecting their workloads, at the two other Trusts, there was less of an issue with admin workloads. They highlighted the opportunities to use admin workers more effectively by taking on a range of tasks that are undertaken by doctors and nurses, who are difficult to recruit.

## 5.4 Perspectives on union support and training to deal with digital technology

In this section, we address the resources available to the two unions for dealing with digitalisation, both in terms of national policy development and locally at hospital level, along with reps' views on what improvements could be made to address the challenges of digitalisation. In this section, data are not attributed to specific representatives.

## Resources in the UK

UNISON's resources are very tight and have diminished over time. A national policy officer highlighted several reasons. Employers have become fragmented over time due to privatisation, such that the union has to deal with around 30,000 compared to 300 in 1993. Balloting for industrial action is expensive, there are threats to facility time and a shrinking activist base, and low pay makes it difficult to increase subscriptions, especially during a cost-of-living crisis. In England, the abolition of the Union Learning Fund has also substantially cut resources available for union education and training. The union has just one national policy officer working on digitalisation across all sectors whose remit also covers civil liberties and climate change, and who was only able to devote about half a day a fortnight to this topic.

> *we're under-resourced… I'm not able to prioritise [digitalisation] as much as I would like because there are too many other areas… (UNISON-national-officer2)*

In many cases, senior reps in the hospital (chair of the joint-union side, for example) were admin/clerical workers. This has the advantage in ensuring that the interests of this occupational group are prominent in UNISON at hospital level. Like many UK unions, however, it can be challenging to recruit union reps. In one Trust, for instance, there were only two reps for 1200 members. At some other Trusts, there was more success, with six full-time reps and 30 workplace reps covering 5000 members in one case. A senior rep at another Trust explained that not having a union rep in a particular department made it difficult to know how digitalisation was affecting workers: '*there is a problem there that you don't have those eyes and ears*'. In some cases, securing adequate facility time was seen as difficult. A regional officer noted that many reps '*do their duties as a kind of voluntary extra on top of their day job.*'

UNISON provides no specific training for reps on digitalisation, although it is covered in a more general way in a more advanced course on negotiation around reorganisation and change. The union has produced some general guidance on bargaining over automation that includes a model agreement (last updated 2018), and is currently developing a new course on digitalisation for shop stewards and health and safety reps. The plan is for this to be an introductory course explaining the terminology around AI and digital technology that may later be developed into a negotiation skills course (UNISON-national-officer3). Key challenges were ensuring that the new course was not too 'f*ormal*' and *'heavy*' (UNISON-regional-officer), along with the difficulties reps faced in taking up union learning opportunities, given limited facility time and workload pressures.

> *They're often so stretched that they're literally just dealing with things on a day-to-day basis, almost in sort of crisis mode… you're definitely getting more of the 'we're struggling to get the time off to do that'. (UNISON-national-officer3)*

In general, UNISON reps felt that having more specific training around how to proactively engage with management over digital changes would be '*a good idea*'. How to ask the '*right questions*' and have the confidence to '*start a conversation*' around the importance of union and user involvement in digital changes is a recurrent theme:

> *it would be focusing on what organising around digitalisation looks like… so if each rep… contacts their senior leadership team to say 'we know that you know digitalisation is increasing and it's important but we want to be involved in that conversation before those processes are in place or before the decisions have been made'… And maybe just giving people the confidence to start that conversation.*

> *Definitely it would be nice to have some training in I think how to broach these subjects with management.*

> *I think it would be useful, because, especially now, sitting talking to you, I'm thinking, I need to know more now, I want to know more.*

> *There needs to be with all the digital stuff coming in some sort of training as a way to how to be able to approach management and get in on that, those decisions.*

Most reps said they wanted more specific technical knowledge and support from the union. This was partly about resourcing from central office but also about having opportunities to share knowledge with other hospital reps in UNISON, given that the same technologies are often being deployed.

> *the stuff around the operational side of it and the day-to-day nitty-gritty… a new technological system and what you may need to be raising on behalf of members.*

> *if somebody needs input you know that is related to understanding what an impact from a technical aspect that if there's a resource or somebody that we can contact*

One rep was very positive about UNISON forum meetings where specific technologies could be discussed:

> *if anybody sort of says 'oh we're looking at getting this technology' I say well you know we have it and we'll sort of discuss what they think it's going to be and what we have had experience of.*

Others, however, did not seem to have any engagement with other areas:

> *I would love to have that communication with other… branches... so that we could talk about what's going on in their hospital and what's working for them, what's working for us and definitely have that communication to be able to help each other.*

*I think definitely it would be good to see how stuff is impacting other areas.*

Two reps felt that the level of information generally that they received from head office had dwindled over the last few years. They wanted more communication about technology developments in the hospital sector.

### Resources in Norway

In the case of Fagforbundet, no issues were raised by national officers about lack of resources. As with UNISON, many of the full-time reps were in secretarial or admin roles. Interviews at hospital level indicated that there were many more reps than in the UK hospitals. At one hospital with 1300 members, for instance, there were two full-time reps, along with around 40 workplace reps. At another hospital in a different region covering 1800 members, there were also two full-time reps, plus 28 workplace reps. There are, nevertheless, challenges in some cases when it comes to recruiting new reps. A senior union rep in one hospital noted there were 10 reps for about 110 members but thought 20 were needed as they covered a variety of occupations and areas. One of the difficulties identified was that members were concerned that there was not time to take on this role alongside their job and that it would take '*their free time'*.

With regard to facility time, Fagforbundet contributes some funding to increase the amount of time-off for some workers. The main issue identified in terms of time-off was for those who either only had one day off a week or no specified facility time. One senior rep noted that the problem was mainly for reps who covered only a small group of clerical staff. Another rep stated that, '*I usually get the time I ask for*', but added:

> *We have very few at work, we have busy days… maybe some days you don't ask for the time because you know it will be a problem for my co-workers, that I leave hours or days for courses*

Another in the same hospital stressed that the standard one-day-a-week was '*not enough*' and they wanted Fagforbundet to push for more time-off in the collective agreement. The lack of time limited the ability of workplace reps to be proactive around digital technologies.

Fagforbundet does not provide any rep training specifically on digitalisation, and a national officer reported that they had not received any requests from *'the reps themselves'.* There was '*very little'* training to help reps engage with management specifically around digital changes, but the officer considered that it would be useful: *'it's very important that the union reps…know how to get the employer to take the reps with them when they implement this in the workplace*'. In their view, the area of digitalisation could be '*scary'* for some reps as *'the*

*employer has fully trained lawyers and everything on their side and our union reps are maybe feeling not adequate to take these questions on'.*

Reps generally commented that digitalisation was a critical issue in the workplace and that training specifically on aspects of digitalisation would be valuable.

> *I think more of what is around it and how will it affect our members, how can we assist our members.*
>
> *if that training would include how to work closer with the project leaders.*
>
> *I think that we need more general knowledge about how to push back towards the management.*

Only one rep stated that such training was not that important for members, citing the shortage of staff and insisting that a job would always be there.

As in the UK, more information and guidance on the impact of specific technologies on staff was something many considered would be beneficial, along with opportunities to share experiences with other reps about the challenges they faced in dealing with digitalisation. The balance between help with how to engage with management versus assistance with knowing how a particular technology is likely to impact on members depends on existing relationships with management. Where there is good cooperation, reps wanted more support on how a digital system will affect their members and how members could be helped to deal with new technology.

More support was not necessarily just about training but the provision of more specific expertise. One group of reps wanted more resources from head office dedicated to digital issues in the hospital sector, which they could draw on when they had particular questions. The complaint was that '*it takes too long to get the answer… then we have already started a new project'*. While relationships within the regions between senior reps and regional reps were in some cases considered to work well, some interviewees referred to a communication gap, as mentioned in Section 5.2.

> *The higher-up union representatives should sometimes… come down to the local level and get a first-hand look at what's going on… they lose touch with the roots down there.*

The union was hoping to address this through a new course:

> *We see so many times that the higher-level union reps, they don't know how to talk to the lower-level union reps. (FGF-national officer)*

The reps reported many opportunities for regular meetings and discussions that take place within regions where issues around digitalisation and new systems could be shared.

There are also national forums, where Fagforbundet reps have the chance to meet up with those in other regions. These provide opportunities to discuss the problems that reps experience in engaging with management over digital change. However, some reps reported that they would like more opportunities to discuss the impact of particular technologies with other reps.

## 6. Summary

The public hospital sectors in Norway and the UK both have institutional structures that allow for union involvement in processes of organisational change. While the law and collective agreements are stronger in Norway, as well as more specific in relation to technology, mechanisms exist for union participation in the UK. The election of a Labour government in Norway in 2021 allows Fagforbundet greater scope for influence in national policy, which may also filter down into the actions of regional and local managers. In the UK, unions have been able to make more progress in influencing policy in Scotland and Wales, where governments have signed up to partnership working, than in England.

Digitalisation is becoming an increasingly important issue for the two unions at national level, even though it has been less of a priority and under-resourced in the UK. Hospital reps report that significant changes have already taken place which have affected the jobs of admin workers and that more are planned. Surprisingly, digital monitoring and surveillance were rarely mentioned at any level, with both unions focused on the security of patient data.

In the UK, there is considerable variation in how far union reps at the workplace are involved in digital change. In England, the research identified patchy involvement, mainly limited to the provision of information and consultation around redundancy and redeployment, but found no evidence of union participation in working groups or pilots. The best example was a Scottish hospital where there was strong evidence of partnership working encompassing digital change projects which involved union reps and workers. Notwithstanding similar governance structures, the single Welsh case presents a picture of top-down change and little influence.

In Norway, there is also variation in involvement. Large digital projects are decided at regional level; there was a view that influence was possible here but restricted by large multi-national technology firms who provide relatively standardised products. Once decisions have been signed-off by Regional Boards, there are limits in terms of what unions can then change at hospital level. Union reps are often involved in project groups with workers and managers helping to embed technology in the workplace, with evidence that this can work well. In some cases, however, union participation does not necessarily lead to influence, while there were also examples of digitalisation being rushed through with little involvement of local union reps

or admin workers. The best examples of the successful introduction of digital systems, while not widespread, are in cases where unions *and* workers were involved in projects that proceeded slowly, allowing problems to be resolved before being expanded to other areas.

Across the UK and Norway, explanations for differences were primarily related to the role of hospital or regional-level management. While less involvement in England can be linked to the political context, the internal market and lack of ability to escalate failures to consult to higher levels, there are still differences here. Senior managers who have a willingness to engage is critical, and positive cases tend to reflect long-term, strong relationships with local unions. Nevertheless, there is also evidence that relationships can improve and, in some cases, deteriorate.

The role of union strength and rep activism is more difficult to assess from the research and requires a larger study. Across the hospitals, UNISON and Fagforbundet typically played a leading role within a multi-union environment, such as chairing the joint union-side committees. That many of the senior reps were former, or current, admin and clerical workers suggests that these workers may not be as 'invisible' as some academic studies suggest. While some reps were highly knowledgeable in relation to digital changes, a few appear more reactive and only saw their role as dealing with outcomes once complaints and issues were raised.

Digital automation in hospitals does not appear to be replacing many admin and clerical jobs. Senior management often over-estimate the capability of various technologies to replace workers, which in a few cases led to redundancies or threats of redundancies only for management having to backtrack. Scotland stands out as the only country with an agreement of no compulsory redundancies. Both Fagforbudent and UNISON play a key role in restricting job losses and supporting members that are faced with redeployment. In both countries, policy officers emphasise the importance of ensuring that workers are trained to deal with the effects of digitalisation. In the case of redeployment, no specific concerns were raised at hospital level. This was not always the situation, however, for workers facing changes within their jobs. In Norway, most reps reported that adequate training was provided to workers when new digital systems or upgrades were introduced, although in one hospital workers lacked time for training due to their heavy workloads. Across the UK cases, lack of access and time to train was far more commonly voiced.

The extent to which unions are able to influence the outcomes in terms of job tasks can be difficult to identify. If local reps and workers are part of local project groups (as in Norway and Scotland), they may be engaged in joint decisions about who will take on which tasks. In many cases, reps stressed the multiple roles that secretaries undertook, and that digitalisation, by replacing some routine tasks, could offer the potential for more *'interesting work'* or simply more of the same – serving two clinics instead of one for example.

At both national and local level, Fagforbundet appears more engaged than UNISON in the question of how the skills of admin workers are being used. The reluctance of many hospitals or departments in Norway to use qualified healthcare secretaries to undertake basic clinical procedures for which they are trained is a source of much frustration. Local unions also identified the potential of other secretaries to take on tasks that would relieve the pressures on nurses and doctors. Due to the grading system of jobs in the UK, UNISON plays a central role in 'pay banding' issues. With digitalisation, management may change the tasks admin workers undertake, such that their role can be down-banded or up-banded, with important implications for pay. Our research uncovered one case where management preferred to remove new tasks from the role rather than up-band workers and pay them more. Such pay grading disputes are conspicuously absent in Norway.

Fagforbundet has significantly more resources available to devote to policy work around digitalisation than UNISON. Both unions are relatively well-organised in local hospitals, but there are some difficulties in recruiting reps and ensuring adequate facility time. Neither union provides training courses specifically aimed at digitalisation, although UNISON is in the process of developing an introductory course. Reps were generally supportive of an increase in training and resourcing of this area of the unions' work. They identified different needs that included: training on how to engage more effectively with management around digitalisation; support in dealing with specific technologies and more opportunities to share knowledge and experience with other reps.

## 7. Reflection

Below we offer some thoughts that Fagforbundet and UNISON might wish to reflect on, given our findings. Some issues are common but we have listed them separately for each union.

- How can the domination of US-based tech companies that 'corner the market' on new digital systems be challenged to avoid rolling-out standardised 'solutions' without addressing local needs?

- What can be done to improve communication between higher-level officers, regional representatives, employee Board members and workplace reps when dealing with digitalisation?

- There is variation in the attitudes and approaches of senior hospital managers to involving admin and clerical workers in the implementation of digital technology. Might it be useful to survey hospital reps to attain a more complete picture as well as gather case-examples

of where ‘the Norwegian model’ of local partnership working is functioning well in relation to digital change?

- Some reps felt restricted by inadequate time-off facilities. Are there opportunities to negotiate additional time-off, particularly given increased workloads related to digitalisation projects and their consequences.

- There are areas where management are not following requirements to consult and involve union representatives. Is this an area where some reps require more support on what to do in these circumstances?

- Would it be useful to introduce into the training of union reps a bespoke component on digital automation? What would such a component consist of and how might it best be delivered? How can the union ensure that local reps are involved in its ‘co-creation’ to make it most effective?

- Many similar technologies have been introduced across Norway. A central resource which gathers evidence from local reps on the key concerns and issues related to specific technologies would be useful. These could form a basis for discussion forums for regional and hospital reps.

- There was little discussion on the issue of monitoring of workers through digital technologies. Is the ability to record and hold data on staff an area that could be a problem in the future?

**UNISON**

- How can the domination of US-based tech companies that ‘corner the market’ on new digital systems be challenged to avoid rolling-out standardised ‘solutions’ without addressing local needs?

- There is variation in the attitudes and approaches of senior hospital managers to involving admin and clerical workers in the implementation of digital technology. Might it be useful to document case-examples of where local union-management working is functioning well? The Scottish case reported has many features reminiscent of what Norwegian best-practice entails. What underpins its success and how widespread is it in Scotland?

- Is there anything more UNISON can do to ensure union reps have sufficient facility time as well as the time available to take part in training activities linked to the union rep’s role in digitalisation?

- How can UNISON help reps and members to understand the importance of digitalisation, either as a threat or opportunity, given other challenges and priorities for workers and the difficulties of mobilising workers around this issue until they are directly threatened?

- UNISON is already moving to create a training course to introduce reps to digitalisation. For those reps already experienced in dealing with digitalisation, would their involvement in the ‘co-creation’ of more advanced or specific training be  the next step?

- Many similar technologies have been introduced across the UK. A central resource which gathers evidence from local reps on the key concerns and issues related to specific technologies would be useful. These could form a basis for discussion forums for senior and hospital reps.

- There was little discussion on the issue of monitoring of workers through digital technologies. Is the ability to record and hold data on staff an area that could be a problem in the future?


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