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Citation: Chen, Y., Currie, G. & McGivern, G. (2022). The role of professional identity in HRM implementation: Evidence from a case study of job redesign. Human Resource Management Journal, 32(2), pp. 283-298. doi: 10.1111/1748-8583.12399

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Link to published version: https://doi.org/10.1111/1748-8583.12399

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AAM version

The role of professional identity in HRM implementation: Evidence from a case study of job redesign

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Abstract: How and why do employees from heterogeneous professional and occupational groups respond to the same HR practice differently – job redesign - and what is the implication of this for HRM implementation? Drawing upon a qualitative case study of job redesign in the English health and social care sector, affecting three distinct groups of employees, we highlight the different ways these employees respond to the implementation of job redesign over time. We contribute to a nascent literature discussing employees' role in HRM implementation. We also show that different types of professionals (occupational professionals, paraprofessionals, and organisational professionals) respond to job redesign differently, depending on its impact on their professional identity, which, in turn, affects its implementation.

Practitioner Notes:

What is currently known about the subject matter?
1. Role of HR professionals, top managers and line managers in HRM implementation.
2. Professional identity affects HRM implementation.

What the paper adds to this?
1. A more nuanced and dynamic analysis of the role of professional identity in HRM implementation, specifically in relation to job redesign.
2. Highlighting the way job redesign affects professionals' jurisdiction, autonomy, status, and sense of professionalism, which, in turn, produces varying responses among different types of professional.
3. An understanding of how different types of professionals influence job redesign .

The implications of study findings for practitioners
1. HR managers need to consider the impact of distinctive professional identity during the implementation of HR practices, such as job redesign.
2. HR managers should accommodate negotiation of job redesign by professionals.

Keywords: HRM implementation, employees, professionals, identity, job redesign.

Introduction

HRM implementation is attracting increasing attention from academics (cf. Bondarouk et al., 2016; 2018). In our study, we define HRM implementation as "the process of translating intended practices into actual practices" (Bondarouk et al., 2018: 2995). The way HR practices are implemented impacts organisational performance, with implementation failure often leading to unintended perverse consequences (Bondarouk et al., 2018; Budjanovcanin, 2018).

Studies of HRM implementation have tended to focus on the role of line managers, HR professionals and top management, and overlooked the role of employee in the implementation process (Budjanovcanin, 2018; Shipton et al., 2016). This is an important oversight, as employees play a critical role in adopting HR practices and can influence whether intended outcomes are realised (Bos-Nehles et al., 2013; Janssens & Steyaert, 2009; Purcell & Hutchinson, 2007). In the few studies that do take a more employee-orientated perspective, they commonly focus on employees' engagement or organisational commitment towards implementation of HRM (Alfes et al., 2013; Bos-Nehles & Meijerink, 2018). There are a limited number of studies that analyse employees' impact on HRM implementation upon which our own study builds (Budjanovcanin, 2018; Meijerink et al., 2016; Piening et al., 2014).

In our study, we focus upon a professionalised organisational context, to study HRM implementation. Despite nascent research on employees' role in HRM implementation, understanding of employees' role in HRM implementation in a professionalised context remains limited. This is an important oversight since professional identity affects how professionals perceive HR practices and affects HRM implementation (Budjanovcanin, 2018; Currie et al., 2016, 2020; Kessler et al., 2015). Theoretically, we seek to build upon such insight about the effect of professional identity in our own study and develop a more nuanced and dynamic analysis of the role of professional identity in HRM implementation within a multi-professional context. In summary, we analyse how professional identity influences professional

groups with different levels of professionalism in their response to a common HR practice – job redesign in our case.

Job redesign is a key HR practice (Foss et al., 2009; Yan et al., 2011), study of which aligns with our theoretical concern outlined above. Job redesign impacts occupational jurisdiction and thus gives rise to professional concern about their identity and status (Bach et al., 2008), particularly their autonomy in professional practice (Foss et al., 2009). Following which, commonly, professionals seek to negotiate and adapt job-redesign during its implementation (Bach et al., 2008).

We also respond to scholars' calls for more diverse theoretical perspectives on HRM (Bondarouk et al., 2018) by drawing on the sociology of professions literature, which focuses on professionals' identity and power in organisations (Abbott, 1988). In contemporary organisations, alongside longstanding occupational professionals, we observe increasing numbers of paraprofessionals and organisational professionals emerging, which impacts professional stratification (Noordegraaf, 2015; McGivern et al 2015). Consequently, we suggest that the same HR intervention might affect distinct professional groups in different ways, with implications for their responses to the HR intervention. Drawing these research gaps together, our study asks the research question: *how do employees' professional identities influence their responses to job redesign and in what ways does this affect its implementation?*

Within our case study, we examine the implementation of job redesign in an English health and social care organisation, which combined three established roles into a single generic role of 'housing assessment officer'. This job redesign affected three distinct professional groups: occupational therapists (occupational professionals), occupational therapy assistants (paraprofessionals) and case workers (organisational professionals). All of these groups were required to carry out tasks previously outside their remit as part of the job redesign. Our study draws upon qualitative fieldwork encompassing 53 interviews (conducted in two time periods

12-18 months apart), 45 hours of observation between these two time periods, and documentary collection and analysis.

Addressing the research gaps identified above, our theoretical contribution highlights the role of *professional identity* in the implementation of job redesign. We show how continuity of employees' professional identity (i.e. whether the practice is congruent with, enhances or detraction from professional identity) affects job redesign implementation. More specifically, we reveal how different aspects of professional identity, enacted over time by different cadres of professionals (occupational professionals, paraprofessionals, and organisational professionals), impact the implementation of job redesign. We show their differential acceptance, and influence upon implementation, of job redesign. Organisational professionals were most accepting because it enhanced their professional identity, occupational professionals enjoyed greatest influence over its implementation because they represented a higher status profession, whose jurisdiction was mandated and regulated to the greatest extent, and who enjoyed the support of their professional association in negotiating implementation of job redesign. Paraprofessionals meanwhile enacted discursive boundary work so job redesign was adapted to maintain, if not enhance, their professional identity. The following section discusses professionals and their role in job redesign implementation, drawing from sociology of professions literature.

Characteristics of professionalised organisations

A profession is "distinct from other occupations in that it has been given the right to control its own work" and is "*deliberately* granted autonomy" in deciding who can carry out the work and how should it be done (Freidson, 1988: 71-72). Professionals (such as doctors, nurses, social workers, teachers, academics, lawyers, accountants, architects) play important roles in many organisations (Abbott, 1988; Muzio et al., 2020). Professionals are characterised and distinguished from other occupations by their specialised and socially-valued knowledge,

accumulated through extensive education, socialisation, and career development, which only members of particular professions possess and are sanctioned to exercise. Professionals also develop distinctive professional identities, defined as "an individual's self-definition as a member of a profession" (Chreim et al., 2007: 1515), which is oriented towards their practice as a professional rather than, for example, identity derived from their organisational membership.

The sociology of professions literature highlights four dimensions of professional identity. First, professional practices and behaviours are commonly regulated by professional bodies and/or the State, to ensure that only those with appropriate expertise carry out professional tasks and professionals practise properly (Currie et al., 2010; Muzio et al., 2020). This creates boundaries and barriers with others upon whom a professional may be interdependent and provides professionals with jurisdiction over their domain of work (Abbott, 1988; Evetts, 2003; Fournier, 2000). Second, professionals defend their jurisdiction and autonomy against incursion from other professional occupations or changes that threaten their autonomy or privileges (Abbott, 1988; McGivern & Ferlie, 2007). Professionals, as "autonomous or self-directing" (Freidson, 1988: xv), defend their knowledge jurisdiction, autonomy and professional boundary against other groups, and resist new practices they perceive as attempting to shape or control them (Ackroyd et al., 2007; Noordegraaf, 2011).

Third, professionals seek to stratify themselves from other professions and occupations to enhance their status (Abbott, 1988). Stratification often takes the form of increasing specialisation and seeking to delegate routine tasks to other occupational groups (Kessler et al., 2015). Professionals' claims for knowledge jurisdiction and autonomy, being mandated and regulated by professional bodies and/or the State, allow them to focus on specialist and higher status work within professional organisations. Finally, professionals claim to focus on client interest, rather than pursuit of self-interest (Freidson, 2001; Wright et al., 2017), seeking public

recognition for their "superior moral fibre" (Muzio et al., 2016: 144). Despite misconduct in certain cases, professionalism based on altruism towards clients remain the essence of professional work (Muzio et al., 2016; Wright et al., 2017).

As professional groups proliferate, different types of professionals, such as paraprofessionals and organisational professionals, are increasingly evident in professionalised organisations, within which occupational professionals have been prominent (Evetts, 2003; Noordegraaf, 2011; 2015). These different professional groups have varied degrees of professionalism. Occupational professionals are state mandated with greater specialist knowledge and status (Freidson, 1988). Organisational professionals, such as marketing managers or HR managers, normally enact specialist roles in a technical domain but, unlike occupational professionals such as clinical professionals, their work is not state mandated and regulated, so may be carried out by other professions (Evetts, 2003). Paraprofessionals or quasi-professionals are employees who are delegated a particular aspect of a professional role and assist occupational professionals (e.g. teaching assistants). Unlike occupational professionals, paraprofessionals are not licensed to practice as fully qualified professionals and therefore are not usually regulated or protected by professional associations (Kessler et al., 2015; Noordegraaf, 2011). Occupational professionals often defend the status quo in response to changes that might affect professional stratification, within which they are dominant, whereas paraprofessionals and organisational professionals may welcome opportunities to extend their remit and take on new roles and gain status (Currie et al., 2016).

Recent HRM research has examined professionals in the health and social care sector. Drawing from sociology of professions literature and organisation studies, for example, Kessler et al. (2015) explore the impact of different professional logics, i.e. a 'specialist-discard logic' and a 'holistic-hoard logic', on the allocation of tasks for nurses (occupational professionals) and healthcare assistants (paraprofessionals), and the dynamics of relationship

between them following this. Reflecting the specialist-discard logic, nurses are keen to discard routine or less desirable tasks to subordinate or other professionals, while stratifying themselves and acquiring higher status roles. By contrast, reflecting the holistic-hoard logic, the value some professions place upon the holistic service/care they provide to clients/patients mean they are reluctant to delegate tasks to subordinates or other professionals. For example, teachers (occupational professionals) are reluctant to delegate tasks to teaching assistants (paraprofessionals) as the former seek to to control and assume full responsibility in the classroom (Kessler et al., 2015). In short, role changes and job redesign impact relationships and interdependencies between different professionals in unpredictable and often conflicting ways, around which we require nuanced insight.

Further exhibiting the complex effects of HR practices upon professionals, Currie et al. (2020) found that new roles are enacted or resisted by professionals dependent upon whether they are seen to enhance or undermine their identities. They show how an appropriate job title enhances the legitimacy of a new role, and training and development help professionals align their professional identity with a new role. Generally, their study highlights professionals have the power to accept or reject HR practices and facilitate or impede HRM implementation, depending on whether they view these HR practices as upgrading or downgrading their status or undermining their identity (Currie et al., 2010; 2020).

Through our study, we extend extant understanding of how professional identity affect HRM implementation and ask the question of how employees' professional identities influence their response to a common HR practice (job redesign) and in what ways this affects HRM implementation. The particular HR practice we focus on is job redesign in a professionalised organisation from the health and social care sector. The following section details our research design including context, data collection and analysis.

Research Design

Research context

Our case of job redesign focused upon services related to home repairs and adaptations for elderly, disabled, or vulnerable people, so that they can live independently in their homes. To create more cost-efficient and client-focused services, our focal health and social care organisation introduced a *generic* role, Housing Assessment Officer (HAO), to integrate discrete services that three different professional groups previously provided: occupational therapists (OTs) who were occupational professionals, OT assistants (OTAs) who were paraprofessionals, and case workers who were organisational professionals (CWs).

All OTs, as occupational professionals, have a university degree (in occupational therapy) and are registered with their professional body (the British Association of Occupational Therapists). Prior to the introduction of the generic role, they carried out clinical assessments and engaged in more complex OT interventions. The OTAs were trained to assist OTs, but not licensed to practice in the profession. Prior to the introduction of the generic role, they engaged in routine OT interventions with clients. CWs have university degrees (mostly in psychology and education) but gained their knowledge through experience of their role, supported by in-house training, for example, regarding technical aspects of their role such as financial assessment of home repair and adaptation.

Following the implementation of the job redesign towards a generic role for all the professionals above in June 2011, a mentorship programme was instituted with the OTs/the OTAs and CWs shadowing each other with the aim to learn each other's role and skills. Alongside this, external providers provided in-house training covering all aspects of the new role of housing assessment officer. In May 2013, a consultation meeting was held with staff and job titles of OTAs and the CWs were changed to Housing Assessment Officer (HAO). Following negotiations between their professional association and their employing

organisation, the OTs retained their job title, and their request to retain jurisdiction over complex cases was granted, although they were expected to carry out financial assessments of home repair and adaptation in line with the new generic roles. After May 2013, with the exception of newly recruited staff, other staff stopped shadowing each other and carried out both clinical and financial assessments on their own.

Before the job redesign, when a service user (an elderly client or their carer) telephoned social services requesting a home adaptation, an OT or OTA would visit them in their home, assess their needs, and recommend housing adaptations (as a *clinical assessment*); this was then passed on to a CW for a *financial assessment* and charitable funding application. Following the job redesign, the HAO (formerly the OTA and the CW), carried out both clinical and financial assessments. OTs carried out both clinical and financial assessments as well but assumed additional responsibility for more complex cases, particularly relating to clinical assessment. CWs also were responsible for cases with more complex financial assessment. Table 1 shows the work and identity of the three groups prior to and after the job redesign.

--Insert Table 1 about here--

Data collection and analysis

We conducted our qualitative case study across two time periods (T1 and T2) to reveal the "different perspectives by different groups over time" (Loan-Clarke et al., 2010: 402), exploring how and why employees responded to a common new HR practice (job redesign) differently, and to understand the employees' role in HRM implementation over time (Guest, 2011). The research team contacted a middle manager in the organisation in June 2012 (one year after the implementation of the job redesign), who subsequently introduced the first author to all staff during team meeting. We invited all staff to participate in our study and received relevant ethical approval before data collection commenced.

We conducted 53 semi-structured interviews in two different time periods (2012 and 2014) (see Table 2). We carried out interviews 12-18 months' apart, so as to reveal changes to employees' views and actions regarding job redesign. All interviewees who remained in the organisation were interviewed twice across the two time periods (see Table 2). Altogether we conducted 28 interviews in T1 and 25 interviews in T2. Interviews lasted for one hour on average and were transcribed verbatim. Interviews focused on employees' views and enactment of new roles and included questions such as details of their current and previous role, aspects they liked and disliked about their new role, their perception of the aim of the job redesign, training and learning opportunities, and how they sought to influence the job redesign. Our questions aimed to uncover professionals' views on the job redesign over time and their involvement in the implementation of HR practice.

--Insert Table 2 about here--

Between the two phases of interviews, the first author also observed five team meetings, two training sessions, one workforce conference, one consultation meeting with all staff and managers, and conducted three days observation in the office (totalling 45 hours). We also collected and examined documentary evidence including meeting minutes, training manuals and job descriptions over the study period. Informal interactions with the interviewees during this observation period – for example, at breakfast meetings, staff birthday drinks, and the Christmas lunch - helped build trust between the researcher and informants. As a result, the informants became more willing to express their views to the researcher (Mantere et al. 2012). Nevertheless, we remained wary of our influence upon data gathered, triangulating observations and documents with interviewees' accounts (Guthrie, 2010).

All authors were engaged in data analysis. When there were divergences in analysis, the authors went back to the data, discussed, and resolved differences. The overall aim of data analysis was to explore how and why employees responded to a common new HR practice, job

redesign, differently. The authors engaged in dialogue about theory and data, which was informed by our literature review on professions and professional identity. First, we coded data to derive first-order concepts (informant-centric coding), through which we identified how employees responded to the HR practice differently. We agreed on a list of 14 first-order quotes and mostly used the informants' terms, which served as the basis for later analysis.

At the second stage of analysis, we derived empirical first-order codes and conducted second-order theoretical analysis of properties and dimensions of the first-order concepts to depict our empirical phenomenon in more theoretical terms (Eisenhardt & Graebner, 2007). For example, we derived the second-order code 'encroached work autonomy' from first-order codes 'being micro-managed by colleagues' and 'being pushed to take on more cases by managers' (see Table 3). As detailed further below in our findings, our analysis revealed the role of professional identity in HRM implementation. We also showed their different enactment of the job redesign across the two different time periods, which revealed how enhancement and maintenance of professional identity for professionals influenced HRM implementation.

--Insert Table 3 about here--

Findings

T1: Experiencing identity threat. All the professionals identified strongly with their occupation. They found their new work role involved tasks that were not previously within their role remit and tasks that defined their professional identity were lost in the new role. For example, both OTs and OTAs perceived the new role had more "administrative tasks" and took them away from practising OT related activities, which they valued more.

> I am an OT. I didn't want to be good at casework, because I wanted to be an OT. It still means a lot of me. People that aren't OTs, who are caseworkers, administrative workers, would be good at casework, charitable funding and all that. (Interviewee 9, T1, OT)

OTs and OTAs found themselves lost in carrying the new role, whilst CWs lacked the confidence to carry out the clinical assessment and felt incapable. This sense of incompetence undermined the sense of professionalism that all professional groups previously enjoyed.

> It just feels really heavy – trying to remember to record this and record that. It's not just that you take a phone call and you take information, you have to pass it on and do something, and copy and paste it there, and I have to have a script sheet, because I'm not sure that, oh, have I done an inappropriate call? Or where do I log in? (Interviewee 5, T1, OT)

> What I dislike is feeling out of my depth… somebody said to me the other day, for instance, "oh, I can't get on this toilet seat"… she said it needs to be higher, so I said, ok, did I know how to check? You feel such an idiot, you are there as the expert, and you don't know how that toilet seat works. (Interviewee 14, T1, CW)

OTs and OTAs found their work autonomy being challenged. OTs and OTAs, who used to enjoy flexible working, were "queried about my (their) whereabouts" [interviewee 5, T1, OT]. They felt they were micro-managed by colleagues and pushed by managers to conduct more cases. We did not observe any complaints by CWs about their work autonomy being encroached. This difference was, in part, due to the different levels of professionalism of the three different professional groups.

> So we are getting pushed by her (a manager) nastily, "Why haven't you done this? Why haven't you done that? I wanted you to go and see the client"… I'm not used to that; I'm not used to someone questioning me and how I do my job. (Interviewee 4, T1, OT)

OTAs experienced lower status with the job redesign. They were asked to attend clinical assessment training courses with CWs and argued that they should not be on training courses on topics they knew about. OTAs strived for OTs' status, rather than that of CWs.

> I've got to go back to basics. I've been doing this job for quite some time, now you've been treated as if you don't know anything. And you've got to start going on various courses and trainings…It's ridiculous! (Interviewee 3, T1, OTA)

Therefore, all professional groups experienced threat to their identities in a number of ways: losing valued activities and sense of professionalism, experiencing encroachment of autonomy and lower status. They resisted the job redesign by avoiding the new role and asking colleagues

to perform the tasks that were not previously in their role remit. As one of the middle managers observed:

> [Middle manager 35] identified that some unusual relationship behaviours are being displayed in teams with some staff being co-dependent on others. (Meeting minutes, 27 July 2012)

Because the management team in the organisation we studied introduced the job redesign in a broad sense, this enabled the job redesign to be locally negotiated by professionals on the ground. Managers were aware that the job redesign would be adapted as it was adopted. As illustrated by managers not changing the job grade, description or specification until the consultation meeting in May 2013, which was almost two years after the initial introduction of the job redesign. As the quote below shows, managers intended the job redesign to be a pilot and were prepared to accommodate local adaptations.

> It [The job redesign] was going to start off for six months, and it got extended, and in the time, we've agreed to extend it, was because we weren't sure at the time the role and responsibilities of the practitioner… it's known as the experiment, so at the moment we are working with our HR group to actually evaluate the job description (Interviewee 35, T1, MM).

To sum up, different types of professionals with a varied level of professionalism experienced threat to their professional identity in distinctive ways upon implementing the job redesign during T1. Moreover, managers did not set a descriptive template regarding how the job redesign played out, allowing professionals to work out how the new role was to be enacted.

T2: Experiencing enhanced professional identity. During T2, all three professional groups experienced enhanced professional identity with the job redesign. Specifically, OTs stratified themselves from others by involving their professional association to ensure that they were responsible for cases with complex clinical assessment, so as to maintain their professional identity; OTAs enhanced their professional identity through stratifying themselves from caseworkers by exhibiting their superior expertise in clinical assessment compared to caseworkers; Caseworkers enhanced their professional identity through holistic hoarding

(Kessler et al., 2015). In this section, we explain in detail how enhanced professional identity was achieved for all three groups.

Drawing upon their (mandated) expert knowledge, OTs argued they were expert in occupational therapy and people outside their profession did not have expertise to carry out activities related to occupational therapy.

> I remember during team meetings there was often things like, "we (OTs) are professionals, we shouldn't have to do this, and they are not professionals, they don't know what we know. We went to college for three years to learn this (occupational therapy)" (Interviewee 19, T2, MM)

Managers then introduced varied new practices whereby occupational professionals' new jurisdiction over complex cases materialised. For example, OTs were given the opportunity (through staff meetings, informal training sessions, conferences and public engagement events) to showcase their knowledge related to occupational therapy. These practices also enhanced OTs' professional identity by preserving their valued activities of a professional role.

> In the meeting, with the new agenda item "case discussion", Laura (OT) took the initiative and led the discussion about what makes an urgent case, which was an opportunity for her to practise her OT knowledge in assessing complex cases, as she later stated in her interview – "It's been quite good, because I'm able to air my OT philosophy in the office, with other members of the team" (Staff meeting observation 5 & Interviewee 7, T2, OT)

OTs also drew on power afforded by affiliation with a professional association. They complained to their professional association about the job redesign, a professional association representative consequently visited the organisation and organised meetings with both managers and staff. These meetings led to the managers designing a new job description for staff, which was officially announced during a consultation meeting held between staff and management with a professional association representative present.

OTAs responded to the job redesign by creating an association between their professional identities and that of the higher status OTs, and differentiated themselves from CWs, who were constructed as doing lower status work. Thus, they created a conceptual boundary (Fournier,

2000) between themselves and CWs. As the following quote illustrates, OTAs were outspoken when they were required to attend the same competency training course together with CWs.

> I've been an OTA for eleven years, and now I have to have competency training the same as CWs, who know nothing about occupational therapy. (Interviewee 1, T1, OTA)

OTAs discursively positioned themselves on a higher status side of a jurisdictional boundary with CWs in T2, claiming clinical expertise that CWs did not have, even as the latter were trained to developed competence in clinical intervention. This was a matter of degree through which OTAs came to be seen as knowledgeable in occupational therapy and treated in the same way as OTs by other colleagues, and enjoyed elevated status compared to T1, where they had been asked to attend competency training courses together with CWs. Both middle managers and case workers were accepting of the jurisdictional boundary, and so OTAs were no longer required to attend the competence-based training programme alongside CWs.

> [OTA 1] and [OTA 13] are very experienced in clinical assessment, so they are very confident, and they are good to ask questions to. (Interviewee 16, T2, CW)

> The OTAs are very experienced in occupational therapy side of things. I know they are very confident to do the straightforward cases, [I] don't think they need training in that regard (occupational therapy). (Interviewee 20, T2, MM)

For CWs, through completing competence-based training, they regained the professionalism that they had lost in T1, a period during which they felt a sense of incompetence while conducting clinical assessment.

> The only thing that was holding them (CWs) back is their competencies. (Now we are) getting them signed off with all the trainings, so now they are trained properly to do the new role… Soon I think they will fly. They will get the experience. They will get the confidence. They will go out and do the job. I think they will enjoy it. (Interviewee 19, T2, MM)

Moreover, once CWs mastered the clinical assessment, they valued their newly gained ability in managing full range of tasks and enjoyed providing a holistic care. Been able to hoard full range of tasks in the new role, CWs saw clinical assessment as part of their role, as shown in the following quote.

> At the start of it, I don't like the sound of it, but now, we can do the job, we can do the role. So it's just bringing it out, putting the right training in, bringing out people's confidence in doing the role…now I'm dealing with medical conditions, assessing people with disabilities, it has changed a lot to what it was, but I enjoyed it and it's part of my role now…I like the fact that clients are able to come to us and you fix all their problems from housing point of view, so that they don't have to come back to separate services. (Interviewee 25, T2, CW)

In addition, we found that employees from all professional groups viewed the client-centeredness of the new role brought by the job redesign during T2 in a positive light. They claimed that with the job redesign they provided better service for clients. Most clients were vulnerable and elderly and appreciated having one person responsible for the adaptation to their homes, since they did not need to get multiple visits from different professionals and would not get confused. The positive feedback from clients contributed to professionals seeing the value of the new role. Therefore, the new way of working, "a more rounded service", aligned with professionals' compassion of care for the clients and was accepted by professionals.

> I like that the client has one point of contact… It's great for clients to be able to ring and actually talk to people who are doing the job on the ground and understand their answers to the questions rather than just documenting on a screen or dealing with different people a few times. (Interviewee 25, T2, CW)

> The new way of working definitely speeds up the client's process, makes it easier for the client so the client knows they just come back to the same person all the time for any problems or any concerns or any queries, and that's good. It feels like a more rounded service to clients, which I like. (Interviewee 12, T2, OT)

In sum, as a result of the job redesign, all professional groups experienced enhanced professional identity. OTs were able to stratify themselves from OTAs and CWs, which allowed them to have the jurisdiction over complex clinical cases during T2. OTAs enjoyed elevated status, compared to T1, by associating their professional identities with higher status OTs and disassociating them from CWs, the latter whom were expected to undergo comptenece-based training in clinical assessment, whereas OTAs expertise in this matter was recognised as superior. CWs enjoyed their newly gained ability in providing a holistic care and

hoarding the full range of tasks. In addition, all professionals groups found that they were able to deliver a client centred service – the hallmark of professionalism.

Discussion

Our case study shows varied responses to the introduction of job redesign in a health and social care organisation by different professionals with different levels of professionalism (occupational professionals, paraprofessionals, and organisational professionals) over time, and their related influence on HRM implementation. During T1, the implementation of job redesign initially threatened the identities, status and autonomy of all professionals. However, during T2, professionals experienced enhanced professional identity in distinctive ways.

Specifically, OTs stratified themselves from others occupational groups to ensure their jurisdiction over complex clinical assessment; OTAs stratified themselves and elevated their status by creating a boundary between themselves and caseworkers; Caseworkers mastered the new role and enhanced their professional identity through holistic hoarding (Kessler et al., 2015). Changes from T1 to T2 were partly due to managers' interventions, such as introducing training, mentorship and allowing professionals' time and space to work out the job redesign and reconstruct their identity, and partly due to changes to professionals' identity.

We contributed to the knowledge of the implementation of job redesign, which we suggest has implications for understanding of=HRM implementation more generally, in three ways. First, we built on a nascent literature discussing employees' role in HRM implementation, moving away from the usual management-centred approach in HRM to an employee-centred approach (Budjanovcanin, 2018; Meijerink et al., 2016; Piening et al., 2014). We show that professional employees engage differently with common job redesign (providing an example of a common HR practice), depending on its implications for their professional identities. We also extended previous research by showing how employees' enactment of HR practices

changed across time, adding nuance to the static picture depicted by current HRM implementation literature (Budjanovcanin, 2018; Janssens & Steyaert, 2009). The role of professional employees was not only in resisting HR practices (Janssens & Steyaert, 2009) but also in using different sources of knowledge-based power to renegotiate the HR practice being implemented (Budjanovcanin, 2018).

Second, we revealed the role of professional identity in the implementation of job redesign, extending Currie and colleagues' work (2020) showing that successful implementation of HR practices in professional organisational contexts often depends on whether implementation enhances or undermines professional identity. While the same HR practice might be introduced and assumptions made about its monolithic effect, our research showed a more complex story. We showed different types of professionals with different levels of professionalism, such as occupational professionals, paraprofessionals and organisational professionals, derived from jurisdictional differences, experienced enhanced professional identity in distinctive ways.

Specifically, occupational professionals can draw from their mandated expert knowledge and expertise-based power and the power of their professional association to renegotiate the implementation of job redesign. This, in turn, can maintain or restore their jurisdiction over complex domains of work and enhance their professional identity (Kessler et al., 2015) in ways not possible for paraprofessionals and organisational professionals.

Paraprofessionals, without a professional association to represent their interests or mandated expertise, can however engage in 'boundary work' (Fournier, 2000) in relation to professional categories and expertise. The paraprofessionals in our case discursively stratified their profession and work as similar to higher status occupational professionals, and different and hierarchically superior to lower status organisational professionals. They did this by invoking clinical professional discourse and claiming clinical professional expertise, beyond that of organisational professionals that went underwent competence-based training in clinical

assessment, while avoiding challenging occupational professionals' jurisdiction over highly complex work.

Organisational professionals can influence HR implementation by focusing on their professions' concern with competence and holistic care. For example, in our case organisational professionals gained the ability to provide holistic care and 'hoard' a range of tasks (Kessler et al., 2015), which allowed them to develop and enhance their professional status and identity. At the same time, competence-based training facilitated their involevement in clinical assessment, albeit they recgnised not just occupational professionals', but also paraprofessionals' superior expertise in this matter. Overall, paraprofessionals' and organisational professionals' influence upon HRM implementation was less than that of occupational professionals.

Third, our research extended Kessler and colleagues' (2015) work by showing how the specialist-discard logic and holistic-hoard logic played out in a professionalised context – providing insights for the role of professional identity in the implementation of job redesign. Reflecting specialist-discard logic, occupational professionals (OTs) delegated simple cases to paraprofessionals (OTAs) and organisational professionals (CWs). OTs managed to restore the previous specialised division of labour and maintained their jurisdiction over complex clinical assessment and professional identity. Reflecting holistic-hoard logic, organisational professionals (CWs) hoarded tasks providing holistic services to clients. Moreover, all professional groups saw the job redesign provided a better service for clients. This aligned with their compassion and care for clients, which above all constituted professional identity – client centeredness (Currie et al., 2020; Muzio et al., 2016). In addition, extending the work of Kessler et al. (2015), our research suggested that professionals are able to move from specialist-discard logic to holistic-hoard logic rather than sticking to one logic.

Practically, we highlight the importance of attention to the implementation of job redesign (Foss et al., 2009), which is often introduced to mitigate challenges posed by the ageing population and increased demand for patient centred care in health and social care (Cooke & Bartram, 2015). To ensure employees engage in implementing job redesign, particularly those crossing professional boundaries, HR managers need to attend to issues relating to professional identities. Specifically, HR managers need to be mindful of maintaining and enhancing professional identity. Our findings suggested that assessment of job redesign might be conducted prior to implementation to ascertain how it affects professionals' identity. Measures could then be introduced to help employees with different levels of professionalism to maintain their professional identity during implementation. We suggest that jurisdiction and autonomy are particularly important for occupational professionals, status for paraprofessionals, and competence and a sense of professionalism are key for organisational professionals. Managers should also be aware that this might lead to adaptation of the job redesign during its implementation (Bach et al., 2008).

Our study has limitations. In particular, our study was conducted in a health and social care organisation, which has distinctive professional dynamics, and others need to assess the transferability of our analysis to other professionalised settings. Moreover, in our case organisation, the managers implementing the job redesign did so loosely, allowing space for professionals to negotiate how precisely this would happen. This seems appropriate for professionalised organisations, such as those in health and social care, within which intrusion by managers into professional jurisdiction may be particularly resisted (Raelin, 1995). We encourage others to carry out further research to examine whther this is so in other organisations, for example in large commercial organisations with more standardised processes and procedures, such as law and accountancy, within which implementation of job redesign might be more prescribed, with less scope for local variation.

Moreover, we note that all professionals, regardless of their level of professionalism, appreciate a holistic approach to care. More research on the antecedents, processes, and outcomes of a holistic approach to care adopted by professional employees is also needed to examine the implications of this phenomenon to HRM implementation. Finally, although our data was presented in a way that implies unanimity within each of the professional groups, we recognise that there may have been some intra-professional differences, which could be explored systematically in future research.

Conclusion

Theoretically we contribute to current debates about HRM implementation in professionalised organisations through developing a more nuanced and dynamic analysis of the role of professional identity in HRM implementation (Bondarouk et al., 2018; Budjanovcanin, 2018; Currie et al., 2016, 2020; Kessler et al., 2015), specifically focusing on the implementation of job redesign. Drawing upon sociology of professions literature, we highlight influence of jurisdiction, autonomy, status, and sense of professionalism for different types of professionals upon the implementation of job redesign. Practically, we encourage HR managers to address distinctive professional identity challenges in their implementation of HR practices and accordingly accommodate the likely local negotiation of these HR practices by professionals.

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Table 1. Professionals' work and identities prior to and after the job redesign

	OT (OT = Occupational Therapist)	OTA (OTA = Occupational Therapist Assistant)	CW (CW = Case Worker)
Work prior to the job redesign	Complex clinical assessment and making recommendations	Less complex clinical assessment and making recommendation	Financial assessment, and apply for charitable funding for service users
Work after the job redesign	Complex clinical assessment and making recommendations, financial assessment, and application for charitable funding for service users.	Less complex clinical assessment and making recommendations, financial assessment, and apply for charitable funding for service users.	Less complex clinical assessment and making recommendations, complex financial assessment, and apply for charitable funding for service users.
Identity prior to the job redesign	Autonomous practitioner, efficient and confident in practicing clinical assessment	Autonomous practitioner, efficient and confident in practicing minor clinical assessment	Autonomous practitioner, efficient and confident in practicing financial assessment
Identity after the job redesign	Autonomous practitioner, efficient and confident in practicing both clinical and financial assessment	Autonomous practitioner, efficient and confident in practicing minor clinical assessment and financial assessment	Autonomous practitioner, efficient and confident in practicing minor clinical and financial assessment

Source: Job specification and staff meeting documents

Table 2 Interview data

Time period 1 (interviewees with * were only interviewed during T1 because they left the organisation after T1 interview)	**Occupational professionals and paraprofessionals in T1**	**Organisational professionals in T1**	**Managers (line manager, middle manager)**
	Interviewee 1, OTA; Interviewee 2*, OTA; Interviewee 3*, OTA; Interviewee 4*, OT; Interviewee 5*, OT; Interviewee 6*, OT; Interviewee 7, OT; Interviewee 8, OT; Interviewee 9*, OT; Interviewee 10, OT; Interviewee 11, OT; Interviewee 12, OT; Interviewee 13, OTA; Interviewee 23, OT	Interviewee 14, CW; Interviewee 15, CW; Interviewee 16, CW; Interviewee 17, CW; Interviewee 18, CW; Interviewee 21*, CW	Interviewee 19, MM; Interviewee 20, MM; Interviewee 35, MM; Interviewee 36, MM; Interviewee 38, SM; Interviewee 50, SM; Interviewee 51, SM; Interviewee 53, SM.
Number of interviews	14	6	8
Time period 2 (interviewees with * were only interviewed during T2 because of sick leave or maternity leave)	**Occupational professionals and paraprofessionals in T2**	**Organisational professionals in T2**	**Managers**
	Interviewee 1, OTA; Interviewee 7, OT; Interviewee 8, OT; Interviewee 10, OT; Interviewee 11, OT; Interviewee 12, OT; Interviewee 13, OTA; Interviewee 23, OT; Interviewee 32*, OT; Interviewee 37*, OTA; Interviewee 44*, OTA	Interviewee 14, CW; Interviewee 15, CW; Interviewee 16, CW; Interviewee 17, CW; Interviewee 18, CW; Interviewee 25*, CW	Interviewee 19, MM; Interviewee 20, MM; Interviewee 35, MM; Interviewee 36, MM; Interviewee 38, SM; Interviewee 50, SM; Interviewee 51, SM; Interviewee 53, SM.
Number of interviews	11	6	8

Table 3 Data coding structure

1st order code	2nd order code	Theoretical dimensions
OTs and OTAs taking on administrative work and spending most time on non-OT work CWs found themselves forced to neglect holistic services for clients	Losing valued activities (all professionals)	**Experiencing identity threat**
OTs and OTAs lost in the process of carrying out the new role and CWs felt incompetent	Undermined sense of professionalism (all professionals)	
OTs and OTAs being micro-managed by colleagues and managers OTs and OTAs being pushed to take on more cases by managers	Encroached work autonomy (OTs and OTAs)	
OTAs being categorised with CWs and on the same training course with CWs	Lower status with the job redesign (OTAs)	
Claiming jurisdiction over complex clinical assessment on multiple occasions Involving professional association to ensure OTs' jurisdiction over complex clinical assessment	Enjoying continuity of OT values and stratification from the others (OTs)	**Experiencing enhanced professional identity**
Associating themselves with OTs rather than CWs and creating a barrier of us versus them	Experiencing higher status (OTAs)	
Treated by other colleagues as knowledgeable in clinical assessment Improved capability of CWs on clinical assessment Enjoying hoarding full range of tasks and holistic services to clients	Regaining professionalism (CWs)	
Single point of access to ease client journey Positive feedback from clients	Being able to provide client with a good service (all professionals)	