

Organising Work for Effective Clinical Governance¹

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Clinical governance is well established in NHS acute hospital trusts reflecting government priorities within the Modernisation agenda including risk management, clinical effectiveness, patient involvement and enhanced professional competence. Its practice is largely defined by the controls with which government requires Trusts to regulate their activities. Whilst its purpose reflects aspirations and standards widely accepted in the NHS community, this paper argues that the regulation of hospital processes is not sufficient to ensure the organisational innovation required to sustain the reflexivity needed for safe, patient focused care.

Indeed policies for health service reform seem detached from wider European trends in work organisation. Recent surveys indicate that the introduction of new forms of work organisation such as empowered teamworking improves performance and innovation. An analysis of change in 1000 Swedish workplaces (Gustavsen, 1996) shows a strong correlation with improved productivity. The same trend can be found in the Employee Participation and Organisational Change survey of 6000 workplaces in Europe which confirms that direct employee participation and teamworking can have strong positive impacts on both productivity and quality of products or services (European Foundation, 1997). EU policy calls on employers to modernise work organisation as a means of enhancing innovation in products and services (Commission of the European Communities, 1997). This is echoed in successive policy statements and guidance issued by the DTI - see for example the 1998 *Competitiveness White Paper, Partnerships with People* (DTI, 1997) and *Living Innovation* (DTI, 2000).

Surprisingly, work organisation achieves little recognition in the Modernisation policy agenda even though the need for workplace change is recognised. According to the NHS Confederation (2002) the need is for a significant shift in management focus, one in which the delivery of targets is "achieved as the by-product of wider and sustained improvements in service quality". Such a shift from short-term target chasing to building the organisational competencies associated with adaptive, innovative organisations would represent a radical transformation of the NHS. However there is little evidence that the scope of such a transformation is adequately recognised or resourced within the Modernisation policy agenda which has little to say on the hard realities of organisational innovation, of how to build effective workplace dialogue and participation, of job redesign and empowerment, of implementing and sustaining genuine teamworking, of creating a work environment which values reflection and creativity, of achieving convergence between quality of working life and performance. While these issues are recognised, (see for example the *Improving Working Lives* standard (DoH, 2001b), the *NHS Taskforce on Staff Involvement* (DoH, 2000a) and the *Managing Change in the NHS* initiative (Iles & Sutherland, 2001)) concrete interventions may prove to be poorly matched with the scale of the need. This message is strongly reinforced in an article by Rosemary Exton, a clinical midwife and trade union steward, elsewhere in this edition of the Journal.

Clinical Governance has self-evidently become the

NHS. However its potential significance goes far beyond the current Modernisation agenda. The environment in which the NHS operates will face unprecedented change in the next decade, marked by rapid innovation in patterns of care and technology, a volatile political environment and more challenging social and cultural expectations (Giddens, 1998). To paraphrase Michael Porter (1985), quality, speed and cost-effectiveness will no longer be sufficient to ensure success: they will become entrance factors which must be met simply to stay in the game. However the fulfilment of short-term targets has become almost the sole preoccupation of politicians and health service managers with worrying consequences for the reflexive and innovative capacity of the NHS. Clinical governance must set itself a more strategic vision, laying the foundations for long-term learning and adaptation in an increasingly unpredictable and turbulent environment.

An approach to clinical governance in which health service organisations do indeed achieve external targets as a "by-product" of their inherent organisational competence and values might be characterised as the 'high road'. The defining characteristics of the high road lie in the creation of organisational spaces and the liberation of the tacit knowledge, experience and talent of the entire workforce in ways which achieve a dynamic balance between service and process innovations. Crucially the high road seeks to reunite job satisfaction and patient satisfaction. In contrast the 'low road' - arguably the dominant mode of clinical governance for most NHS Trusts in the present environment - is driven by cost, performance measurement, punishment and reward. For NHS staff it frequently results in a deterioration in the quality of working life (Meadows et al, 2000) which remedial HR initiatives cannot redress. For Trusts this results in increasing problems with recruitment and retention (see, for example, Ball, Curtis & Kirkham, 2001).

This paper explores the origins, significance and problems of clinical governance for NHS acute hospital trusts. It examines the limitations and contradictions of the low road, analysing data from a recent cross-sectoral analysis of new forms of work organisation in Europe to identify the organisational choices and dilemmas implicit in the high road. Critically the paper argues for the integration of the *regulatory* perspective based on external performance measurement and the *developmental* perspective based on the enhancement of organisational competence.

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THE IMPLEMENTATION OF CLINICAL GOVERNANCE

By the mid-1990s doubts about quality and safety of patient care, underlined by certain high profile failures, raised serious questions about the effectiveness of existing quality improvement and assurance measures. Emerging problems included poor management of information, clinicians in management without relevant skills and target-driven quality initiatives achieving only limited improvement in care. Fair access, consistency ('postcode prescribing') and the apparent failure to share lessons also fuelled national debates on ensuring consistent high quality services.

The New NHS: Modern, Dependable White Paper (DoH, 1997) sought to combine efficiency and quality, broadening the scope of performance targets by placing quality of services on an equal footing with financial measures. The new focus on quality required "every NHS Trust to embrace the concept of 'clinical governance' so that quality is at the core". National standards would be developed through National Service Frameworks and a National Institute of Clinical Excellence. At local levels Clinical Governance would become part of the Chief Executive's responsibility in every Trust. Other structural changes included the introduction of Trust Board sub-committees to monitor implementation and ensure that improvements to local services were achieved. Principal challenges included the need for greater consistency between Trusts and greater integration between the individual components of clinical governance. Effective communication, clarity of purpose, the reduction of professional demarcations and the active involvement of all professionals at ward and clinical levels were seen as crucial. Monitoring would be undertaken by the Commission for Health Improvement. Considerable emphasis would be placed on the assessment of structures and processes relating to patient involvement, risk management, clinical audit, staff development and information.

Implementation within Trusts

Clinical Governance objectives are pursued through a series of measures implemented by Trusts:

Accountability

Ultimate responsibility sits with the Chief Executive supported by a designated senior clinician to ensure that systems are in place and monitored.

Quality Improvement

Clinical audit, National Confidential Enquiries, staff development, implementation of the Caldicott Report on patient information and the monitoring of records.

Risk Management

Integration of clinical and organisational risks acknowledging that both affect patient care.

Managing Poor Performance

Ensuring that incidents and complaints are reported and investigated, and that lessons are shared and lead to widespread improvements. The early identification of competency issues is also required. Support to staff involved in reporting concerns is seen as crucial.

National reporting requirements have grown substantially and, as well as Commission for Health Improvement reviews, organisations are required to collect and report data for many other assessments including performance ratings, clinical indicators and

the Clinical Negligence Scheme for Trusts. In the early stages of Clinical Governance national assessments concentrated mainly on structures and processes. While it could be argued that their findings may have been useful in identifying areas for innovation, in practice the number and resource implications meant that outcomes were weighted toward quality assurance rather than quality improvement.

In most Trusts some components of Clinical Governance were already in place but with variable impact on quality of care. Even during the early stages the mixed reception which Clinical Governance received from many managers in NHS Trusts cast doubt on the prospects for substantial innovation and change. Evidence² from meetings during 2000 at which the implementation of Clinical Governance was discussed showed that 'enthusiasts' began to implement the framework with little external guidance. However there was also widespread scepticism or indifference, characterised by comments such as:

'More top-down must do's that will take us away from patients'

'If we were just left alone to get on with it patient care would improve'

'This is just another fly-by-night initiative which will go away'

'We're already doing clinical audit - what more do you want?'

'This is just policing - not improvement'.

In short, commitment to the pre-existing components of Clinical Governance such as clinical audit and risk management was questionable. Moreover the new framework was being built on weak foundations, characterised by:

- poor levels of feedback to staff
- a defensive approach to incidents, complaints and litigation
- the belief by individual clinicians that they would be put at risk
- the perceived risks to the organisation of transparency and scrutiny
- the anticipation of excessive paperwork.

PRACTICAL STEPS TO IMPLEMENTATION

Many Trusts appointed Clinical Governance facilitators to support implementation. Teams within Trusts were also able to access programmes run nationally. The Clinical Governance Support Team (CGST) instigated a series of programmes which involve developing the skills of small groups of clinical staff who work together, enabling them to review their service and identify improvements. Further local and national level training is available on tools such as process mapping, problem solving and risk assessment.

Effective implementation, however, has to transcend some significant obstacles. Information from four

²Author's personal notes from meetings involving different Trusts.

Trusts received in response to inquiries during March 2002 identified a series of obstacles to implementation:

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- limited feedback on the outcomes of complaints and incidents
- staff involvement within several clinical areas and professional groups remains very limited: Clinical Governance continues to be seen principally as an issue for management
- dominant voices distort decision-making processes
- achieving national targets within very short timescales takes priority over real organisational and service innovation.

Compounding these difficulties Boards may lack the vision or capacity to establish values and directions which enable Trusts to rise above imperatives imposed by the 400 or so external performance targets. Targets also appear to induce reactive senior management cultures, stifling innovation and preventing the ability to deliver targets “as the by-product of wider and sustained improvements in service quality”.

These conclusions are supported by findings from the Commission for Health Improvement’s Clinical Governance Reviews (www.chi.nhs.uk). Ten recent reports were reviewed: in eight the Commission identified concerns about the ad hoc nature of clinical audit, research and/or risk management, highlighting an overall lack of strategic direction and multidisciplinary perspective.

Structures and standards alone are unlikely to produce the continual improvement needed for effective Clinical Governance: “The basic components are a coherent approach to quality improvement, clear lines of accountability for clinical quality systems and effective processes for identifying and managing risk and addressing poor performance. Above all, though, clinical governance is about the culture of NHS organisations. A culture where openness and participation are encouraged, where education and research are properly valued, where people learn from failures and blame is the exception rather than the rule, and where good practice and new approaches are freely shared and willingly received.” (Professor Liam Donaldson, Chief Medical Officer, Department of Health, Clinical Governance website www.doh.gov.uk/clinicalgovernance/).

Likewise: “Clinical Governance is about changing the way people work, demonstrating that effective teamwork is as important to high-quality care as risk management and clinical effectiveness.” (CGST website, www.cgsupport.org).

Critically this points to an organisational gap: considerable management resources are targeted at the need to achieve top-down performance targets while the potential capacity of frontline staff for continuous incremental improvement remains largely unharnessed. Clinical Governance becomes defined as a managerial objective focused on compliance rather than service innovation: quality assurance without quality improvement. Indeed management practices to achieve compliance may undermine the conditions for bottom-up innovation, and many examples were found where local initiatives were abandoned because of national audit requirements.

At one level government policy does recognise that staff development and multi-disciplinary working

practices play important roles in effective Clinical Governance. Yet traditional management attitudes, practices and work organisation constrain the extent to which current measures are sufficient to achieve and sustain quality improvement. The emphasis of policy remains firmly on the structures and processes required to measure performance and ensure compliance, with a relatively weak commitment to developing the underlying organisational competence of Trusts.

ORGANISATIONAL DIMENSIONS OF CLINICAL GOVERNANCE

One of the key challenges is to ensure the end product is not quality assurance without quality improvement. This requires that a strong link is established between clinical governance and organisational innovation.

We have argued that measurement of *performance* against clinical governance indicators does not in itself permit assumptions to be made about the nature of effective *practice* at clinical team or management levels. It implies a highly mechanistic view of organisational behaviour, a ‘black box’ perspective in which outputs directly mirror commands. The pervasive cultural influence of FW Taylor’s ‘scientific management’ (Taylor, 1911) is apparent: the hospital is a machine whose activities respond directly to the performance criteria against which it is measured.

Tayloristic origins lie in the emergence of mass production in the early 20th Century and are closely associated with Ford. Taylor himself proposed a management system which sought to eliminate inefficient variations in work procedures by prescribing the ‘one best way’ of carrying out individual tasks. However the division of tasks did not only relate to distinctions between different manual skills. Taylor advocated that ‘All possible brain work should be removed from the shop floor and centred in the planning ...department ...’ (Taylor, 1911).

Workers would concentrate on manual tasks freeing up managers’ capacity for intellectual activities, thus opening a deep chasm between the conception and planning of work on the one hand and its manual execution on the other. It fundamentally challenges the ability of employees to exercise control and autonomy in their working lives (Hague, 2000); equally it denies organisations full access to employees’ knowledge and experience.

While the NHS is far removed from an early twentieth century automobile factory, parallels are clear in terms of task separation, the division between conception and execution, and the unidirectional nature of target setting. In the wider world Tayloristic practices are increasingly recognised as a constraint on the adaptability and innovative capacity of organisations, especially in an increasingly uncertain (social, political, economic) environment. Less tangibly neo-Tayloristic thinking imposes intellectual constraints on governmental and managerial ability to reconfigure health service organisations.

Hospitals are complex organisations: day-to-day processes involve responding to non-standard problems in conditions of uncertainty. Moreover day-to-day problem solving and innovation has to recognise the often competing claims of multiple stakeholders. Effective clinical governance must therefore place a considerable premium on the ability

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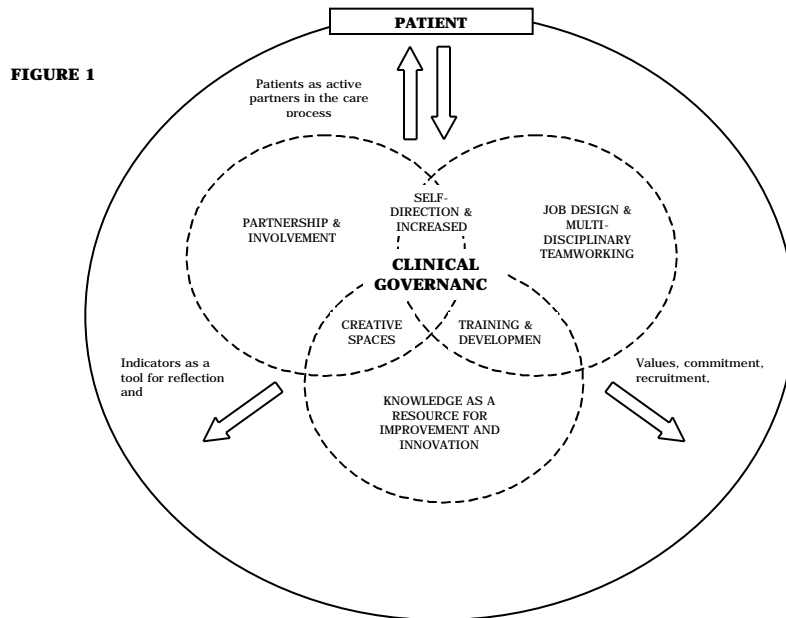
of organisations to harness the tacit knowledge and creative potential of employees. This involves much more than the ability to recruit and retain staff with necessary competencies. The emphasis on developing individual competence needs to be matched by *organisational* competence – building an approach to work organisation which engages all levels of employees in planning, quality assurance, problem solving and innovation (Cooke & Seely Brown, 2000). Establishing this work environment involves a complex and contextualised process of dialogue, learning and organisational innovation based on interdependent processes which embrace workplace partnership, job design, teamworking, and quality of working life (Totterdill, Dhondt & Milsome, 2002). The paper by Rosemary Exton in this edition of the Journal shows how hard it can be to ensure the equitable and effective implementation of workplace change.

Work organisation must be seen as a reflexive process, not an end state. Data from the Hi-Res project, a European research review and analysis of some 120 case studies of organisational innovation, were examined for relevance to the NHS. The Hi-Res findings suggest that workplace innovation cannot be defined in terms of the identification and implementation of a series of blueprints to change discrete aspects of an organisation. Although the traditional way to accomplish change is through the application of generalised concepts to specific problems according to a predetermined set of rules, it is now increasingly argued (see for example Fricke, 1997; Gustavsen, 1992) that this is a roadblock to real change. Rather it is important to understand the complex learning paths which characterise change in real situations. Pettigrew (1987) for example argues for greater focus on the internal and external contexts

which drive, inform and constrain change. Such commentators criticise the common perception of change within management texts as rational and incremental, thereby supporting the use of normative change models. They argue instead that change is a dynamic and uncertain process which emerges through the interplay of many factors. Successful change always involves painstaking research, negotiation, experimentation, critical appraisal and redesign over many cycles (Totterdill, Dhondt & Milsome, 2002).

Hi-Res recognises the importance of learning from case study experience but seeks to avoid prescription or the dubious claims of universality embodied in 'key learning points' (Hague, 2002). Rather there is a need to understand the untidiness of real-life change processes embodied in the dilemmas, contradictions and choices faced by practitioners. Work organisation is essentially contested, reflecting complex interactions between internal and external drivers, influences and learning. In this analysis, organisational innovation struggles towards a virtuous circle in which reflexive practices capture employee knowledge and experiences to create a dynamic interaction between product or service innovation and organisational change. Hi-Res therefore identifies and explores the 'arenas' in which work processes are negotiated and tested.

The following section draws on the Hi-Res analysis to identify the specific organisational dimensions of clinical governance. Figure 1 identifies three principal high road arenas: knowledge as a resource for improvement and innovation; partnership and involvement; job design and multidisciplinary teamworking.



³Hi-Res: *Defining the High Road of Work Organisation as a Resource for Policy Makers and Social Partners*. Project undertaken for the European Commission by a consortium of partners from 6 Member States led by The Work Institute at Nottingham Business School. See Totterdill, P., Dhondt, S., Milsome, S., 2002

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While clinical procedures are codified to minimise risk and maximise effectiveness, judgment and discretion are central to the day-to-day process of dealing with patients. Service improvement and risk management depend on the ability to capture learning and experience from practice, create spaces for reflection and innovation, and distribute knowledge as an organisation-wide resource. This goes far beyond the narrow 'learning from mistakes' approach within the NHS *Organisation With a Memory* (OWAM) initiative (DoH, 2000b).

Garvin (1993, p.80) refers to the "learning organisation" as "an organisation skilled at creating, acquiring and transferring knowledge, and at modifying its behaviour to reflect new knowledge and insights."

At the most basic level, organisational learning can emanate from repeated tasks and activities which result in progressive adaptation and greater efficiency. At a higher level however the learning organisation progressively modifies its structures, technologies, practices and cultures to maximise and utilise the learning capabilities of its people (Shapiro, 1998; Stalk et al, 1992). Critically "Although organisational learning occurs through individuals, it would be a mistake to conclude that organisational learning is nothing but the cumulative result of their members' learning. Organisations do not have brains, but they have cognitive systems and memories." (Hedberg, 1981, p3).

This re-emphasises the importance of the distinction between individual and organisational learning. Argyris (1977) distinguishes between single-loop learning (in which the need for improvement is identified by individuals but where the objectives and policies of the organisation remain essentially unchanged) and double loop learning in which the organisation has the capacity to reflect on itself and to develop appropriately adaptive behaviour. Double loop learning can be identified with the reflexivity characteristic of the high road of clinical governance, creating a collective knowledge resource to support the dynamic balance between organisational innovation and service innovation. However the bridge between single loop and double loop learning can be seriously impeded in the hospital context by professional demarcations and organisational divisions. Recent illustrations can be found in the Kennedy (2001) Report into children's heart surgery at the Bristol Royal Infirmary, and the Toft (2001) Report into a death at the Queen's Medical Centre, Nottingham.

Organisational structures, technologies, practices and cultures either help or hinder organisational learning and improvement. The Hi-Res study identifies several cases where new approaches to work organisation have been introduced to overcome identified obstacles to learning and improvement, ranging from the introduction of semi-autonomous teamworking to the physical integration of R&D and production functions.

While these concepts are acknowledged within the NHS Modernisation agenda, the capture, analysis and distribution of knowledge in the hospital context is not simply about the creation of centralised 'good practice'

databases. Rather it focuses on two dimensions of work organisation: the establishment of workplace practices conducive to partnership and dialogue

between management and employees, and the establishment of effective multi-disciplinary teamworking.

PARTNERSHIP, INVOLVEMENT AND PARTICIPATION

In many Trusts forms of workplace partnership have become established to deal proactively with industrial relations issues, ensuring early consultation on pay and conditions, employment changes and organisational restructuring. However emergent thinking moves partnership away from a specific focus on industrial relations, recasting it as a potentially important driver of, and resource for, organisational innovation (Dawson, Hague, Knell & Totterdill, 2002). In Ireland, for example, social partners and government identify workplace partnership as central to the modernisation of work organisation. In particular it is seen as a vehicle for initiating change, ensuring its widespread 'ownership' by employees thereby enhancing effectiveness and reducing risk of innovation decay (Savage, 1999; Sharpe & Totterdill, 1999). In the Health Service this is recognised by the *Report of the NHS Taskforce on Staff Involvement* (DoH, 2000a) which argues that opportunities for active participation in the workplace help staff to "feel valued and make a better contribution to service delivery". However the resulting *Action Plan* reveals only limited measures to support implementation at Trust level (DoH, 2000c).

Employees increasingly expect rewarding work and a high quality of working life, a key component of which is the ability to influence their own work environment (Knell, 2001; Hague, Huzzard, den Hertog & Totterdill, 2002). Meaningful work has always offered the NHS an important advantage in attracting and retaining employees, even where quality of working life is problematic (Meadows et al, 2000; Nottingham City Hospital NHS Trust, 2002). 'Health service values' have always been one of the Health Service's most important intangible assets, though one which can no longer be taken for granted without more explicit staff recognition, involvement and self direction.

Partnership in its fuller sense has to permeate all levels of the organisation. Representative measures (such as partnership agreements, management/staff side panels or employee directorships) may play an important role in anchoring partnership firmly within the practice and culture of an organisation. However they do not ensure opportunities for direct employee involvement which, in clinical governance terms, can enable the full knowledge and experience of staff to be utilised in identifying risks and opportunities for improvement. In part such direct employee involvement is a product of effective job design and teamworking (see below) but in complex organisations such as hospitals 'dialogue structures' which cut across and by-pass line management channels could become an important mechanism for challenging established practice and promoting innovation. Dialogue structures can include organisation-wide events such as Change Conferences designed to inform corporate strategy, ad hoc project groups or inter-team forums. In each case they need to be governed by agreed procedures designed to ensure full participation by all levels of employee, thereby enabling the force of the better argument to prevail (Gustavsen, 1992). Above all there needs to be an acceptance by management that lean, cost-driven organisations are not innovative

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organisations: people need slack to be creative together.

Employee involvement and participation challenges senior and middle management prerogative, exposing decisions and styles to much greater scrutiny. At a minimum this requires the acquisition of new competencies by many managers, and in many cases the resign of the management function within organisational structures (for a radical example in healthcare of the elderly see Sherrin, 2002a).

'Bottom-up' approaches to organisational and service innovation require careful preparation and resourcing, using evidence-based tools to promote dialogue, trust and the transformation of traditional management practices. This, as yet, is scarcely recognised in the government's approach to staff involvement.

JOB DESIGN AND TEAMWORKING

Traditional approaches to job design and work organisation are no longer sustainable in a hospital context which demands greater responsiveness to patient needs. As recent CHI audits illustrate (www.chi.nhs.uk) professional demarcations, poor inter-professional communication and lack of autonomy in non-medical staff roles are obstacles to the delivery of safe, effective and patient-focused care.

Teamworking has been one of the defining characteristics of new forms of work organisation, with deep roots in European thinking about management and organisation dating back to the 1940s (Sherrin & Procter, 2002b). The current interest in teamworking dates back to its rediscovery in the North American manufacturing sector in the mid-1980s, since when the concept has spread widely into other areas of work. However the term is increasingly used to describe such a diverse range of workplace situations that arguably it has become meaningless. Mueller & Purcell (1992) attempt to clarify the modern conception of teamworking by drawing on the definition used in GM/Opel:

- the team works on a common task
- its work is spatially concentrated and it has a recognisable territory
- the allocation of tasks is largely organised by the team
- the team encourage and organises the acquisition of multiple skills
- it has decision-making power over time and appropriate means
- there is team spokesman/leader
- the team has some influence on who will join it.

What distinguishes a team in the sense used here from a collection of workers who merely work in the same department is the degree of autonomy it enjoys in relation to formal line management structures. However – and this is particularly pertinent to the health service context – it is also necessary to consider the quality of dialogue and innovation which takes place inside the team. If teams are to be more than decentralised units for the production of a given service, all team members must have the potential for a high level of reflexivity unconstrained by internal demarcations and privileges (Gustavsen, 1992).

Within the NHS progress has been made in certain areas of job design, notably the expansion of nursing roles into areas of practice traditionally reserved

exclusively for doctors. However the nature of clinical work organisation remains largely neglected and considerable variations in practice exist even within individual hospital Trusts.

At a clinical level, the distinction between team-based and non team-based approaches to patient care was clarified in a study of five paediatric renal units in different European countries (Centre for Work & Technology, 1995). Although each of the units described themselves colloquially as 'teams', two broad organisational approaches could be distinguished:

- In the more traditional model, patients and their families are seen by the medical consultant who decides whether they should then be referred to other professionals such as dieticians, clinical psychologists or social workers. These referrals could involve patients and their families in multiple visits to the hospital, often with significant gaps. Eventually the consultant will receive reports on the patient from the other professionals and will use them to make a diagnosis and prescribe treatment on the basis of his or her own judgment. In many cases the consultant and the other professionals will be located in different parts of the hospital or even on different sites and will meet only rarely. Separate patient notes will be kept by each professional so there is no integrated case history.
- In the much rarer team-based model (only found at one hospital in the paediatric renal study) each professional group is located within a common area, at least on relevant clinic days. Depending on the case history all the relevant professionals will be present at the consultation, or will be available for referral shortly afterwards. The different professionals will confer on the spot and ensure that the patient leaves with the benefit of an integrated diagnosis and treatment plan. Clinic sessions are followed by case meetings at which both the medical and psycho-social aspects of each patient's condition will be considered. Diagnosis and prescription are therefore a continuously negotiated process based on high levels of mutual trust and understanding between the different professions. For patients and carers this provides a relatively seamless route through the different aspects of care.

The different professional groups (including doctors) involved in the team-based model each reported enhanced levels of job satisfaction compared with their previous experience of more traditional approaches. In part this reflected improved clinical results generated by the more effective pooling of expertise; in part it grew from a sense of mutual support and sharing between team members. Nurses and other professionals commented on their ability to use competencies to the full in a team setting, enjoying higher levels of discretion and respect. Interaction between professionals in a team environment also generates high levels of innovation in terms of service improvement and team development. The team was also a potential (though largely untapped) resource as a 'dialogue structure' to promote wider employee engagement with corporate strategy.

Significantly, although the team-based model demonstrated tangible patient benefits there was no

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hospital-wide strategy to adopt the approach as the norm for clinical work organisation. Indeed the wider organisational environment in which the paediatric renal unit existed acted as a significant constraint on teamworking, particularly because of:

- limited control over budgets
- tension between vertical line management based on professional groups and team accountability
- limited ability to recruit its own membership (team members were often recruited by line managers without wider involvement)
- the lack of corresponding team practices in related parts of the hospital (for example ward staff) leading to broken lines of communication
- poor information technology support, preventing the creation of integrated, multi-professional case notes.

At corporate level the hospital's understanding of team principles was limited and there was little evidence of central support to develop the team further or to avoid innovation decay. Stronger support was required for non-medical staff in developing teamwork competencies including facilitation skills; arguably this should eventually lead to a separation in roles between *medical* leadership and *team* leadership in order to reinforce open dialogue and extended participation.

Teamworking should not be restricted to the point of service delivery (a wider conclusion drawn from the Hi-Res research) but needs to become a defining characteristic of all aspects of work, both routine and developmental, at all levels of the organisation. In this sense teamworking emerges not as a formulaic model but as an approach to work organisation which broadens job design and challenges both hierarchical and horizontal demarcations in order to optimise levels of agility and innovation. It also provides the day-to-day context for enhancing quality of working life.

CLINICAL GOVERNANCE AS A REFLEXIVE PROCESS

In summary, the arenas of organisational learning and innovation described above offer the scope to shift clinical governance from emphasis on compliance to improvement and innovation. If the current focus on performance management implies a mechanistic view of hospital organisations, the high road in contrast emphasises their organic nature and their potential for learning, risk-taking and innovation. Indeed it offers a profound challenge to the Tayloristic separation of planning and delivery which lies at the heart of current policy.

CONCLUSION

This paper argues that distortions in the implementation of Clinical Governance result in quality assurance without quality improvement. While there is recognition of the importance of staff in achieving effective Clinical Governance, there is little practical understanding at Trust level of how to achieve this by reuniting patient satisfaction and quality of working life.

Likewise there is little evidence that Trusts recognise the need to strengthen the basic, interdependent building blocks of post-Taylorist work organisation: knowledge creation and distribution, partnership and involvement, and multi-disciplinary teamworking. The prioritisation and resources given to enhancing these building blocks simply do not match the obstacles

encountered in attempting to change traditional forms of work organisation and management practice.

Acute hospital Trusts need to formulate a more strategic role for Boards, to value staff involvement and participation as a core strategic value, to build team-based practice throughout their organisations, to redefine the roles and competencies of managers, and to build the skills required to make new forms of work organisation successful. Few Trusts can achieve this on their own. The question is whether government can develop modes of policy intervention capable of animating and resourcing such widespread organisational innovation.

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