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An Integrated Approach to Organisational Improvement
and Innovation in Ireland’s Health Care System



Report of the Hospital
of the Future Project

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Foreword

The publication of this report co-incides with a period of immense change for the Irish health care system. All around we see evidence of the pressures that are having a profound impact on the way in which health care is delivered, and the quality, safety and efficiency of that health care. Changing population demographics, increasing levels of demand for service provision, significant budgetary constraints, improving regulatory systems for quality and safety and the integration and re-organisation of the primary and community care and acute hospital systems are just some of the forces driving change in the health care system in Ireland. Ultimately, it is the management, staff and unions working in the health care system that must respond to the pressures for change. How this response is managed, and whether it is done collaboratively or confrontationally, will have a major impact on the quality and depth of the change and its implications for service users. The evidence strongly suggests that management, staff and trade unions achieve better outcomes – including patient care outcomes – when working collaboratively than when working exclusively through models rooted in traditional industrial relations or conventional approaches to management and work organisation.

As we enter this second decade of the new millennium, we also see evidence of profound changes in workplaces, working environments, the dynamics of industrial relations and the model of partnership that has prevailed for some decades. These matters provide the focus for this report, which brings us fresh evidence from the frontline of health care delivery showing the range of ways in which managers, staff and unions can play a pivotal role in shaping change and innovation in the health care system. The report also paints a challenging picture of change and innovation as often sporadic and haphazard. A culture of continuous improvement is not yet pervasive in the health care system; there are too many gaps and barriers in terms of the quality of how managers and senior clinicians manage, and how staff, trade unions and patients are involved and engaged in an improvement and innovation agenda.

This report presents compelling evidence of how processes for managing change and innovation sometimes work – and other times fail – in our health care system. The findings remind us that health care facilities, when managed with high levels of staff and trade union engagement and involvement, can achieve improved efficiencies, higher quality and safety of health care, and a better quality of working life for staff. The report sets out a progressive agenda that advocates for participative governance as an approach to reconciling the currently-fragmented governance system within the acute hospital environment.

The participative governance approach outlined here calls on managers, clinicians and unions to recognise the complementarity between direct and indirect engagement with staff as a key element in the search for improved efficiency, quality and safety in the delivery of health care.

Coming as it does in the wake of the ratification by the Irish Congress of Trade Union of the Public Service Agreement 2010 – 2014 (the “Croke Park Agreement”), we believe that this report provides a strong, evidence-based imperative for staff and union engagement and involvement in delivering real transformation in the health sector. It does so while articulating the conceptual basis for direct and indirect staff engagement, reconciled in a manner that has long been espoused by both management and unions in the health sector – where the principles of partnership are implemented in a relevant and effective way at every level in the health system, and impact on the day-to-day working lives of staff, unions and management.

We would like to thank all who contributed to this report: Dr. Ruth Barrington, who skillfully chaired the Steering Committee, the members of the Steering Committee, the Technical Working Group, the Expert Liaison Group, as well as the staff of the Health Services National Partnership Forum and the National Centre for Partnership and Performance. We would like to thank the research consortium from UKWON Ltd. and IPC Consulting, who proved themselves both highly adept and patient in the conduct of their work in most challenging circumstances. Finally, we would like to thank the managers, front-line staff and trade union representatives working in the acute hospital system who contributed their time and expertise to participate in this research.



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Executive Summary

Introduction

This report was jointly commissioned by the *National Centre for Partnership and Performance* and the *Health Services National Partnership Forum*. It was conceived as an inquiry into the nature of high performance in the acute hospital system. While the particular research context for this report is Ireland's acute hospitals, the findings are readily transferable to other areas of the health system and indeed have relevance for the wider public service.

It focuses on roles and relationships between management, staff and unions, and how these affect performance and outcomes. Above all, the aim is to identify conditions under which hospital staff at all levels can use and develop knowledge, skills and innovative potential to the full to achieve quality improvement and sound governance.

The research, carried out by an international consortium of experts in the field of work organisation, is based on the most extensive analysis of work practices ever undertaken in the acute hospital system including a comprehensive survey of key respondents with data from more than half of all acute hospitals. In addition, interviews were conducted across 7 acute hospitals with more than 150 staff from the front line clinical and non-clinical roles as well as hospital management and union representatives. The researchers also obtained comparative performance data from HSE and hygiene data from HIQA.

The analysis focused on five key dimensions of organisational practice:

- Direct Staff Involvement in Service Improvement
- Collaboration and Teamwork
- Shared Governance.
- Partnership
- Strategic Human Resource Management

Data from the survey and nationally-available performance data for the 26 hospitals were analysed to test for relationships between participative practices and clinical, organisational or staff outcomes. While the availability of suitable performance data was limited, the approach did highlight some statistically-significant correlations between workplace practices, levels of staff involvement, and outcomes in terms of patient safety and efficiency levels. The findings from interviews with front-line staff, management and trade union representatives provide a powerful picture of the nature of change and innovation in a hospital setting, and highlight the challenges facing managers, staff and unions in improving quality and efficiency.

Findings

- We identified many participative initiatives which are improving patient care and hospital performance. But there is no systemic approach, either at hospital level or national level, to introducing or disseminating participative practices even when there is evidence that they work.
- A number of statistical correlations were found between participative practices and performance, particularly in relation to hygiene, staff turnover and sickness absence. However, the lack of appropriate data, particularly in relation to quality of patient care and staff well-being, seriously impeded this aspect of the analysis.
- In many hospitals, existing partnership structures play an important if low profile role in maintaining sound industrial relations and a climate conducive to change at local level. The importance of this should not be underestimated. However their impact on the ability of frontline staff to contribute knowledge and experience to service innovation or quality improvement is very patchy.

- Integrated governance is emerging as a major force for improvement and innovation in the health services. Powerful new clinical directorate structures will become major drivers for organisational change in every acute hospital. Yet in most cases hospital structures concerned with governance, quality improvement, innovation, industrial relations, partnership and staff engagement remain fragmented within discrete silos. At this critical juncture for the health services, emerging developments and new thinking in relation to models for staff engagement, partnership, clinical governance, quality and risk management, and so on provide an opportunity to explore profound questions about integrated approaches to building a high-involvement culture.
- Multidisciplinary working between health service professionals remains a major challenge, and its absence represents a significant area of weakness in many clinical areas. Clinical Directors appear to lack sufficient guidance or direction in this regard.
- In some cases national performance management structures are leading to real improvement but there is also a widespread compliance culture based on “ticking boxes” and this undermines sustainable change.

Context

This report is published at a challenging time for both health service employers and health sector trade unions. The existing partnership model in the health sector is under intense pressure. So too are existing governance and management systems at local level. Newly-emerging policies including Clinical Directorates and the HSE Employee Engagement Strategy offer potential opportunities to drive change and innovation at the workplace, but their success will depend on achieving support from both front-line staff and from health sector unions. The publication of the report will coincide with and may usefully feed into discussions between the Government and public sector unions on the possibility of enhanced public sector reform as a key response to the current crisis in the public finances.

The report reaffirms the principle of and identifies practical methodologies for developing an integrated and mutually-reinforcing system of direct and indirect staff involvement in innovation and continuous improvement. The proposals are based on empirical evidence from this and other health systems, taking what works effectively in practice and seeking to implement it as the norm rather than the exception.

The conclusions in the report highlight some practical measures that can be taken by both health service employers and health sector unions at national level, and by management, unions and staff on the ground, to deliver high quality, safe and efficient care for the patient, while enhancing the quality of working life for staff. These measures can be implemented quickly and can provide momentum for addressing the safety, quality and efficiency issues that are to the fore for health service employers and unions.

Summary of Recommendations

- Government / Department of Health and Children, to work with health service employers, health sector unions and other key stakeholders to create a policy and regulatory environment conducive to transformation, including renewed commitment in national policy to a participative approach to quality improvement and efficiency. Specifically,
- Health service employers, including the HSE, and health sector unions to actively develop a new model of “Participative Governance” and staff engagement where representative / partnership engagement and direct involvement of front-line staff are seen as two mutually-reinforcing parts of the same model.

- Health Sector unions and employers, including HSE, to collaborate, with other stakeholders, on a **Strategic Engagement and Innovation Initiative**, including designing, implementing and responding to a system-wide staff survey in 2011 to provide national and local data on employee engagement and innovative ideas from the front line for achieving efficiency and improving quality and safety. At local levels, the initiative offers the opportunity to involve local partnership committees, Executive Management Teams and Clinical Directorates to manage the 'ideas generation' phase and to implement innovative proposals across three key areas – patient care, hospital efficiency and staff well-being.
- Action Learning to be supported through the establishment of an **“innovation cluster”** of hospitals using direct & indirect staff involvement models to address key performance issues relating to patient care, hospital efficiency and staff wellbeing. Innovation clusters to engage in widespread dissemination of learning and experience throughout the healthcare system, supporting the revamp of the HSE's Innovation Awards.
- Build system-level capacity to animate and sustain innovation and change, including the use of existing HSNPF and HSE capabilities to support local-level management, unions and staff in models of participative governance and management. This includes the adaptation of HealthStat, Health Atlas and Performance Monitoring capabilities for provision of near real-time performance data to local partnership groups, including information on patient care, hospital efficiency performance, and staff wellbeing indicators.

Part A

Part A introduces the research project in the context of the strategic changes that are underway in the health services, and reviews the international literature on the relationship between staff involvement and performance, especially within the hospital context. A conceptual model of “Participative Governance” is then introduced; its aim is to reconcile current approaches to partnership and staff involvement with the emergence of integrated governance as a key driver for change in the hospital system.

Chapter 1

The Changing Face of Ireland's Health Services

1.1 Introduction

"It is widely accepted that continuing to do things as they have been done in the past will lead to health and social care systems that are unable to cope, financially unsound and unable to provide quality care."

Health Services Executive Transformation Programme 2007 – 2010

Ireland's health care system is undergoing a series of profound changes that will fundamentally shape the nature and quality of health care for the decade to come and beyond. Some of the most significant developments currently underway include the reconfiguration of the systems and organisational models to support more integrated delivery of health care at community level, the implementation of new governance and management arrangements in hospital and community-based health-care facilities, the ongoing development of a standards-based approach to health care, and an emergent model of continuous improvement and operational excellence. An ageing and more diverse population, rapid advances in the science and technology of health care, changing expectations from consumers/patients and staff, and increasing public concern following high-profile issues relating to quality and safety of patient care mean that, in the words of Professor Drumm, "change is not an option – it is a necessity."

That such change is taking place against a backdrop of considerable financial stringency and increasing uncertainty in the industrial relations climate does not make the modernisers' task any easier. In a situation of declining resources there is considerable emphasis on the challenge of achieving efficiencies and cost-savings while maintaining quality of patient care and service levels. These contending priorities present a series of complex challenges for management, unions and staff working in the health sector.

The scale and complex nature of such changes poses significant challenges for policy makers, regulatory authorities, management, staff and trade unions within the health system. Health service employers and health sector unions are faced with pressing issues such as organisational restructuring, staffing levels, productivity improvement, patient safety, workforce flexibility, skill mix, and pay and conditions. Nowhere else in the public service has systems-change of this magnitude and complexity become such an established part of the everyday landscape within which managers, staff and trade unions must function. Advancing such change in the current context of retrenchment and cost-containment makes for one of the most challenging periods in the history of the health services. Demands for greater efficiencies, for safer and better patient care, and for a better quality of working life for staff mean that traditional institutional arrangements and organisational practices that were once considered appropriate for managing change and enabling innovation are no longer seen as adequate.

With a workforce that accounts for approximately one-third of those employed in the public service, and a projected budget reduction in 2010 of more than €1 billion, the health sector will be one of the primary arenas where the resolution of the current crisis in the public finances will be played out. As this report is published, there is much that remains to be determined about the type of strategies and relationships at national and local level that can produce effective solutions to the issues facing management, staff, unions and patients in the health services.

1.2 About the project

This report has emerged from the *Hospital of the Future* project, which was conceived in 2007 as a research inquiry into the organisational factors impinging on high performance in the acute hospital system. It has focused on the roles and relationships between management, staff and unions, and how these affect performance and outcomes. This report is intended to provide an evidence-based input to the debates that are now taking place about the changes and responses that are needed at national and local level in the health sector.

The research presented here is based on the most extensive empirical investigation ever undertaken in Ireland into the relationship between governance and management systems on the one hand and positive outcomes for patients as well as management, staff and trade unions working in the Irish health system on the other. The report presents insights from the front line; from hospital managers, Clinical Directors, Directors of Nursing, HR Directors, Trade Union representatives, and from front-line staff themselves. It focuses on their experience of change and innovation in their jobs, and how this has been supported or inhibited by institutional arrangements and the governance and management systems that they work within.

The research builds on earlier work by the National Centre for Partnership and Performance, which investigated these issues in private sector firms in Ireland (NCPP, 2006). This earlier research shed useful light on the nature of work systems and management approaches in companies with higher levels of innovation, productivity and employee well-being. Adapting this model of inquiry to an understanding of the relationships between work practices and performance in health care systems is not without complexity. Compared to the typical private-sector firm, an acute hospital is a significantly more complex organisational entity in terms of its range of stakeholders, governance systems, regulatory and standards frameworks, organisational structure, range of services provided, and the often intricate interdependencies between it and other parts of the health system. Developing a credible explanation of the relationship between

organisational practices on the one hand and on outcomes for patients, staff and management on the other, requires careful treatment.

Nonetheless, the international literature does reveal compelling evidence of the ways in which participative approaches to management and employee involvement lead to better outcomes for patients, staff and managers, as well as to enhanced roles for trade unions as knowledgeable and respected participants in change. The findings in this report reveal important new evidence of what is and is not happening at national and local level to support the management of change, improvement and innovation. Drawing on this evidence and the broader body of international research, the report highlights some strategic and practical options that can support better approaches to building high-performance organisations, capable of delivering efficient and safe care to patients in a high-quality working environment.

While the particular research context for this report is Ireland's acute hospitals, the findings are readily transferable to other areas of the health system and indeed have relevance for the wider public service. The report explores some of the implications for management practices and governance systems in the health sector, the role of partnership, and the challenges and opportunities for change and innovation that exist for health-sector managers, trade unions and staff.

The project has been implemented with the active participation of key stakeholders including representatives of health service employers including the HSE, and health-sector trade unions. Their role has been vital in helping the research team to focus on key issues, to gain access to hospitals and other institutional actors, to test propositions, and to refine its analysis and conclusions. In particular the Project Steering Group chaired by Dr. Ruth Barrington has been central to the formulation of the recommendations contained within Chapter 7.

1.3 Structure of the report

This report comprises three parts:

Part A

contains an overview of the research findings from the wider literature and from this study, grounded within a practical policy context. Chapter 1 begins with a brief review of the policy context for public-sector reform. It then focuses on the health sector and describes the challenges in the sector for organisational change and innovation, looking at the strategies for employee involvement and partnership in the health services and demonstrating that strategic policy already sets the context for a new and more inclusive model of workplace partnership. Chapter 2 reports on relevant findings from the literature and from the survey undertaken as part of this study into the relationship between strategic human resource management, partnership, staff involvement and performance. It builds on this overview to outline a broad conceptual model, drawing together representative and direct involvement in building a systemic view of quality improvement and governance.

Part B

contains a detailed technical description of the methodology and outcomes associated with the national survey of acute hospitals undertaken as part of the research project. This was designed to explore possible relationships between five key areas of organisational practice (strategic HRM; direct staff involvement in service improvement; multidisciplinary teamworking; staff involvement in clinical governance; partnership) and a bundle of performance measures. Chapter 3 presents the survey findings of the acute hospitals, detailing the type of participative governance and management systems and practices. Chapter 4 examines the issue of high performance in the acute hospital system, and explores how the systems and practices in place impact on performance levels.

Part C

Chapter 5 draws on detailed evidence from study visits to seven acute hospitals, identifying excellence in practices which enable staff at all levels to contribute to quality of patient care, service improvements and hospital efficiency. Chapter 6 draws on the evidence from Chapters 2

through 5 to operationalise the conceptual model and to draw conclusions for the respective roles of the different actors. Finally, Chapter 7 presents the conclusions and recommendations.

1.4 High involvement as a key proposition for managing change

One of the imperatives underpinning the transformation of the health services is the need to harness all available resources, not least the skills, experience and imagination of the workforce. A fundamental assumption evident in all major change programmes and strategies at national level and at local facility level is that the management, staff and unions working in the health services, and the quality of the relationships between them, are essential to the effective planning and implementation of change.

The Transformation Programme proclaims that projects for change “should involve virtually all of us who are directly employed by the HSE and HSE-funded agencies.” The HSE publication *Improving Our Services: A User’s Guide to Managing Change in the Health Service Executive* (2008) makes the point that people affected by change “must have the opportunity to participate actively in the change process and to develop a sense of ownership and commitment to the change. The direct participation and engagement of front-line staff plays a key role in shaping the change and delivering its outcomes. In acknowledgement of the long tradition and culture of staff involvement in the development and delivery of services, staff and their unions should be engaged at an early stage.” The Health Sector *Protocol on Handling Significant Change* is a prime illustration of the adoption by both employers and unions of the collaborative, partnership approach to handling change in the sector.

While this proposition is clearly set out in successive strategies and protocols for partnership and human resource management in the health services, it is also evident in reports examining issues such as service reconfiguration, patient safety, and so on. For example, the 2008 Report of the Commission on Patient Safety and Quality Assurance (the ‘Madden Report’) points out that the common finding arising from various reports into high-profile adverse events was the need

for new organisational arrangements to improve clinical quality, and the need to develop a culture where staff involvement is a vital element of the search for quality and safety in patient care. Similar assumptions regarding the centrality of staff involvement and participation underpin our understanding of how to ensure continuous process and quality improvement, service redesign and reconfiguration, and the adoption of new treatment protocols and technologies.

1.5 High performance as a key objective in transforming public services

From a public policy perspective, the high performance agenda has become increasingly prominent in relation to the delivery of public services generally in Ireland. In 2008, the *Report of the Taskforce on the Public Service and the OECD Review of the Irish Public Service* reiterated the need for Ireland's public services to become increasingly focused on the delivery of more effective public services.

The *Transforming Public Services* agenda emphasises the need to embed a performance culture across the Public Service, where underperformance, both at the level of the organisation and the individual, is addressed by building capacity for performance management and continuous improvement. It calls for greater efforts to standardise and monitor the distribution of performance ratings across organisations to ensure effective operation of the performance management system, and to support and develop management in facilitating a more challenging performance debate within the workplace. The Public Service Agreement 2010 – 2014 demands the use of evidence-based performance measurement, to drive continuous improvements in efficiency and effectiveness. The OECD note that in Ireland the focus to date has been on performance reporting, rather than managing for performance. It argues that, instead of focusing on inputs and processes, the focus needs to be on outputs and outcomes, allowing better measurement of how the Public Service is meeting targets and objectives. It highlights the importance of setting realistic performance targets within organisations, which cascade from the top to the individual, and where managerial capability is vital to achieving these goals.

1.6 The acute hospital context

The HSE Transformation Programme and the Integrated Service Provision plan set out a clear objective to achieve significant changes in the role of hospitals. This is further articulated in the HSE's integrated model of health care which describes the need to fundamentally shift the focus of service provision in the health system from a heavy reliance on acute hospitals:

[health care delivery will] shift further out of large institutions and into ambulatory, community, and home-based settings. Hospitals and nursing homes will serve increasingly acutely-ill patients while an evolving continuum of care will meet the needs of others. Care integration across primary and secondary care enables patients to move easily between hospitals and the community. The role of the acute hospital evolves to become more specialised as the more ambulant and less sick are managed elsewhere.” (P.A. Consulting, 2007)

The HSE recognises the challenges inherent in moving towards the preferred model of health care. At one level it requires whole-systems change, both to develop the capacity of the primary, community and continuing care sector, and to achieve its integration with the acute care sector. It also highlights the changes that will be required in behaviours and work practices within hospitals and the primary and community care sector alike:

Changing behaviour is typically the most difficult aspect of any reform programme. Practitioners have well established processes and viewpoints based on years of actual operational experience. In many occasions, learned behaviours have been the most appropriate for the system they have been working in. The system change must therefore coincide with a change by those working it. (P.A. Consulting, 2007)

The research literature offers considerable empirical evidence of the importance of effective systems for direct staff involvement in the design and implementation of organisational innovation, as a means of identifying and managing risks (to staff and patients), improving the quality of patient care and patient satisfaction, achieving significant efficiencies and innovative solutions to problems,

and enhancing the levels of employee engagement and job satisfaction. Well-publicised research by West et al (2002) in UK hospitals claimed to identify a direct causal relationship between human resource management and team-based forms of engagement on the one hand and mortality on the other, creating considerable interest throughout the country's National Health Service.

In a practical sense there is an abundance of both evidence and experience to show that systems for high involvement enable or elicit high levels of staff participation. Various terminologies are used to describe the range of participative practices that enable staff involvement, and include, for example, integrated care pathways, multidisciplinary teamworking, shared governance, collaborative problem-solving, and so on. These and other participative governance and management practices are underpinned by various legislative and regulatory frameworks or arrangements, including strategic human resource management, information and consultation provisions, the quality and risk management framework, clinical governance guidelines, and workplace partnership.

Given the strength of the proposition about the value of employee involvement and the aspirations expressed over recent years by the HSE and by health sector unions and professional associations, what evidence is there that such approaches are becoming a reality in the health services? Emerging innovations in governance and management systems are creating new opportunities to involve health service staff in the improvement of quality and efficiency. However, establishing conditions conducive to improvement and innovation must be matched with building the skills and capabilities – among management, clinicians and other front-line staff – to lead and participate in the management of change. A far greater focus is now evident in relation to how people working within the health system are managed, and how the skills and capabilities of front-line staff can be better leveraged by effective models of employee engagement.

1.7 Partnership – An Enabling Framework

1.7.1 *The Role of Social Partnership*

Over the past decade, the national social partnership agreements have been instrumental in creating the framework conditions for change and modernisation in the health sector. Successive agreements have provided a medium-term framework to maintain stable industrial relations and facilitate change and innovation. These agreements provided a framework that allowed unions and employers to reach broad agreement on priorities for the health sector, reiterated their strategic commitment to partnership as the agreed approach to achieving these changes, and provided for the resources to support a partnership approach in the health sector at sectoral, regional and local levels.

During the course of the research for this report, there has been a clear reminder of how the presence or absence of a social partnership-type agreement between public sector employers and unions has a fundamental bearing on the capacity of both sides to engage in a complex and challenging change agenda. The newly-ratified *Public Service Agreement 2010 – 2014* sets out what is undoubtedly the most demanding set of challenges that health service employers and unions have ever had to face. In doing so, the agreement highlights the centrality of partnership to managing and implementing change, and creates opportunities for health sector employers and trade unions to instigate new approaches to collaborative change.

1.7.2 *Workplace Partnership models in the Public Service*

The type of representative participation or Partnership Committee model that has previously emerged across the public service, including the health sector, should be seen as a necessary first step in the devolution of employee participation and partnership principles and values throughout the workplace. From the outset, Partnership Committees at workplace level (in both the public and private sectors) were always intended as *enablers* of the further development of partnership practices and participative working. Partnership Committees across the public sector

as a whole have focused on a mix of information-sharing, consultation and joint identification and implementation of improvement projects. Committees regularly establish and support multi-skilled and experienced project teams to address specific projects utilising a partnership approach, and these project teams frequently include front-line staff (though as we demonstrate below, the picture is somewhat patchy in the hospital sector). A key role of Partnership Committees therefore, has been to create the necessary conditions, relationships, and trust needed to routinise the active co-operation and involvement of front line staff/management in service planning and improvement.

Following its establishment in 2001, the National Centre for Partnership and Performance focused on guiding the development of partnership models beyond their establishment stage, towards the concept of "second-generation" partnership. *Building a Coalition for Change: Implementing the Health Strategy using a Partnership Approach* (NCP, 2002) identified the opportunity for partnership in the health sector to support the implementation of the Health Strategy, but requiring it to be remodelled and repositioned, linking it with mainstream organisational change programmes, focusing on core strategic goals and in effect moving towards "second-generation partnership." The National Workplace Strategy (NCP, 2005) highlighted that the quality of the workforce, leadership capability and the quality of workplace partnership are key to supporting high levels of workplace innovation and change. Workplace innovation and change encapsulates the adoption of new workplace practices, structures and relationships. It recognises the importance of developing new ideas about how to do things and how to involve employees in doing them.

1.7.3 Workplace partnership in the health sector

Successive national social partnership agreements including *Partnership 2000*, *the Programme for Prosperity and Fairness*, *Sustaining Progress, Towards 2016* and the recently-ratified *Public Service Agreement 2010 – 2014* have embodied commitments to the modernisation of the wider public sector including health services. Each of these agreements supports the development of

trade union/employer partnerships, employee participation, consultation, co-operation, development of shared objectives and partnership processes designed to enable participative approaches to organisational change and modernisation of public services.

Over the past decade, health service employers, trade unions and management have agreed to develop, implement and sustain workplace partnership arrangements and processes as an integral part of the modernisation agenda. The strategic mechanism to achieve this in the health services sector has been the establishment (under the provisions of *Partnership 2000*) of the Health Services National Partnership Forum (HSNPF) in 1999 as a joint management/trade union steering committee for "Workplace Partnership in the Irish health services." Its mission statement argues that:

Working together for a Better Health Service enables a new active relationship in managing change characterised by employee participation and consultation, the development of joint objectives, co-operation and trust and the delivery of patient-focussed quality Health Services.

The early years of the HSNPF were focused on supporting the establishment of partnership systems at a local level. By 2006, the strategic approach to partnership in the health sector had significantly evolved, as is evidenced by the HSNPF Annual Report 2005:

"As we complete our programme of work ... there is a very clear sense that we have made the transition from first generation partnership, based on projects and pilot programmes, to second generation partnership, where we have integrated partnership principles and practice into the way we do things at all levels in HSE. This is reflected in our strategy and policy documents, in our service plans, in our workplace practice and our service delivery ...

The needs of patients and service users are to the fore, and the mutual interests of management, staff and trade unions are clearly spelled out as the common ground upon which we will build ...

The trade unions in the health services again demonstrated ... an ability to engage with the HSE reform agenda in a constructive and

positive manner, keeping the needs of patients and service users to the fore, acknowledging the management and business issues, whilst addressing the interests of our members ...

The work that we have done ... on building the next phase of partnership, agreeing a set of common interests, developing a Protocol on Handling Significant Change in the health services, together with the reaffirmation of the Health Services Partnership Agreement in the context of the new HSE structures, deepens and strengthens the partnership."

The *Protocol on Handling Significant Change* and the accompanying *Statement of Common Interests*, demonstrate that national health care strategy has, within the context of successive social partnership agreements, sought to build strong bridges between representative forms of partnership on the one hand and enhance direct staff involvement in service improvement, planning and delivery on the other. This convergence at the strategic policy level lays the foundations for a new type of workplace partnership model, which goes far beyond the scope of industrial relations.

At a local level many management and trade union representatives value the partnership-based relationship between them, which has provided the basis for some of the most effective and sustainable solutions to issues such as service reconfiguration, improvement of patient care, performance improvement and staff well-being. Nonetheless, there is no doubting that, in the context of the challenges facing the wider partnership model in Ireland, partnership in the health sector has arrived at a critical juncture. Stakeholders are in broad agreement that any future guise needs to be radically different from its current form. Within the health sector, this trajectory for the evolution of partnership has been envisaged for some considerable period, and while important progress has been made there is now a need to realise the potential of partnership in more challenging circumstances.

1.8 Summary

The *Hospital of the Future* project sets out to develop a better empirical understanding of the nature of high performance, and to use this evidence to inform the efforts of management, staff and unions to engage more effectively in innovation, problem-solving and performance improvement. In the course of this, the project addresses the growing recognition of the need for new approaches to employee involvement and engagement. This includes revisiting the prevailing partnership model and building on the important achievements of existing representative structures, while at the same time directly engaging front-line staff and management more systematically in quality improvement and governance. Such a model needs to be grounded in firm evidence of what is currently working well in hospitals, while striving towards heightened convergence between the issues of patient care, cost-effectiveness and quality of working life. Existing partnership arrangements within the health service are generally held to be valuable if underused resources in this change agenda, not just because they can be instrumental in creating an industrial relations climate conducive to transformation but because they may hold the key to engaging "all of us" in the process.

However, achieving the mix of strategies, policies, practices and initiatives required to involve staff, unions and management effectively in managing change and improving performance is a complex challenge. It blends the evolving paradigm of representative partnership, the emergence of strategic human resource management capabilities within the HSE, the role of direct staff involvement at unit and department level, and the development of a model of employee engagement. In particular it requires new thinking about how these elements can be reconciled within an integrated governance framework. The resolution of these questions will offer HSE management, health sector unions and staff at the front line a new paradigm in terms of influencing and managing change, one also likely to be of significant interest to the public service as a whole. It can also offer health sector unions and the HSE a new paradigm for how partnership at the national level can support and engage with partnership, governance and quality improvement at the local level.

Chapter 2

Employee Involvement and Performance – Exploring the Evidence

2.1 Introduction

Researchers have long attempted to establish the nature of the relationship between organisational performance and productivity on the one hand and a range of human factors such as employee involvement, employee engagement and quality of working life on the other. Cumulatively, the research shows beyond much doubt that a positive relationship does exist. However, the quest is fraught with methodological and conceptual dilemmas. Much of the research focuses on the role of governance and management systems, including policies and practices for human resource management, the role of front-line management, as well as systems of indirect or representative involvement such as workplace partnership. The result is a complex body of knowledge that requires careful interpretation. The impact of people on performance is mediated by a wide range of contextual factors: in short, there is no simple algorithm.

Despite the complexity associated with this research, the proposition that employee involvement and engagement impacts on the quality and safety of patient care, the efficiency and innovativeness of health care delivery, and the well-being and quality of working life for staff in the health services is one that warrants careful examination. It has important implications for the way that managers manage, the way that clinical teams are organised, and the way that staff perform their work.

Extensive survey and case study evidence demonstrates that the introduction of participative forms of work organisation improves performance and innovation, especially where representative participation and direct employee involvement are combined in a mutually reinforcing manner (Totterdill, Dhondt and Milsome, 2002). A review of European, North American and Australian literature for

the European Commission demonstrates a clear consensus about the existence of a positive relationship between participative forms of work organisation and performance (Savage, 2001). One of the most significant studies, the Employee Participation and Organisational Change (EPOC) survey of 6000 workplaces in Europe, confirms that direct employee participation and teamworking can have strong positive impacts on both productivity and quality of products or services (European Foundation, 1997). Macy & Izumi (1993) found that team development initiatives and the creation of autonomous work groups were responsible for the most significant gains in terms of financial performance. Indeed the principal motive of most companies that introduce teamworking is to enhance the performance and productivity of their organisation (Cotton, 1993; Weldon & Weingart, 1994).

In health care, effective teamwork also contributes directly to better patient outcomes. West, Borrill and Unsworth (1998) found that health care teams with clear objectives and high levels of staff participation make a critical contribution to effectiveness and innovation in health care, while enhancing team members' well-being. A further well-known study claimed that post-surgical mortality could be reduced by the combined effect of a bundle of practices including teamworking, training and appraisal (West, Borrill, Dawson, Scully, Carter, Anelay, Patterson and Waring, 2002). However, Bartrum, Stanton, Leggat, Casimir and Fraser (2007) argue that there are limitations with these studies: first, direct causal links between specific HR practices and patient outcome are difficult to prove due to the presence of so many other potential variables, and second, patient mortality alone is an unreliable measure of performance. Several authors also show that effective teamwork, particularly in health care settings, has been difficult to achieve because of barriers and perceived status differentials between professional groups such as

doctors and nurses. Gender issues, multiple lines of management, and the lack of organisational systems and structures for supporting and managing teams act as further inhibitors (Borrill, West, Shapiro and Rees, 2000; McNulty, 2003; Ferlie, Fitzgerald, Wood and Hawkins, 2005).

In short, the research evidence demonstrates beyond doubt that the way in which work is organised makes a very significant impact on the ability of employees to enhance performance – both in terms of traditional variables such as productivity and in terms of the rate of product, process and service innovation on which the sustainability of organisations increasingly depends. It also suggests that representative partnership can create an organisational climate conducive to discretionary effort as well as the conditions within which participative work practices are likely to develop – though further research is certainly needed to elaborate this latter dimension in greater detail. Above all, the research suggests that the greatest impact on performance is found where there is a systemic approach in which representative partnership, participative forms of work organisation and supportive HRM practices combine in ways which encourage employees at all levels to contribute their tacit knowledge and competencies to the full.

2.2 Exploring the relationship between partnership and performance

Despite the attention that partnership has received over the past decade, there is no agreed definition amongst either researchers or practitioners (Guest and Peccei, 2001). Different actors adopt different definitions; likewise the elements of partnership appear in diverse combinations in different workplaces. At one level “partnership” simply constitutes a loose label for an approach to union–management co-operation that encompasses a wide range of variants (Haynes and Allen, 2001). However the plethora of empirical data and case study material that seeks to link “partnership” to performance actually describes a constellation of activities that at the very least embraces industrial relations, human resources management and work organisation (see for example NCPP 2002, 2003; TUC, 2000; IPA 1997, 2007). This is not necessarily

a problem provided that the distinctive roles played by the different elements of partnership in enhancing performance are understood.

In exploring the impact of the various forms of participation on outcomes, there has been extensive debate about whether direct or representative practices have the greater effect. At the level of formal collaborative partnership arrangements there is little evidence of a direct causal link with improved organisational performance in terms of, for example, productivity, customer satisfaction or quality of working life. Indeed Guest and Peccei (2001) argue that representative participation has no significant positive effect on employee attitudes and behaviour and, if implemented on its own, can have a negative impact on performance. One possible explanation for this is that representative participation in isolation will fail to overcome low levels of management trust in the workforce. Employees themselves may also become cynical about formal partnership structures and agreements that appear remote and have little visible impact on their own working lives (Pass, 2008).

However an important body of research has begun to show not that representative partnership has a direct impact on performance, but rather that it exerts a positive influence on the development of activities and practices that may do so. When partnership arrangements exist alongside participative workplace practices, they result in mutual benefits through improved information-sharing and greater levels of trust between employers, unions and employees (Oxenbridge and Brown, 2004) and to a heightened impact on performance (Batt and Applebaum, 1995).

This combination of representative and direct practices has been characterised in terms of “employee voice” (Boxall and Purcell, 2003). For employee representatives there is evidence that formal partnership enhances the degree of influence they are able to exert over employment and workplace issues through consultation and early involvement in decision-making (Ackers, Marchington, Wilkinson and Dundon, 2005). It also strengthens the robustness of the structures, such as works councils and trade unions, within which they work (Guest and Peccei, 2001). Union

representatives are adapting and carving out new roles, leading to greater involvement in establishing joint rules and procedures (Bacon and Storey, 2000). From an employee perspective the evidence suggests that representative partnership creates opportunities to exercise greater autonomy and direct participation (Batt and Applebaum, 1995). Moreover, employers pursuing high-performance, high-involvement practices are “likely to be impatient with traditional adversarial approaches to collective representation” (Kessler and Purcell, 1995).

The transposition of the *European Directive on Employee Information and Consultation* into domestic legislation in Ireland in 2008 was designed to strengthen the notion of employee voice. It is argued that the Directive represents an opportunity to influence the quality of industrial relations with the potential for widespread general gains that have come to be associated with the concept of partnership (Sisson, 2002).

The importance of employee voice in this sense is that it is directly linked to greater workforce commitment to the organisation, reflected in lower levels of absence, turnover and conflict, and improved performance (Applebaum and Batt, 1994; Huselid, 1995). Partnership can lead to the enhancement of employment standards as the decent treatment of employees comes to be seen as integral to the achievement of high performance (O’Connell, 2003). Purcell et al argue that employees who experience consultation and involvement are more willing to “go the extra mile” (Purcell, Kinnie, Hutchinson, Rayton and Swart, 2003). Where unions and management collaborate, employee trust is enhanced (Bryson, 2001) supporting a more positive psychological contract (Rousseau, 1995; Guest, 2000) thus creating higher levels of organisational commitment, motivation and job satisfaction. Teague (2005) argues that partnership can be the conduit to improving organisational competitiveness by mediating between employee wishes for decent work and managerial efforts to upgrade performance.

In terms of organisational performance, the Involvement and Participation Association (IPA) study, *The Partnership Company: Benchmarks for the Future*, found that almost all the partnership-based

companies responding to a survey felt that their approach to management – employee relations keeps them up with or ahead of their competitors. In addition, half of the respondents believed that partnership offers the potential for better product and service innovation, sales growth and volume, profit margins and overall profitability (Guest & Peccei, 1998). Moreover, this is supported through case study evidence demonstrating that there is a positive relationship between the existence of consultative councils and economic performance as measured by productivity growth (Fernie and Metcalf, 1995).

Research evidence also links representative partnership to problem-solving, adaptability and innovation when it is associated with direct participation. Effective partnership can create a culture that embraces change and organisational innovation, representing a strategic move towards higher value-added products and services in the knowledge driven economy (NCPP, 2004). Describing innovation as “the successful exploitation of new ideas” Bessant (2006) argues that the perceived work environment (comprising both structural and cultural elements) does make a difference to the level of innovation in organisations. Similarly Kark and Carmeli (2008) suggest that employee creativity makes an important contribution to organisational innovation, effectiveness and survival but that it is influenced by the work environment and level of encouragement.

Improved collaboration, upskilling and opportunities to share tacit knowledge are created through more effective communication and the direct involvement of employees in problem-solving, design and improvement of work processes (Bryson, Forth and Kirby, 2005; Ichniowski, Kochan, Levine, Olson and Strauss, 1996). Indeed Teague (2005) argues that an overarching “enterprise partnership” can harness an organisation’s resources, including the tacit knowledge of employees, more effectively than the leadership models which currently dominate the change management literature. Martinez, Lucio and Stuart (2002) argue that partnership is central to the modernising agenda as a means of permanently substituting co-operative relations for conflict at work. Co-operative relations in this sense are

predicated on an extension of employee rights and a commitment by representatives to work with employers, rather than against them, in the interests of improving organisational performance (Danford, Richardson, Stewart, Tailby and Upchurch, 2005). Guest and Peccei (2001) take up this theme and argue that the balance of advantage must be mutual.

2.2.1 *Partnership as direct employee participation*

A major test of representative partnership's impact on performance therefore concerns its ability to increase the level of employee influence not just at policy level but over day-to-day operations (IPA, 2007). Viewing partnership as systemic, deeply embedded and far-reaching is central to this perspective. In short, combining direct and representative participation together with an emphasis on job design and quality has the most positive effect on employee attitudes and behaviour relating to productivity, output quality and innovation (Guest and Peccei, 2001; Beaumont & Hunter, 2005; WERS, 1998). This builds a climate of trust where individual employees are confident that their contribution will be valued (CBI-TUC, 2001). Recent research also highlights the importance of a set of internally consistent policies and practices in ensuring that human capital contributes to the achievement of an organisation's business objectives: these include compensation systems, team-based job designs, flexible workforces, quality improvement practices and employee empowerment (Lado and Wilson, 1994; Huselid, Jackson and Schuler, 1997). As Teague (2005) suggests:

Organisations with mutually reinforcing employment practices achieve superior performance as their collective impact is greater than the sum of individual measures.

Indeed, neither representative nor direct forms of participation are necessarily beneficial when applied in isolation (Guest and Peccei, 2001). Representative partnership alone may fail to engage front-line employees, and benefits for employers or the workforce can be hard to realise. However, representative committees may also create a culture and instigate concrete practices that inspire managers to implement and sustain direct

forms of involvement. The new generation of line managers, union representatives and employees appear more at ease with a combination of inclusive (direct and indirect) rather than exclusive (direct versus indirect) voice practices. Managers are becoming more confident in organising direct exchanges of opinion with employees, while union representatives and employees increasingly expect them to do so (Wilkinson, Dundon, Marchington and Ackers, 2004).

2.3 **Exploring the link between Human Resource Management and performance**

While numerous empirical studies (Borrill, West, Shapiro and Rees, 2000; West, Borrill, Dawson, Scully, Carter, Anelay, Patterson and Waring, 2002; Huselid, 1995) have found significant links between "people management" and organisational performance, Pauwea and Boselie (2005) and Hesketh and Fleetwood (2006) argue that the relationships cited in research literature "are often statistically weak and the results ambiguous." Likewise an analysis of 104 empirical studies undertaken between 1994 and 2003 concluded that evidence of a causal relationship is inconclusive (Boselie, Dietz and Bon, 2005).

Many of the studies analysed by Boselie, Dietz and Bon focus on the implementation of High Performance Work Systems (HPWS) in which the central elements are claimed as the ability, motivation and opportunity for employees to participate (Appelbaum, Bailey, Berg and Kalleberg, 2000). Yet despite the high profile achieved by HPWS in management literature, both the concept and its explanatory value in clarifying the relationship between HRM and performance remain poorly defined (Pauwe and Boselie, 2005) and sometimes ambiguous.

Becker and Huselid (1998) attempt to throw light on this complex picture by drawing a distinction between traditional HR functions "that focus on transactions and compliance activities" and the "HRM system", a notion that they appear to consider proximate to the concept of HPWS:

We emphasize the importance of the global or overall HRM system because we believe that it is the systemic and interrelated influence of HRM policies and practices that provides their

inimitability, and therefore provides a strategic lever for the firm. Such internally consistent and externally aligned (with firm competitive strategy) work systems are generally thought to include rigorous recruitment and selection procedures, performance contingent incentive compensation systems, management development and training activities linked to the needs of the business, and significant commitment to employee involvement ... An internally consistent and coherent HRM system that is focused on solving operational problems and implementing the firm's competitive strategy is the basis for the acquisition, motivation and development of the underlying intellectual assets that can be a source of sustained competitive advantage.

Likewise Boxall and Purcell (2003) argue that the potential for sustained competitive advantage rests with HRM's ability to add value to the organisation by stimulating employee involvement and discretionary effort, through careful selection and retention of skilled employees, by resourcing workplace practices such as teamworking, and by avoiding the substitution of workforce knowledge with technology or sub-contracting. Likewise Flood, Guthrie, Liu and Mac Curtain (2007) found that HR management practices do not directly influence corporate performance but rather do so indirectly through HPWS by influencing the motivation, behaviour and performance of employees. Purcell, Kinnie, Hutchinson, Rayton and Swart (2003) similarly argue that HR Departments and line management together have a crucial role in encouraging employee behaviour appropriate to high levels of organisational performance. Indeed it is the stimulation of discretionary effort through motivation and opportunities to participate, combined with a culture of respect and recognition, which may explain how human resource potential is realised as "performed labour" (Appelbaum, Bailey, Berg and Kalleberg, 2000).

This analysis raises two principal problems. Firstly, most existing research evaluates the impact of HPWS on conventional indicators such as profit, productivity, costs and labour turnover. While these remain important, the real test of HPWS is whether they foster the innovations that enhance the quality of products, service delivery and processes. It is these innovations on which the sustainability of

organisations increasingly depends, and the extent to which they are increased by HPWS remains a critical but largely unanswered question.

This in turn leads to the second and more fundamental dilemma for HRM practitioners and researchers. If, as the above researchers suggest, the establishment of a relationship with performance rests at the level of "the HRM system" or HPWS, then the distinctiveness of HRM itself as a focus of analysis is seriously weakened. For example while the HRM literature may claim participative practices such as teamworking as part of the "HRM system", there is much less evidence to suggest that such workplaces innovations are typically led (let alone successfully led) by HR practitioners rather than operational managers (Purcell and Hutchinson, 2007). In short, HRM's claim to embrace every aspect of human activity in the workplace is unhelpful.

More convincing is Teague's (2005) argument cited above that superior performance is associated with organisations that demonstrate mutually reinforcing employment practices (including core HRM activities such as selection, reward, management development and training) "as their collective impact is greater than the sum of individual measures." Thus for example Cappelli and Neumark (1999) found that the impact on productivity of work practices such as self-managed teams is strongest when combined with innovative pay and reward practices such as profit-sharing or gainsharing.

In summary, HRM has a role, but it doesn't determine the impact of human and organisational factors on performance. Research into the impact of HRM has been weakened by conflating its sphere of influence with that of partnership, work organisation and direct staff involvement. A more productive approach would be, as Teague implies, to study the conditions under which complementarity between these distinct but interdependent domains can be achieved.

2.4 Employee well-being

Employee health and quality of working life is steadily becoming recognised as a competitive asset; the growth of corporate concern with

“healthy working” bears testament to this trend (see for example the corporate learning network *Enterprise for Health*¹). Occupational health and well-being measures are increasingly considered sound investments, which yield direct economic benefits to the company (Zwetsloot and Pot, 2004). Employee well-being is related to subsequent improved performance (Wright, Bonett and Sweeney, 1993; Guest, 2002); similarly, companies in which employees report high job satisfaction and organisational commitment were found to have higher financial performance over a ten year period (West and Patterson, 1998). Stressed individuals are more likely to be absent (Ulleberg and Rundmo, 1997) and less likely to continue working at the company (Cavanaugh, Boswell, Roehling and Bourdreau, 2000).

In the health care sector employee satisfaction correlates strongly with patient satisfaction (Varkey, Sudhakar, Karlapudi and Hensrud, 2008) and clinical outcomes. A US study demonstrated that rates of hospitalisation for patients of primary health care teams were lower where individual team members were most satisfied with their working relationships (Sommers, Marton, Barbaccia and Randolph, 2000). US hospitals that attracted and retained good nurses through effective people management demonstrated lower patient mortality rates (Aiken, Havens and Sloane, 2000; Upenieks, 2003). Kramer and Schmalenberg (2004) suggested that nurses employed at these “Magnet” hospitals experienced higher levels of empowerment and job satisfaction due to the greater accessibility of nurse leaders, better support for autonomous decision-making by clinical nurse leaders and greater access to the information and resources required for empowerment.

Designing work systems that enable employees to use their skills and motivation fully benefits both employees and organisations alike (Delery and Doty, 1997). Participative work practices such as teamwork, which enhance employee motivation and quality of working life, play a particularly important role in reducing employee stress (Shortell, Zimmerman, Rousseau, Gillies, Wagner and Draper, 1994), enhancing job satisfaction and mental health, and improving retention (Borrill, Carlette, Carter, Dawson, Garrod, Rees, Richards, Shapiro and West, 2001).

2.5 The line manager: barrier reef or change entrepreneur?

A further body of research with clear consequences for the relationship between organisational practices and performance concerns the role and behaviour of line managers. The role of front-line managers is crucial to the effectiveness of HR practice because it is they who implement and bring it to life. Purcell, Kinnie, Hutchinson, Rayton and Swart (2003) found that the front-line manager is the most important factor in explaining variations in both job satisfaction and discretionary behaviour, and is one of the most important factors in building organisational commitment. Front-line managers can both permit and encourage people to be responsible for their own jobs, but they can also stifle employee performance through controlling or autocratic behaviour.

Research reveals many instances where line managers emerge as a “barrier reef” to organisational change (Exton and Totterdill, 2004). In this analysis, enlightened policies and approaches adopted at Board or senior management levels are dissipated by the inertia and resistance of middle and line managers who may have a strong psychological investment in the status quo. Lack of positive engagement with change can take several forms including explicit dissent, excessive focus on compliance with targets at the expense of embedding new ways of working in organisational practice, and occasionally even active sabotage. This is particularly evident where change embodies a commitment to active employee involvement, either in the process or as a sought outcome. In brief, sources of resistance to change may well be found amongst managers who feel that their status and authority are threatened by initiatives designed to empower employees.

Middle-management reluctance to engage staff effectively often reflects mixed messages and conflicting priorities from above, the need to deliver short-term business results, a lack of time and training, and a lack of incentives given to them for fulfilment of this additional work (Exton and Totterdill, 2009; Brewster and Holt Larsen, 2000; McGovern, 1999). Moreover, managers often feel particularly powerless in the face of resource constraints, considering that senior management

1. www.enterprise-for-health.org

was not sufficiently aware of resulting risks and consequences including the “knock-on effects” for other areas of practice such as recruitment and retention. In the words of one UK hospital manager there was no mechanism for evaluating “the costs of non-investment” (Box 1 below).

The academic literature identifies middle and line managers as among the potential impediments to a participative workplace. Marchington and Wilkinson (2000) suggest three sets of reasons why middle and line managers might be especially resistant. They do not believe in the principles of direct employee participation, “especially those schemes that are more far reaching”. Where they acknowledge value in the principle, they have concerns regarding its actual operation, and how it may conflict with commercial or customer-service requirements, and are concerned about their own future employment security and career prospects. Munro (2002) argues that middle management “obstructionism” was a relevant factor in her analysis of partnership working at a community health care organisation.

On the other hand when the design of change both engages and reassures line managers, unanticipated benefits in the form of entrepreneurial behaviour can emerge. “Policy entrepreneurs” (Summers, Raines and Prakash, 2005) are often line managers (though they may equally be union stewards or front line workers) who, having embraced the values of proposed change, find creative spaces between formal structures. Typically they engage employees at all levels, finding innovative solutions to the implementation of change, and enhancing their effectiveness and sustainability. Such entrepreneurial behaviour is associated with the alignment of three principal factors: board-level and senior management support for empowered or unconventional behaviour; sufficient slack or ambiguity in organisational regulation and procedures to allow for individual problem-solving and initiative; individual experience of work as empowering and developmental, promoting creative and entrepreneurial self-identities amongst a sufficient mass of individuals. Our recent research (Exton, 2008) has shown that small variations in

Box 1 Understanding the Barrier Reef

At a UK teaching hospital in the Midlands, a partnership-based steering group responsible for the implementation of an NHS-wide programme concerned with quality of working life decided that an “Inquiry” be established to report on why HR-related hospital policies were being implemented unevenly across the organisation. A group of managers from different functional areas met on four occasions to discuss obstacles to policy implementation, facilitated by one of this paper’s authors in his role as a Non-Executive Director and the other in her role as secretary of the hospital’s trade union consortium. The concealed intention had been to ensure the inclusion of managers from those parts of the organisation that were underperforming in HR policy implementation as well as those characterised by “good practice”. However, although the Inquiry’s discussions were often lively and insightful, many participants in the first meeting did not return, possibly because there may have been a degree of discomfort in the need to evaluate practice in their own areas of responsibility. This left a small but committed group, whose draft report was completed in June 2005. It concluded that middle managers:

- were overwhelmed by emails and paperwork with little differentiation between “priority” and “routine” communications;

- accepted the need to manage within rigid financial constraints but were given little indication of how to resolve conflicting objectives and to prioritise between competing demands on limited resources;
- often received too little information on the rationale for new policy initiatives (especially in relation to the business or clinical case for change) making it difficult to appreciate their importance;
- were rarely offered the opportunity to bring their knowledge and experience to the policy design process;
- were often poorly briefed by senior management on effective approaches to policy implementation;
- were risk-averse through fear of blame and poor performance ratings;
- lacked opportunities for peer support in discussing common problems, sharing successful practices and raising issues of shared concern with senior management;
- lacked, in at least some cases, the training and competence required to manage change successfully.

these factors at workplace level can produce very different outcomes even within a single corporate structure such as the UK's National Health Service.

2.6 Towards a conceptual model of participation and high performance

2.6.1 Introduction

Both the international evidence reviewed above and the headline findings from our own research suggest that participative forms of work organisation are clearly associated with improved performance and outcomes. Clearly, *the way in which work is organised* makes a very significant impact on the ability of employees to enhance performance – both in terms of traditional variables such as productivity and in terms of the rate of product, process and service innovation. It suggests that participative work practices are a fundamental aspect of effective management and governance systems, and are dependent on the behaviour of front-line staff, management and clinicians. It also suggests that representative partnership can create an organisational climate conducive to discretionary effort as well as the conditions within which participative work practices are likely to develop – although further research is certainly needed to elaborate this latter dimension in greater detail.

Above all, the research suggests that the greatest impact on performance is found where there is a *systemic* approach in which participative forms of work organisation, supportive HRM practices and representative partnership combine in ways that encourage employees at all levels to contribute their tacit knowledge and competencies to the full.

Representative partnership is understood to be effective principally when it stimulates and sustains direct employee involvement through participative forms of work organisation. In the hospital context, such organisational forms are likely to focus principally on, for example, multidisciplinary teamworking (Rafferty, Ball and Aiken, 2001; Borrill, West, Shapiro and Rees, 2000), participative approaches to learning from errors and risk assessment (Spencer and Walshe, 2006; Wilkinson, Rushmer and Davies, 2004), embedding continuous improvement in the day-to-day activities of front-line staff (Nembhard and Edmondson, 2006) and

high-involvement innovation (Adams, Bessant and Phelps, 2006). As we have seen there is also evidence that partnership itself may help to stimulate and sustain such forms of direct staff involvement (Batt and Applebaum, 1995; Guest and Peccei, 2001; IPA 2007; NCPP, 2008).

In short, current research provides ample reason to believe that the focus in *Towards 2016* on integrating direct and representative staff involvement within a mutually sustaining relationship (see Chapter 1) is soundly based in evidence. It also offers a compelling prospect: a virtuous circle in which social partners' search for harmonious industrial relations, clinicians' natural desire to enhance the quality of care received by their patients, and the aspirations of front-line staff for greater recognition and engagement of their knowledge, experience and creativity are mutually reinforced.

Yet the practical realisation of this joined-up vision is more elusive. While research evidence supports the proposition that specific types of participative practice can lead to positive patient or organisational outcomes, there is little research on the nature or effectiveness of whole system transformation in hospitals. The task is therefore to construct a systemic model from the fragments of evidence that are available.

2.6.2 Joining up the fragments: from Integrated Governance to Participative Governance

Arguably the key concept – the glue that holds the model together – is that of integrated governance. Integrated governance is acquiring an enhanced profile in Ireland and in many other parts of Europe as patients, politicians and other stakeholders demand increasing transparency and assurance about standards of patient care in public health services. Combining both clinical and corporate governance, it is a term used to describe the whole system of controls and assurances that provide accountability to stakeholders and ensure the delivery of cost effective outcomes relating to the quality of patient care and use of public resources. While governance remains embryonic in the Irish health services, the concept is strongly reflected in the HSE's 2009 *Service Plan* which seeks to:

Introduce a new integrated clinical and corporate governance structure to support the concept of integrated working practices and clinical networks

The different elements of sound governance are closely interlinked but typically include (to varying degrees in different countries) clinical effectiveness, the quality of patient experience, clinical and organisational risk, the capacity to deal effectively with complaints, the ability to learn from mistakes, continuous improvement and innovation, optimal resource allocation, financial probity, and accountability to the public, employees, funders and other stakeholders.

International practice suggests that performance management and organisational innovation constitute the two main pillars of governance:

Performance measurement is a key tool of governance, enabling standards and targets to be agreed with stakeholders and areas of risk to be monitored. It also enables progress towards the achievement of targets to be measured through data collection relating to appropriate indicators. Performance against indicators will typically be validated by audit, led by internal or external quality assurance bodies. The positive link between performance monitoring and improved organisational performance has been well documented (Scanlon, Darby, Rolph and Doty, 2001; Julian, 2002). Performance monitoring has also been shown to enhance organisational effectiveness, ensure accountability, raise management standards and foster collaboration within the health sector (Leggat, Narine, Lemieux-Charles, Barnsley, Baker, Sicotte, Champagne and Boilodeau, 1998).

Performance indicators in the health care context may cover a broad range of practice including, for example, clinical outcomes, hospital acquired infections, financial management and quality of working life. Experience suggests the need to consider the detailed cost of procedures and other financial indicators, service indicators focusing on satisfaction with service delivery and clinical indicators evaluating the processes of care and resulting patient outcomes (Ballard, 2003).

In some countries performance measurement may be externally imposed by government, social insurance entities or regulatory bodies. Even in countries where external regulation is limited, internal performance measurement and audit will play a key role in ensuring effective governance. The need for performance data is particularly

evident in assessing the impact of public health interventions. Heller and Page (2002) suggest that a major impact could result from the routine incorporation of data collection within health practice, using well designed standardised forms to gather information on patient outcomes in medical practices and hospitals. However, routine data, essential for service planning, are often variable in quality, completeness and availability; policy makers may fail to act on evidence that is not clearly communicated, limiting its potential value. Heller and Page also found that there are many examples in the health sector where performance data is collected but never used. This, they argue, is usually a function of a lack of precision in the reasons for data collection, poor data quality, or difficulties and delays in accessing data.

As with many other OECD countries, the focus to date in Ireland has been on performance reporting, rather than managing for performance. (OECD, 2008).

The second pillar of governance, *organisational innovation*, concerns the creation of working practices, procedures and cultures required to ensure sound governance. Central to this pillar is the provision of a working environment in which staff at all levels can develop and utilise their full range of competencies and creative potential to achieve continuous improvements in patient care and organisational effectiveness. In summary, key practices associated with such a working environment are likely to include

- partnership structures that enable trade union and workforce representatives to contribute front-line knowledge and experience to strategic objective setting, service planning and performance monitoring;
- the active involvement of staff at all levels in the identification and management of risk to patients or the organisation;
- systems and practices that encourage the full reporting of untoward incidents by staff at all levels, and the assimilation of resulting lessons throughout the organisation;
- an effective whistleblowing policy that enables any member of staff to report genuine concerns without fear of retribution (Yamey, 2000);

- a commitment to continuous learning and improvement, including the provision of time and resources to support innovation by all staff;
- multidisciplinary teamworking, empowering staff at all levels and from different professions to contribute to the diagnosis, planning and delivery of patient care through informed discussion rather than status.

For health care policy-makers and managers, the real difficulty lies in securing an appropriate balance between performance management and organisational innovation. Performance measurement per se does not automatically lead to high standards or improvement. Rather, as experience from the UK suggests, it can distort management effort by ensuring compliance with performance monitoring and audit requirements at the expense of real, patient-focused innovation (Wanless, 2004). Hunter (2003) argues that delivering on targets distorts priorities because practitioners manage to target what can be measured rather than what might be more important; they encourage “gaming” since managers live in a blame culture and cannot be seen to fail; and they induce a silo mentality as the targets, even where they endeavour to be cross-cutting, are performance-managed according to vertically hierarchical accountability. In addition, performance data have been criticised for lack of robustness and systematic auditing, and for focusing on what is easily measurable (Bevan and Hood, 2006). In short, regulation can too easily lead to quality assurance without quality improvement. An appropriate relationship between performance management and organisational innovation is therefore one in which the delivery of targets is achieved as the by-product of wider and sustained improvements in service quality and governance.

Governance in the sense described here needs to be shared throughout the workforce and should become a key element in individual job design and task descriptions. In return, employees at all levels gain greater recognition and respect, enhanced ability to exert influence and, in consequence, improved quality of working life. Trade unions also gain a higher profile and a new role as knowledgeable participants in governance and innovation processes. A partnership-based approach

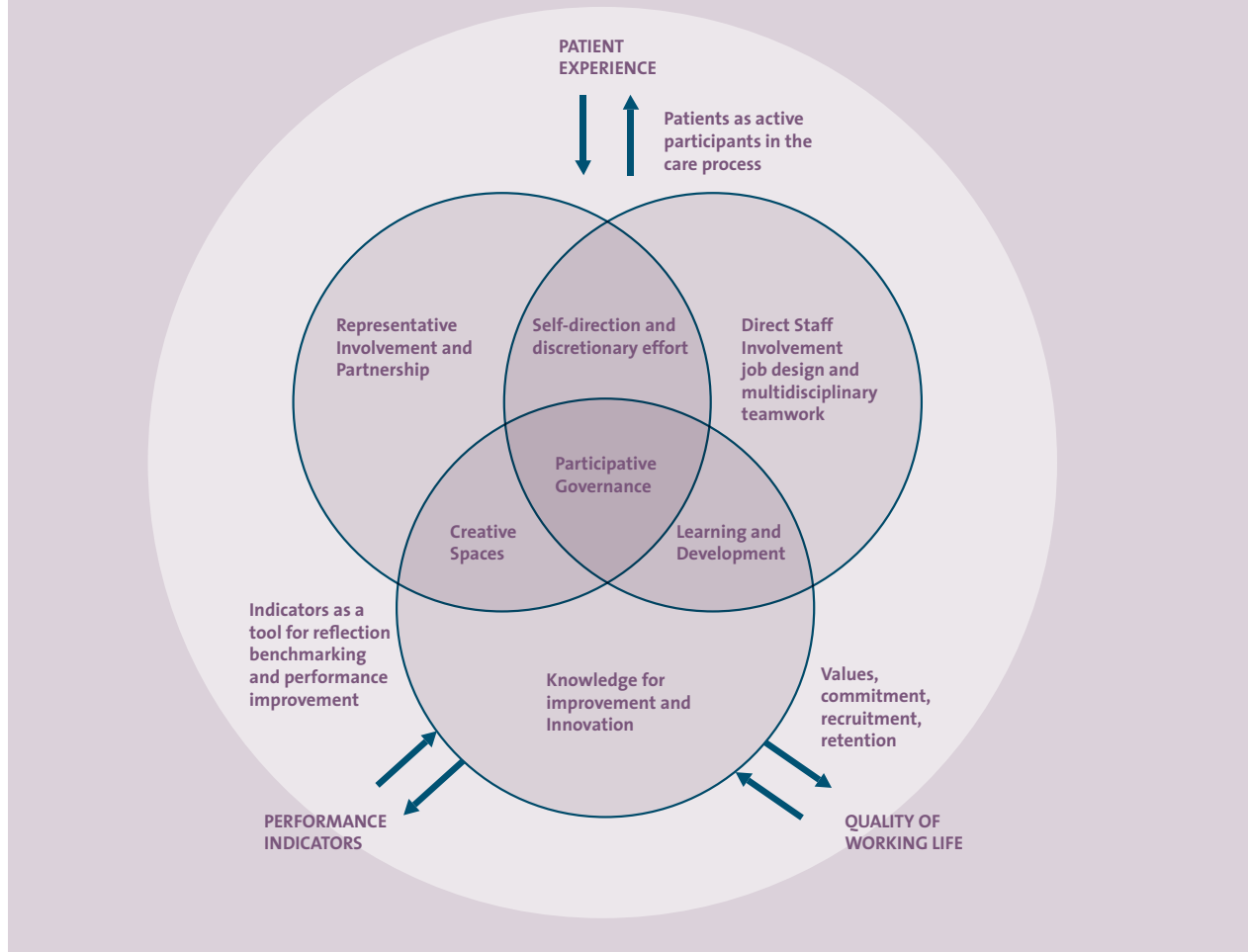
to governance in which health service organisations do indeed manage to achieve external targets as a “by-product” of their inherent organisational competence and values might be characterised as the “high road”. The defining characteristics of the high road lie in the creation of organisational spaces and the liberation of the tacit knowledge, experience and talent of the entire workforce in ways that achieve a dynamic balance between service and process innovations (Moss and Totterdill, 2003). Crucially, the high road seeks convergence between cost-effectiveness, patient-centred care and job satisfaction, showing that care can be made more effective, safer, faster, patient-friendly, efficient and professionally satisfying.

In contrast, the “low road” is driven by cost, performance measurement, punishment and reward. For hospital staff it frequently results in deterioration in quality of working life (Ball, Curtis and Kirkham, 2001; Meadows, Levenson and Baeza, 2000), which remedial HR initiatives are incapable of redressing. Apart from increasing problems with recruitment and retention, the failure to involve staff at all levels of service development and provision represents a lost opportunity for service innovation and quality improvement. This is certainly recognised in high-level policy discourse: latterly in the UK, for example, the Darzi Report (2008) proposes to “empower front-line staff to lead change that improves quality of care for patients”.

Yet the question remains of how to involve and empower staff in ways that lead to enhanced quality of patient care. Den Hertog (2009) suggests that there appears to be no lack of new vision and ideas, however the basic problem of health care innovation seems to involve the implementation and diffusion and phases.

Effective governance relies on the *systemic* alignment of organisational structures and practices with the goal of providing high quality and cost effective patient-centred care. Such an approach, which we have called *Participative Governance*, explicitly seeks to remove the “walls and ceilings” (den Hertog, 2009) which separate partnership structures from clinical and corporate governance. Participative governance emphasises the mutually reinforcing effects of strategic partnership-based dialogue and participative

Figure 1 A Conceptual Model of Participative Governance



forms of work organisation, including effective partnership between senior management and clinicians, trade unions and employees, widespread staff involvement in risk management, quality improvement and service innovation, the widespread use multidisciplinary teamworking and the erosion of professional demarcations (Moss and Totterdill, 2003).

2.6.3 Partnership

Workplace partnership is generally thought of in terms of representative structures and processes involving management, trade unions and staff in open dialogue about opportunities and challenges facing the organisation, enabling strategic decisions to benefit from a wide range of knowledge and experience. However, partnership can also act as the guardian of *direct* involvement by front-line staff through the promotion and protection

of participative work practices. Partnership Committees can play several complementary roles including but not limited to traditional industrial relations (IR), for example:

- sustaining non-adversarial IR;
- facilitating major change through the avoidance of IR issues, active participation in design and implementation, and the creation of a positive attitude to change amongst the workforce;
- instigating proactive strategic HRM policies to address issues such as equality and diversity, bullying and harassment, and attendance management;
- creating and disseminating practices throughout the hospital conducive to continuous quality improvement and clinical governance;

building a “partnership climate” throughout the organisation, including a participative management style, a “no-blame” culture, high levels of risk/incident reporting and ability of all staff to contribute ideas for improvement. Thus partnership appears to operate at different levels. Formally it provides a mechanism that can minimise adversarial conflict, creating a climate conducive to innovation and change. Partnership maturity is reached when committees formulate and debate options based on open information-sharing rather than simply responding to proposals or decisions (Farnham, Horton and White, 2003).

The real potential impact of partnership on hospital performance, however, lies beyond the operation of formal structures; rather it is to be found in its ability to stimulate high levels of direct staff involvement and participation. Partnership committees can play a key role in disseminating “partnership behaviours” amongst line managers and clinicians, thereby enabling front-line staff to make full use of their knowledge and experience and encouraging “discretionary effort.” This potential synergy between representative and direct involvement has been clearly articulated in the context of health-sector partnership in Ireland. Examples include the following:

- The Health Services Partnership Agreement, which articulates as a key principle the importance of “Opportunities for staff and their representatives to be involved in and contribute to meeting the organizational challenges, the development of strategies and service planning.”
- The Action Plan for People Management, which states that it will: “place particular emphasis on the development of organization-based projects on which all staff can work together to be part of the change process. Partnership is deemed the most appropriate vehicle for the implementation of the new change agenda
- The HSE Change Management Guide states that “The principles of the HSE Transformation Programme 2007-2010 and the Health Services Partnership Agreement... are core reference points for the approach to change outlined in this Users’ Guide. A strong value is placed on

upon the process of listening to and acting upon the grounded sense of reality that emerges from meaningful participation and involvement of service users, staff and other key stakeholders”.

- An extract from the Terms of Reference of the HSE’s PCCC Transformation Working Group (a partnership-based group in which management, a wide range of staff and trade unions worked together to establish more than 100 operational Primary Care Teams) illustrates the synergy between representative partnership and direct staff involvement:

“[PCCC Working Group]...to work together to achieve the shared vision of a reformed PCCC service that is person centred, integrated and team based. (T)he partnership approach has a key role to play in bringing about this vision, with a sustainable, high quality outcome, based in the needs and interests of the public, all service users, and also meeting the needs and interests of management, staff and unions in a manner that is transformational and robust and is fair and equitable to all parties.”

Chapter 5 shows that while examples of direct staff involvement directly attributable to Partnership Committees can be found in the acute hospital sector, they are sporadic rather than systemic. As such it is unsurprising that our statistical analysis finds no relationship between the strength of partnership practices and levels of direct staff involvement. In contrast to the sporadic evidence from Irish hospitals, Exton and Totterdill (2004) report a case study from the UK, where a partnership agreement between management and trade unions at Nottingham City Hospital explicitly recognised the role of the Partnership Forum in promoting the direct involvement of staff in quality improvement, clinical governance and patient participation. On a larger scale the US healthcare provider Kaiser Permanente has reached an agreement with its trade union coalition which recognises a common commitment to the improvement of patient care through participative ways of working (Kaiser Permanente Partnership Agreement, 2005).

2.6.4 Job design and teamworking

The content of individual jobs and the organisation of work are the essential building blocks of a participative approach to governance and quality improvement, creating the potential for clinical staff at all levels to use their full range of professional knowledge and skills, blurring disciplinary boundaries in order to provide an integrated approach to patient care. It is recognised that the quality and safety of the care delivered by clinicians depend substantially on the performance capability of the organisational systems in which they work. While individual clinician competence remains important, systems redesign is seen as critical for improving care processes to prevent errors from occurring (Institute of Medicine, 2003). Crucially, these approaches include the development of team-based approaches to care delivery (Institute of Medicine, 2000).

Studies in health care consistently support the value of ways of working in which education and communication systems, people management and reward systems, and culture are all geared towards interdisciplinary working (Michie and West, 2004). The characteristics of these successful teams were clear: shared objectives between professional groups, role clarity, participation, support for innovation, emphasis on quality of patient care, and support for each other. Borrill, West, Shapiro and Rees (2000) found that hospitals that promoted teamwork were more effective, more innovative, had lower staff stress levels and delivered higher quality health care.

Specialisms such as emergency care, for example, particularly lend themselves to the team approach. In the UK the National Confidential Enquiry into Perioperative Deaths (2002) concluded that more than 70% of the patients who died were emergency admissions not fully assessed for other medical problems before intervention, and that a team approach is necessary to deal with urgent situations effectively (Saltman, O'Dea, Farmer, Veitch, Rosen and Kidd, 2007).

When front-line employees collaborate, they openly share task-related knowledge and questions, which results in more informed patient care decisions (Clemmer, Spuhler, Oniki and Horn, 1999). Similarly, Nembhard, Tucker, Horbar and Carpenter (2007)

found that collaboration enables multidisciplinary teams to respond effectively to the ambiguous information prevalent in health care. Through sharing of tacit knowledge, providers increase their capacity to interpret changing patient care conditions and act directly upon this information, thus improving patient outcomes (Preuss, 2003; West, Guthrie, Dawson, Borrill and Carter, 2006).

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 that 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 opportunity to contribute to open dialogue in which “the force of the better argument prevails” unconstrained by hierarchies, demarcations and privileges (Gustavsen, 1992).

The dominant position of the medical profession among the health professions (Brown and Crawford, 2003; Currie and Suhomlinova, 2006) means that, in practice, “professionally led” is often a euphemism for “medically led”:

Medicine remains an occupation with legislative and ideological backing for its claimed mandate to define what constitutes knowledge and expertise in clinical work performance” (Dege-ling and Maxwell, 2004).

Doctors often claim that their specific legal liability for the welfare of patients inhibits their ability to share the management and delivery of care with other professional groups. However this would appear to conflate different issues. Case law and inquiry findings in a number of countries appear to suggest that adequate consultation with other disciplines involved with the patient is a prerequisite for safe care (see for example Walshe and Shortell, 2004). Moreover, there is no evidence from multidisciplinary healthcare teams that medical leadership is undermined through the incorporation of knowledge and experience from other disciplines into the design of clinical practice (Xiao, Seagull, Faraj and MacKenzie, 2003). In such cases the consultant retains the overview

and facilitates the creation of a coherent synergy between the different specialisms (see for example the paediatric renal case study below).

Other healthcare professionals, such as nurses and Allied Health Professionals (AHPs), believe that they, as well as doctors, have the ability and responsibility to define clinical quality, and resent being marginalised when new initiatives are discussed (Wilkinson, Rushmer and Davies, 2004). "Turf battles" around quality between clinicians from different professions are common (Hart, 1996; McNulty, 2003; Weiner, Alexander, Baker, Shortell and Becker, 2006). Within hospitals in several European countries, 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 hospitals. Arguably the adoption of team structures in health care enables management control to disempower entrenched elites, changing the dynamic between professions such as doctors, physiotherapists and nurses (Saltman, O'Dea, Farmer, Veitch, Rosen and Kidd, 2007). The benefits for patients are increasingly transparent:

Creating a culture of safety involves breaking down barriers and levelling an often uneven playing field so that executives, administrators, clinicians, and patients and their families treat each other as partners on one team – a team that has mutual respect for and trust in one another – with the goal of ensuring patient satisfaction. (Mercurio, 2007:212).

Teamworking should not be restricted to the point of service delivery (a wider conclusion drawn from the study by Totterdill, Dhondt and Milsome, 2002) but needs to become a defining characteristic of all aspects of work, both routine and developmental, at all levels of the organisation. For example if, as the Institute of Medicine (2003) asserts, patient safety is indistinguishable from the delivery of quality care, then formally organised quality improvement teams should constitute an effective systems-based approach for tackling many patient safety problems (Weiner, Shortell and Alexander, 1997). 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. The boundaries of teams may become more fluid as organisational structures evolve responsively around patient needs, rather than reflecting traditional demarcations. Characterised by dialogue and trust, extended teamworking offers a positive trajectory for quality of working life, offering scope for personal development through self-direction, building wider relationships and participation in both operational and strategic innovation.

Building on the principle of extended teamworking practice, the concept of Clinical Microsystems (CMS) is increasingly used across Europe and the US as a system-level improvement strategy (Golton and Wilcock, 2005). CMS appears to present health-sector organisations with a flexible framework for supporting teams in leading purposeful quality improvement work aligned to corporate priorities (Golton and Wilcock, 2005). Based on a US study, common features of high-performing microsystems include highly effective inter-professional teams, an explicit focus on quality, which meets patient and staff needs, and collaboration and communication to enable the flow of information necessary to achieve these objectives (Varkey, Karlapudi and Hensrud, 2008). As functioning units microsystems should have clinical and business aims, linked processes, a shared information and technology environment and should produce services and care that can be measured as performance outcomes. These systems evolve over time and are (often) embedded in larger systems or organisations (Foster, Johnson, Nelson and Batalden, 2007).

2.6.5 Knowledge sharing as a resource for quality improvement and innovation

Robust governance places knowledge distribution, learning and reflexivity close to the heart of the work process at all levels of the hospital. Likewise effective and sustainable improvement and innovation depend crucially on harnessing the knowledge and experience of staff at all levels (Parker, Kirchner, Bonner, Fickel, Ritchie, Simons and Yano, 2009). Quality improvement and innovation depend on the ability to capture learning and experience from practice, distribute

Box 2 Teamworking in a Paediatric Renal Setting

At a clinical level, the distinction between team-based and non team-based approaches to patient care was examined in a study of five paediatric renal units in different European countries (Totterdill, 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 judgement. 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 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.

From Totterdill (1995)

knowledge as an organisation-wide resource, and create spaces for reflection (Wilkinson, Rushmer and Davies, 2004).

Policy makers, boards, executive management teams and sometimes Partnership Committees may enjoy a sophisticated level of knowledge and insight into the threats and opportunities that face the hospital, enabling them to make informed strategic choices. However, these choices often have profound implications for day-to-day working practices, even though the strategic decision-makers' knowledge of "what works" on the ground is likely to be limited. The tendency from the corporate level is often to see the organisation as a "black box" which is meant to deliver required outputs in response to directives from the top. Delivery failures are seen as dysfunctional rather than as a potential opportunity for learning and reflection (Wilkinson, Rushmer and Davies, 2004). Front-line staff, in contrast, tend to know that management instructions need to be interpreted and adapted in order to make them work in a practical way. This process of interpretation and adaptation is grounded in the tacit knowledge that employees gain through experience, often learnt through extensive trial and error and the sharing of ideas with peers. Even in the most strictly regulated work settings, the use of tacit knowledge is rarely absent as a means of improving practice or solving unexpected problems (Preuss, 2003; West, Guthrie, Dawson, Borrill and Carter, 2006).

Knowledge-sharing can be seriously impeded in a hospital context by professional demarcations and organisational divisions, which constrain open dialogue, questioning and interdisciplinary collaboration. In the UK and Ireland, landmark examples can be found in the Kennedy Report (2001) into children's heart surgery at the Bristol Royal Infirmary, the Toft (2001) Report into a death at the Queen's Medical Centre, Nottingham and the Harding Clark (2006) Report into the inappropriate use of surgical treatment at the Lourdes Hospital, Drogheda.

However, these failures often reveal longstanding problems that have been present, and known about, for years or even decades before they were brought to light. The most important barrier to disclosure

and discovery tends to be the endemic culture of secrecy and protectionism in health care facilities in many countries:

There is a pervasive 'club culture' in which at least some doctors and other health care professionals prioritize their own self-interest above the interests of patients, and some health care organization leaders act defensively to protect the institution rather than its patients. (Walshe and Shortell, 2004).

Institutions and clinical services where major failures have been recorded worldwide were often accredited by quality assurance programs and approved by governmental licensing authorities. Despite this, Walshe and Shortell (2004) found that they often lacked fundamental management systems for quality review, incident reporting and performance management, or that those systems had been bypassed with ease. They frequently showed little collaboration between managers and clinicians and a lack of coherent clinical leadership.

In addition to the most obvious and frequently mentioned barriers of lack of time and resources, healthcare professionals describe a wide range of barriers to quality assurance and quality improvement. Many of the barriers identified arise from the well-documented problems of working effectively between and across health professions (West, Barron, Dowsett and Newton, 1999; McNulty 2003; Caldwell and Atwal 2005; Dopson and Fitzgerald, 2005; Ferlie, Fitzgerald, Wood and Hawkins, 2005), such as poor relationships between clinicians and managers (for example Johnston, Crombie, Davies, Alder and Millard, 2000). Lack of clear role definition also affects communication between clinicians and audit staff, and between primary and secondary care staff (Roberts, Lowe, Barnes and Pearson, 2004). Davies, Powell and Rushmer (2007) suggest that while more time and more resources may be necessary or helpful, they are unlikely to be sufficient to overcome the substantial barriers to engaging clinicians actively in successful quality improvement.

Different health professional groups refer to diverse barriers reflecting their respective roles and positions in health organisations. AHPs and therapists refer to the barriers of high workload,

insufficient managerial support and “inadequate skills” to access and implement evidence-based practice (Welch, 2002). Nurses describe how they find it difficult to implement evidence-based practice because of factors such as staff shortages, perceived lack of authority to bring about change, reliance on active consultant support, and difficulties in reconciling research evidence with their own beliefs, experience and the practicalities of providing care (Rycroft–Malone, Harvey, Seers, Kitson, McCormack and Titchen, 2004). Healthcare managers (including clinicians who undertake managerial roles) cite a wide range of barriers to quality improvement relating to organisational factors, their own role and the attitudes and positions of other healthcare professionals (Davies, Powell and Rushmer, 2007).

Barriers identified by doctors (Johnston, Crombie, Davies, Alder and Millard, 2000) include intangible factors (for example “clinical aspects of care too difficult to audit”), uncertainty about how to take forward the results of audit, practical factors (incompatible computer systems; not enough secretarial time), psychological factors (fear of being undermined by assessment and criticism), skills factors (lack of IT skills), inter-professional issues (“language barriers”), and competing demands (for example from contractual changes and increased paperwork). Historically doctors have been accustomed to professional self-regulation as the dominant mode of quality assurance and have been prepared to comply with the requirements of these mechanisms. However, increased public concerns over arrangements for regulating the professions and an increased focus of attention on quality assurance mechanisms (Sutherland and Leatherman, 2006) have weakened the traditional status quo. Many doctors have viewed the changes as a significant threat to the closely guarded concept of professional autonomy and have shown suspicion and hostility towards externally regulated quality assurance activities (Davies, Powell and Rushmer, 2007).

Moreover, the motivation of employees to work on quality improvement is dependent on the nature of the exchange relationship they have with the employing organisation, that is, on the psychological contract between the organisation and the employee. Schalk and van Dijk (2005) argue

that this relationship is often greatly disturbed during the organisational and policy changes that have become regular features of working life in European health services.

Attitudes towards quality and safety are certainly influenced by the overall work environment in hospitals. Patient safety can be enhanced by the impact of team training and supportive management on organisational culture. A culture of blame, in which errors are seen as personal failures, should ideally be replaced by a culture in which errors are seen as opportunities to improve the system (Bognár, Barach, Johnson, Duncan, Birnbach, Woods, Holl and Bacha, 2008). Although research has not yet demonstrated a clear link between reporting, intervention and improved outcomes, it can reasonably be assumed that a better understanding of errors and their causes will lead to a reduction in their frequency. In particular, error reports by physicians represent an important source of intelligence from the front-line of care. However, Kaldjian, Jones, Wu, Forman–Hoffman, Levi and Rosenthal (2008) found that “a substantial number of physicians are not reporting errors” with significant implications for efforts to improve patient safety and the quality of care. Reasons given include a lack of knowledge on how to report errors and concerns about legal liability. They were even less likely to report near misses, representing an underused resource for learning and improvement, but were more likely to report errors if they knew they would receive subsequent feedback.

Questions about legal liability regularly arise in discussions about error reporting because of concerns that information may be discoverable in malpractice proceedings. In response to the apparent gap between attitude and practice among doctors regarding medical errors, it has been suggested that reporting systems should be made confidential since fears of legal liability clearly inhibit compliance. In the US there have been calls for legislation to protect physicians under the umbrella of peer review by making the reporting and discussion of errors privileged. Such legislation could reassure wary physicians that their conscientious efforts to improve the quality of health care will not be used against them (Kaldjian, Jones, Barry, Forman–Hoffman, Benjamin and Rosenthal, 2008).

In both health and social care, many inquiries into untoward incidents produce similar findings despite addressing cases that appear to have little in common. Walshe and Higgins (2002) found common themes from their study of thirty inquiries into serious incidents in the UK National Health Service. These included disempowerment of staff and patients – those who might have raised concerns were discouraged or prevented from doing so. Professional isolation, inhibiting the transfer of innovation, and hindering peer review and constructive critical exchange were also cited, along with inadequate leadership, and system and process failure. Other factors include poor communication both within the healthcare organisation and with patients, resulting in a systemic failure to identify problems.

The involvement of front-line staff in the assessment of risk, and an approach to incident reporting and subsequent learning which is clinically relevant and free from the fear of retribution, represent important ways of capturing the day-to-day experience and tacit knowledge of front-line staff as a resource for improvement and innovation. Reflecting guidance in the HSE's *Quality and Risk Management Standard* (HSE, 2007), which argues that “quality and risk management is everybody’s business”, clinical staff must be able to report concerns about quality at the earliest opportunity and be aware that such reporting is valued by the organisation. Walshe and Shortell (2004) describe how these systems must be embedded at the clinical front line, for example, through safety reports during clinical rounds, flagging error and safety issues as patient care shifts change, holding regular multidisciplinary team safety meetings, and giving immediate feedback to clinical staff on errors and safety reports. They argue that organisations should also have explicit, properly resourced internal systems for reporting, investigating and triaging quality concerns to ensure that serious problems get rapid, high-level attention. This includes an effective whistle-blowing policy, which enables any member of staff to report genuine concerns without fear of retribution (Yamey, 2000). Moreover, there should be a clear policy on the circumstances in which external agencies need to be notified of a problem, or called in to advise or investigate.

Leadership and teamwork are fundamental in devising standards and systems that respond to the reporting of errors and their open disclosure to patients. Those directly managing clinical work need to play a pivotal role in re-orientating the expectations and practices of units, in particular those of senior medical clinicians. This role is only fully realised when clinical managers are skilled and empowered to interpret policy, connect people and systems, enact new practices and evaluate progress. It is clinical managers who span the organisational boundaries within and between horizontal and vertical teams. Consequently they are most likely to shape the rules, norms and values in the wider environment within which clinicians work. Innovations, like open disclosure of errors to patients, can be put at risk without full deployment of this organising capability (Sorensen, Iedema, Piper, Manias, Williams and Tuckett, 2008). Senior managers’ personal participation in front-line improvement teams may in contrast be less important than their leadership in creating an organisational culture conducive to quality, as well as their willingness to put in place the organisational supports necessary for reducing error and improving safety (Weiner, Shortell and Alexander, 1997).

Beyond this, good organisations, including hospitals, embed a set of reflexive mechanisms within the daily working life of staff to enable continuous learning and improvement (Boud, Cressey and Docherty; 2005). Reflexivity focuses on the need to bring the thinking employee’s tacit and explicit knowledge, their experience and their creativity into the centre of work practices. The most common organisational spaces to support reflexivity are forums that provide legitimacy for reflection and the formal opportunity for a collective or group to meet and “discuss things”. These may include the types of multidisciplinary clinical or service team meetings discussed above, specifically where time is set aside from day-to-day casework in order to learn from recent experiences and anticipate immediate challenges. Continuous improvement groups and high involvement task groups represent other organisational forms (Edmondson, 2000; Bate and Robert, 2002).

Evidence suggests that, given the pressures of front-line care and service demands, successful implementation of quality improvement and service innovation is unlikely to occur unless health organisations are willing to allocate time for front-line staff members to participate in quality initiatives. Parker et al (2009) suggest that for this to occur:

those participating in a particular quality improvement effort not only must be permitted time off for meetings but must also see a reduction in their clinical duties so they can attend such meetings without penalty. In short, health care organizations must pay providers not only to see patients but also for working toward improving the care that those patients receive.

The physical design of the workplace is also important, supporting serendipitous interaction between the members of multidisciplinary teams as well as providing spaces for collective reflection. Apart from formal meeting rooms these include the “free areas” where coffee and meal breaks are held, and places where people can gather informally. In the UK the design of some clinical departments includes wide corridor areas with informal seating, specifically designed to support impromptu discussions about individual cases between different professionals.

Inter-organisational learning is also an important dimension of knowledge-sharing, which leads to improvement and innovation. For example the UK’s National Health Service established a Cancer Services Collaborative network in 1999 to improve the system of care delivery for patients with suspected or diagnosed cancer. It explores system redesign initiatives through patient pathway development, implementation and monitoring to improve access to services, reduce delays and improve continuity and co-ordination of care. Bate and Robert (2002) conclude that improvement collaboratives are based on many of the concepts of knowledge-management (for example, cross-boundary knowledge transfer and communal exchange of knowledge), but argue that their impact could be strengthened if these concepts were elaborated further. In particular, they propose a more organic model of collaboratives, with less emphasis on rules, regulations and reporting

relationships, and a greater focus on people processes. In practice this would involve a greater emphasis on sharing tacit knowledge (“know-how”) alongside explicit knowledge (“know-what”); the creation, as well as the application, of knowledge; the development of more effective networks; and the establishment of communities of practice, as opposed to time-limited project teams.

Information technology offers further important opportunities to improve patient safety and to contribute to better and continuous improvement of quality. Technical learning mechanisms based on the use of information and communication technology are giving rise to virtual communities, which are increasingly important for healthcare professionals (Shine 2002). The elimination of written clinical notes is also an achievable objective with existing technologies, and the advent of electronic medical records and electronic databases are transforming organisations’ ability to co-ordinate, distribute and make use of data (Heller and Page, 2002). As information technology continues to develop in the health sector, the integration of both clinical and financial data should provide the foundation on which quality improvement practices can be developed, enabling teams to study and improve patient care processes systematically (Weiner, Alexander, Baker, Shortell and Becker, 2006). This, of course, provides a further driver towards the types of multidisciplinary teamworking described in the previous section:

These developments require medical educators and health professionals to move from a 20th-century paradigm of the physician who was in solo practice, held autonomy as a central value, prided himself or herself upon continuous learning and the acquisition of new knowledge, and laid claim to infallibility when confronting patients and colleagues. The 21st-century paradigm is that of physicians who understand teamwork and systems of care in which they can provide leadership (Shine, 2002).

2.7 Integrating partnership, teamworking and knowledge: towards an operational model of Participative Governance

The outline model presented above shows that representative partnership and participative forms of work organisation, such as multidisciplinary teamworking and knowledge-sharing, combine to form the principal, mutually reinforcing dimensions of the high-road hospital. (IPC, 1999; Sharpe and Totterdill, 1999). Involving employees in both design and implementation activities can help to ensure "ownership" of the process and alleviate some of the problems of inertia and innovation decay seen in many projects. In this respect, partnership is not viewed as another managerial fad for coercing employees to endorse management strategy, but as a framework for animating and driving innovation.

Partnership thrives when it is supported by an engaged and empowered workforce. Academic critics of partnership point to studies that show a divide between employee or trade union representatives on partnership forums and workers at the front-line (Heaton, Mason and Morgan, 2000). Indeed, the position of representatives can be fraught with contradiction where front-line employees do not enjoy opportunities for productive reflection and dialogue in their working lives. In contrast, direct staff involvement, where it exists, can generate insight and understanding in ways that actively inform representative partnership dialogue. Partnership structures can provide the means of gathering and assimilating the day-to-day experiences of empowered teams, identifying both success factors and the obstacles and blockages to patient care that require intervention at corporate level.

On the other hand, formal partnership structures can animate and safeguard the empowerment of front-line employees through participative forms of work organisation (Munro, 2002). Each of the approaches to participative work organisation and staff involvement discussed above needs to be nurtured and protected in hospitals, especially the right and obligation of front-line staff to take part in multidisciplinary working, incident reporting, risk assessment, continuous improvement and shared learning.

Research and experience abound with failed attempts to empower front-line staff in the absence of a wider partnership culture in the organisation (Tailby, Richardson, Stewart, Danford and Upchurch, 2004). Empowerment threatens traditional ways of managing, from the top of the organisation to the front-line supervisor, and organisations develop antibodies to protect their established order against infection from new and disruptive practices. Managers accustomed to playing a policing role feel threatened by empowerment and can consciously or unconsciously promote innovation decay and the erosion of real teamworking. Moreover, in the absence of proactive and supportive trade union representation, teams in the UK health service were found to develop defensive positions. These were manifested in work group norms and culture, which conflicted with those of the organisation and the union (Heaton, Mason and Morgan, 2000). In short, Partnership Committees need to monitor and protect the empowerment of front-line staff, involving strong lines of communication and the authority to enforce partnership values.

There has been an international movement away from undertaking discrete improvement projects towards developing organisation-wide improvement strategies in healthcare. Increasingly, organisations are setting ambitious and wide ranging goals at a corporate level, setting performance measures and aligning the work of teams with corporate goals to deliver focused, measurable improvements in services for patients (Bevan, 2005). These organisation-wide or system-level improvement strategies focus on providing strategic co-ordination and purposeful direction to improvement work at an organisational level (Bate, Bevan and Robert, 2004). The systemic nature of most clinical governance problems implies that quality improvement initiatives are only likely to be effective when they are implemented across multiple settings, disciplines and departments. There is little or no improvement if quality projects work at cross-purposes through poor co-ordination, inappropriate sequencing or a lack of synergy which spreads resources too thinly (Weiner, Alexander, Baker, Shortell and Becker, 2006).

However, quality improvement implementation is demanding on individuals and organisations. It requires sustained leadership, extensive training and support, robust measurement and data systems, realigned incentives and human resources practices, and cultural receptivity to change (<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1702526> \l "b4o" Institute of Medicine, 2001). In addition, the systemic nature of many quality problems implies that the effectiveness of an initiative may depend on its implementation across many conditions, disciplines and departments. This too often proves challenging (<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1702526> \l "b55" Meyer, Becker and Vandenberghe, 2004). If successful, though, implementing quality improvement initiatives in this manner may create a durable infrastructure for enhancing quality organisation-wide (Weiner, Alexander, Baker, Shortell and Becker, 2006).

In summary, the conceptual model outlined in this section stresses the interdependence between the three arenas of partnership, participative forms of work organisation such as multidisciplinary teamworking, and mechanisms that harness the full knowledge resources of the entire workforce towards quality improvement and innovation. We would characterise this as a stakeholder model, centred on the right and obligation of actors to work towards win-win outcomes at the levels of strategic policy, organisational change and day-to-day operations. The UK's CBI–TUC Productivity Challenge Best Practice Working Group summarises the synergy succinctly:

Involving individual employees or teams in decisions that affect the day to day organisation of their work helps create a culture of autonomy and responsibility. And systems for encouraging employee feedback and suggestions are key to innovation and building commitment to continuous improvement.

Collective voice is important in building a climate of trust where individual employees are confident that their contribution will be valued. Equally valuable is its role in helping to identify shared objectives and resolve conflict. The involvement of employees' representatives can create the sense of mutuality that is essential for the sustainability of new working practices – the belief that both the employer and workers are reaping real benefits from improvements in work organisation (CBI–TUC, 2001).

The focus on direct involvement in this model can be distinguished from approaches that bypass trade unions and partnership structures. Managerialist models take a narrowly instrumental view of involvement, limiting its scope to that of a useful tool for harnessing employee knowledge or commitment to be deployed at management discretion. Such perspectives underestimate the extent of the trust-building required at organisational (and arguably at societal) level to secure and sustain employee engagement and to avoid conflict (Sisson, 2005).

Part B

Part B presents the detailed technical description of the research methodology, the survey findings that map out the nature of participative governance in the acute hospital system, and a statistical exploration of the association between participative governance and outcome measures including patient care, hospital efficiency and staff well-being.

Chapter 3

Participative Governance Systems and Management Practices: Evidence from the Survey

3.1 Introduction

This chapter presents the findings from our survey, the most in-depth survey ever conducted in Ireland's acute hospital system on workplace governance and management systems and practices. The results shed useful light on the range and diversity of practices that are found in different hospitals across the country.

The survey was based on a multi-part questionnaire that captured data for approximately 400 variables. Each hospital appointed a response co-ordinator, whose role was to delegate the completion of the questionnaire sections to key respondents, including the Chief Executive/General Manager, Senior Medical Director/Clinical Director, Head of HR, Chairs of Partnership Committees/Local Forums, Department Clinical Director and Nursing Lead (for Obstetrics and Cancer departments). The hospital partnership committee, or equivalent, was asked to validate the entire set of responses prior to returning the data.

The questionnaire was structured into the following sections:

- Direct Staff Involvement in Service Improvement, including the level of involvement by front-line staff in service planning and service improvement in relation to patient care pathways, quality improvement, patient service improvement, teamworking and cleanliness/hygiene
- Collaboration and Teamworking, including policy and practice in relation to multidisciplinary teamworking
- Shared Governance, including policy and practice in relation to untoward incidents, management of complaints, risk assessment, benchmarking of clinical practice

- Partnership, including an examination of both the formal arrangements at the corporate level of the hospital between senior management, trade unions and staff, including communication, consultation and shared decision-making, and an examination of the front-line partnership practices including levels of direct staff involvement in service planning, continuous improvement and risk management
- Strategic Human Resource Management, providing a profile of the hospital's approach to the strategic management of human resources, including resource level for HR function, level of HR management devolved to unit/departmental level, performance management, training and development, HR policies, leadership development
- Staff Performance and Staff Outcomes, including levels of voluntary turnover of staff, levels of sickness absence, levels of IR issues, levels of disciplinary issues, levels of adverse staff incidents.

The survey also gathered extensive information on the hospital profile to establish control variables for the analysis. Issues examined included workforce size, budget, bed capacity, statutory/voluntary status, casemix profile, specialty departments, and governance arrangements.

3.2 Response Rate and Sample Characteristics

A total of 49 hospitals were invited to participate in this survey. The final response rate yielded just over half (26 out of 49) of the hospitals. Across a range of criteria, this sample proved to be highly representative of the Irish acute hospital system.

- In terms of ownership, 17 of the hospitals were HSE-owned statutory hospitals, while 9 were public voluntary hospitals.

- In terms of location, 8 were Dublin-based hospitals while the remaining 18 were located across all the other HSE network regions outside of Dublin.
- In terms of size, the hospitals ranged from some of the smallest acute hospitals in the State (with bed capacity of less than 70 beds, annual budgets in the order of less than €40 million and staffing levels in the order of 250 whole-time equivalents), through to some of Ireland's largest teaching hospitals (with bed capacity of more than 700 beds, annual budgets of more than €250 million and staffing levels in the order of greater than 3,000 whole-time equivalents).
- In terms of services provided, the sample included hospitals that provided a full range of acute adult and paediatric care through to hospitals whose services were dedicated to specialised care in areas such as obstetrics, cancer care, and orthopaedics. The sample included four of the country's eight "Casemix 1" / Group A hospitals, which are the large teaching hospitals providing specialist services at a supra-regional or national basis (e.g. obstetrics, major organ transplantations, complex cancer treatments, etc.)

3.3 Direct Staff Involvement in Service Improvement

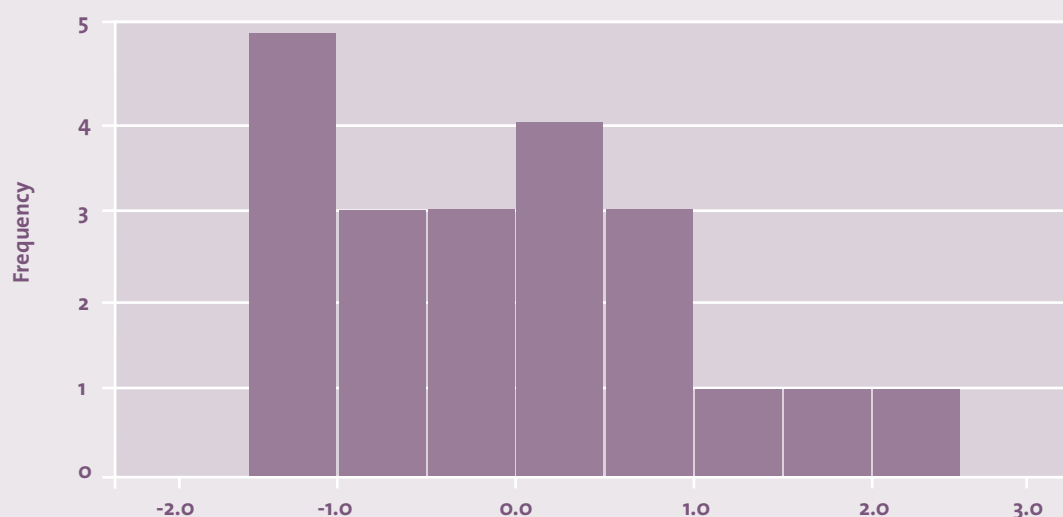
The survey examined hospital-wide practice in relation to the involvement of staff at all levels in continuous improvement and innovation, both in front line clinical and service areas and at the wider organisational level. Measures in the survey included level of involvement by front-line staff in service planning and service improvement in relation to patient care pathways, quality improvement, patient service improvement, teamworking and cleanliness/hygiene.

There are some potentially encouraging signs of good practice in relation to direct staff involvement. The data reveal significant variability both between hospitals and within departments within the hospital. Figure 2 illustrates this variability as measured by the composite Direct Staff Involvement Index:

Factors that contribute to this variability include:

- **Service improvement** through staff management teams: the vast majority of hospitals reported that joint staff management teams have been established to address issues including patient care pathways, quality improvement, patient service improvement, teamworking, and cleanliness hygiene standards.

Figure 2 Direct Staff Involvement Index-Distribution of Scores



- **Multidisciplinary approach to service improvement:** 75% of hospitals reported that multidisciplinary clinical teams meet at least monthly to look at service improvement. 14 (58%) of hospitals reported that service improvement teams always include front-line staff as a matter of hospital policy, while 9 more (36%) sometimes do. Only one hospital reported that front-line staff are never involved in service improvement teams.
- **Staff involvement in service planning:** half of the hospitals provide many or all staff with an opportunity for involvement, while the other half report that only some or no front-line staff have the opportunity to be involved.
- The subsequent site visits revealed numerous unit-based examples of failures to implement official hospital policy or HSE policy. Such failure can tend to coincide with performance or outcome “blackspots” in the organisation where there are problems in terms of staff morale and employee and industrial relations that can very often be revealed with reference to measures of efficiency, quality and safety of patient care, or staff well-being.
- Asked what the most significant obstacles to staff involvement in service improvement were, the following were the most frequently-cited issues: time and resource constraints (18

mentions); resistance to change (4 mentions); inadequate systems and forums for ideas management/innovation management/continuous improvement (3 mentions); top-down service planning and budget setting leaves no room for meaningful staff involvement (3 mentions).

3.4 Collaboration and Teamworking

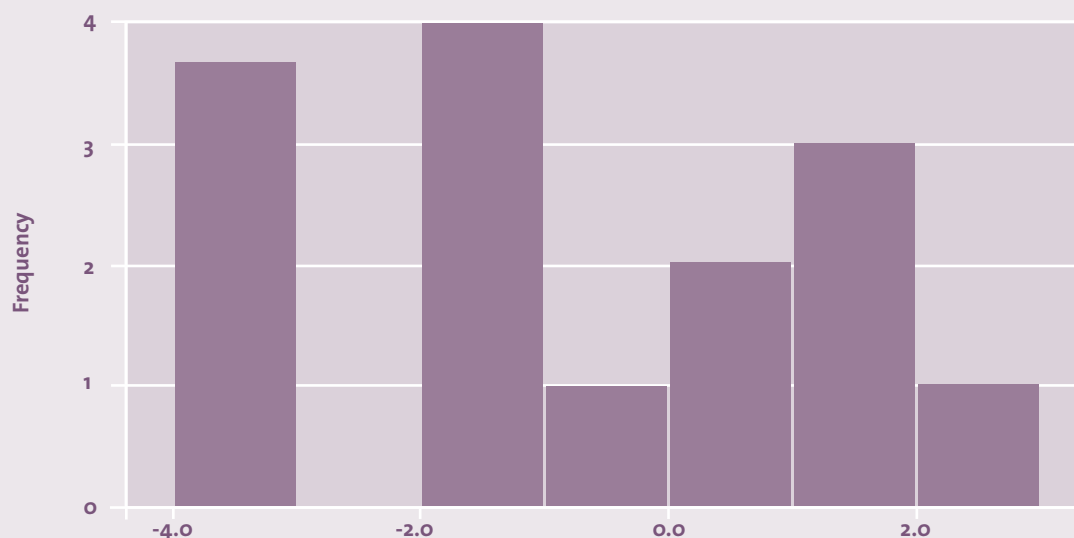
The survey measured the extent of collaborative working across disciplinary, professional and organisational boundaries in order to facilitate integrated patient pathways as common practice in the hospital.

The findings again reveal significant differences across and within hospitals, in terms of levels of collaboration and teamworking. Figure 3 illustrates the differences between hospitals based on the Collaboration and Teamworking Index score:

The factors that underpin the variance in collaboration and teamworking include:

- **Multidisciplinary combined outpatient clinics:** There was a clear divide between hospitals that “always” or “usually” held multidisciplinary combined outpatient clinics (approx. 70%), and those that “sometimes” or “rarely” held such clinics.

Figure 3 Collaboration and Teamworking Index – Distribution of Scores



- **Multidisciplinary ward rounds:** Just over half the hospitals (55%) reported that either all or the majority of their wards routinely operate multidisciplinary ward rounds, while the remaining 45% indicated that only a minority of or no wards (in 3 hospitals) operate on this basis
- **Multidisciplinary continuing clinical education and training:** This is a regular feature in 52% of hospitals' training & cpd programmes, but less regular or non-existent in 48% of hospitals
- **Formal policy to support teamworking through multidisciplinary training and facilitation:** 11 hospitals (46%) reported this to be in place, with 13 (54%) saying that it is not a feature of their approach
- Improving patient care pathways through multidisciplinary teamworking was reported to be undertaken in the majority (77%) of hospitals
- Asked what the most significant obstacles to multidisciplinary teamworking were, the most frequently-cited issues were: time/resource/workload constraints on multidisciplinary teamworking (6 mentions); unavailability of medics to participate due to multi-site commitments (4 mentions); professional or

organisational culture resistance to new ways of working and making decisions (3 mentions); lack of availability of AHPs (2 mentions);

3.5 Shared Governance

Shared governance refers to the system of controls, practices and culture governing the safe, effective and efficient delivery of care to patients. This section sought to establish the extent to which staff at all levels of the hospital are routinely engaged in the improvement of practices relating to risk, quality, efficiency, effectiveness, user involvement, clinical audit, untoward incidents and complaints.

Figure 4 reveals the extent of the difference between hospitals in their approach to shared governance.

The key factors underpinning this variation in scores include the following:

- Investigating untoward incidents: In terms of a no-blame approach to investigating untoward incidents, 3 hospitals reported that they had not adopted a no-blame approach, another 6 reported that they had a policy but it was not supported by specific training for managers, 5

Figure 4 Shared Governance Index – Distribution of Scores



others reported that the policy was supported by training for some managers, while 10 reported that the policy was supported by training for most managers.

- **Managing complaints:** The majority (75%) of hospitals had put measures in place to train and support managers in managing complaints, while the remaining 6 hospitals had no measures in place.
- **Involvement of front-line clinical staff in benchmarking clinical practice:** 9 (39%) hospitals reported that this is uncommon or never takes place; 6 indicated that it takes place sometimes, while 8 stated that it is common practice throughout the hospital;
- **Whistle-blowing Policy:** Only one hospital indicated that it had a formal whistle-blowing policy, 22 others indicated they did not.
- **Public/Patient Involvement:** 10 hospitals had no formal policy for public/patient involvement at clinical level, in 10 others front-line staff play a key role in public/patient involvement.

Risk Assessment Practices:

- Figure 5-Figure 7 highlight the significant variation that exists across hospitals, in relation to their approach to involving front-line clinical and support staff in risk assessment, in relation to staff, patients and budget/performance issues.
- The findings reveal significant variation in how hospitals are managing risk and implementing shared governance, highlighting somewhat alarming instances of the lack of involvement of front-line staff in formal risk assessments of patient and staff safety, and of budgetary and performance issues.
- Finally, asked what the most significant obstacles to successful staff involvement in clinical governance are, the following were the most frequently cited responses: constraints on participation due to time, resource, workload issues (9 mentions); inadequate skills, training or knowledge of clinical governance (9 mentions); low morale, lack of confidence in clinical governance, fear of blame (6 mentions); lack of clinicians in management roles (2 mentions); organisational culture in the hospital (2 mentions).

Figure 5 Involvement of front-line clinical and service support staff in formal risk assessments relating to staff

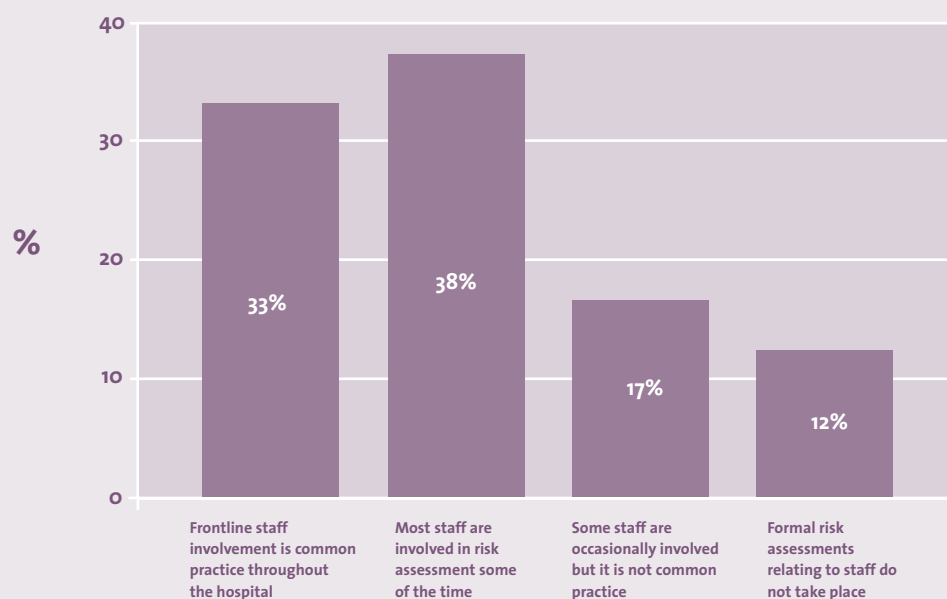


Figure 6 Involvement of front-line clinical and service support staff in formal risk assessments relating to patients

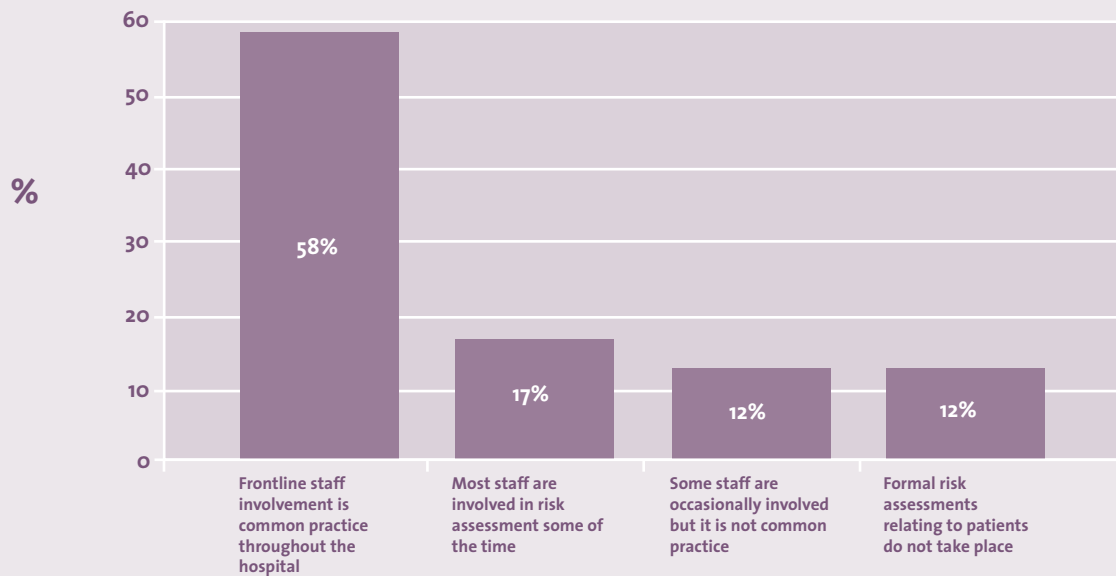
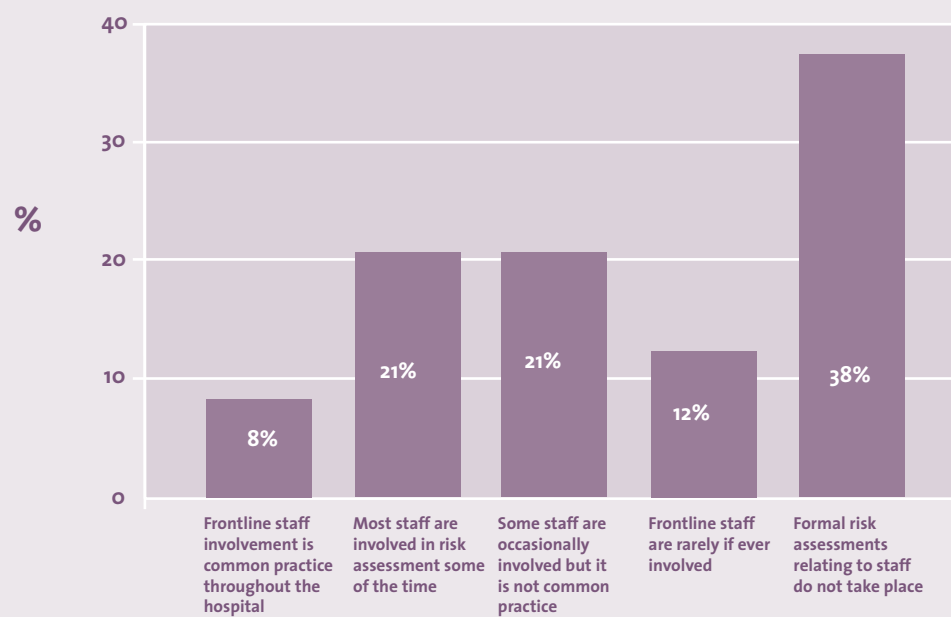


Figure 7 Involvement of front-line clinical and service support staff in formal risk assessments relating to budget and performance issues



3.6 Workplace Partnership

The development of workplace partnership in the acute hospitals has been strongly shaped by the series of national partnership agreements and by the series of HSNPF strategic plans and agreements. However, it is clear that the evolution of partnership arrangements at local level has also been influenced by local factors, including the level of commitment by and capacity of local management and unions, the local industrial relations history, the organisational culture and so on.

The questionnaire contained a series of measures looking at two different aspects of partnership within the hospital.

Formal Partnership was described as the formal arrangements in place at the corporate level of the hospital to facilitate collaborative relations between senior management, trade unions and staff.

Partnership Practices was a measure of the sophistication of partnership in the organisation – the level of involvement and participation of key stakeholders, the frequency of engagement, and the type of issues that feature on the agenda.

Figure 8 Formal Partnership Index – Distribution of Scores

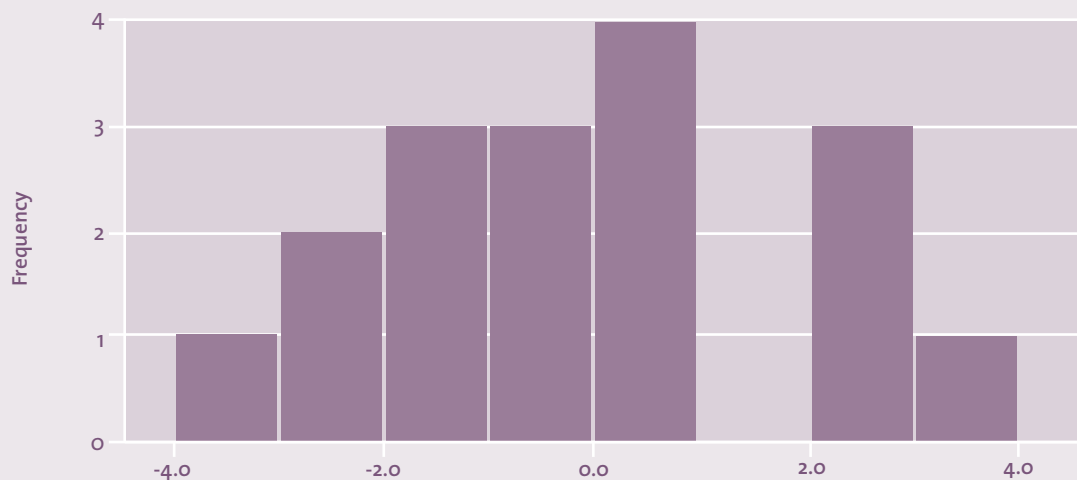
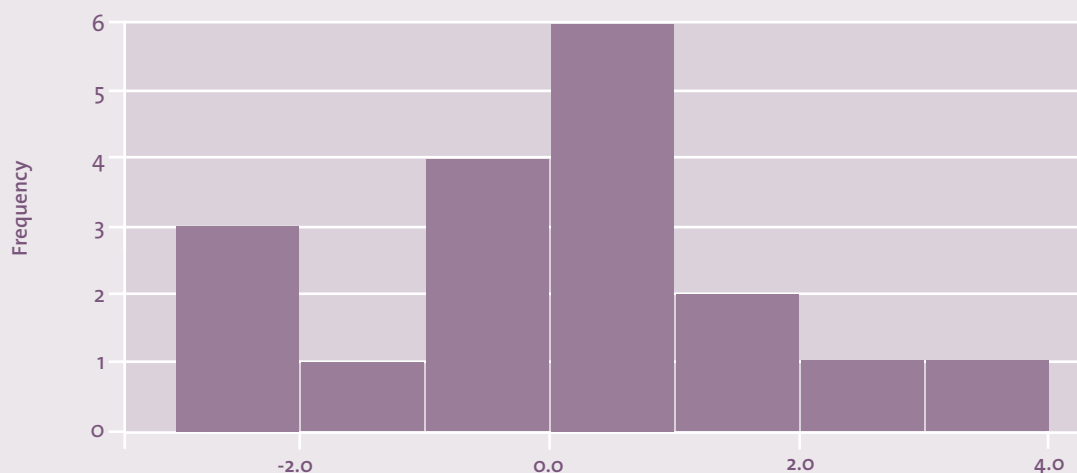


Figure 9 Partnership Practices Index – Distribution of Scores



The survey confirmed a wide diversity of arrangements for workplace partnership within the hospitals.

The following statistics serve to illustrate the diversity of arrangements at local level:

- 19 out of 26 hospitals (73%) had a formal partnership committee active in the hospital. Another 5 hospitals (20%) had an alternative local forum for management and trade union/employee representatives to discuss non-IR issues. Only one hospital reported not having an arrangement of any sort.
- The frequency with which the partnership committee/partnership forum meets varies noticeably, with 11 (42%) committees/forums meeting at least monthly, and another 7 (27%) meeting approximately every two months. One other meets less than quarterly but regularly, while 2 meet irregularly and less than quarterly.
- There is considerable consistency across hospitals in terms of which stakeholders participate routinely at partnership meetings. The majority of committees report regular attendance from senior management representatives, HR representatives and trade union/professional association representatives. 16 hospitals (62%) report that clinical/medical directors attend partnership meetings “rarely” or “never”, while 5 hospitals (19%) report more regular attendance by clinical/medical directors.
- The vast majority of hospitals (89%) agree that employee/trade union representatives are able to contribute to the agenda for partnership dialogue.
- 17 of the hospitals (71%) reported that they had formally adopted the protocol on *Handling Significant Change Through Partnership*. However, the implementation of the protocol is varied, with 56% of hospitals reporting that it is utilised “always” or “most of the time” by partnership committees, but 44 % of hospitals reporting that it is only “sometimes” or “rarely/never” utilised by the partnership committee.
- There is significant variation in what actually gets routinely discussed at partnership meetings. Issues most likely to be discussed **frequently** (“often” or “always”) include future plans (87%), training (78%), welfare services and facilities (74%), staff well-being issues (74%), and work organisation changes/innovations (61%). Issues most likely to be discussed **infrequently** (“occasionally” or “never”) by partnership committees include pay issues (13%), regulatory developments (26%), leave and flexible working arrangements (30.4%), efficiency issues (34.7%), staffing levels (39%), and financial issues (39%). The issues of infrequent involvement would appear to be those that are either outside the control of local management and unions, or those that require more technical engagement.
- There is a highly variable report regarding the implementation of the health services Information and Consultation Directive, with 42% of hospitals reporting that it is used to a significant extent (“all” or “most of the time”), but 58% reporting that it is used only infrequently (“sometimes” or “not at all”).

17 (71%) of the hospitals have a formal workforce communications strategy, with 7 (29%) reporting in the negative.

In terms of union cohesion, there is a mixed picture emerging – with 11 (42%) of hospitals having no group or structure representing all the trade unions, another 6 hospitals (23%) having occasional, informal meetings with the group of unions, and 9 hospitals (35%) having a formal structure/grouping of health sector unions.

21 of the hospitals (84%) reported having a partnership facilitator employed or allocated to the hospital, with 4 (16%) reporting in the negative.

Asked what were the most significant obstacles to partnership in the hospital, there was a wide range of issues raised, but the most frequently-identified issues included: time constraints on people’s availability to participate (9 mentions); union members’ participation (7 mentions); participation of medical personnel (4 mentions); participation of management (2 mentions).

These findings clearly highlight the range of approaches to and experience of workplace partnership through the formal channels of a partnership committee. The perception of significant diversity in arrangements and hospital-level discretion was subsequently borne out by the site visits, which demonstrated clearly that there is not a unitary blueprint in place for partnership at the workplace level. Local management and unions have developed a range of approaches and practices, which are determined by factors such as legacy relationships (positive or negative), management capacity and union capacity. What operates in one location in the best interests of a vibrant partnership process can function in another location to stymie and impede the emergence of a partnership system locally.

3.7 Strategic Human Resource Management

SHRM is broadly defined as an approach to the strategic management of human resources in accordance with the policies, aims and objectives of the hospital and the HSE. SHRM includes all those activities affecting the behaviour of individuals in their efforts to formulate and implement the strategic needs of the organisation. SHRM can be further defined as a system or pattern of planned human resource deployments and activities intended to enable the organisation achieve its goals.

During 2009 the HSE continued to develop a HRD strategy incorporating a significant focus on employee engagement and leadership development. The strategy advances a model based on the devolution of IR responsibilities to line managers, and a reconfiguration of the HR directorate to incorporate the IR and employee relations functions.

The HSE Service Plan 2009 recognised that 2009 would present many challenges from a HR perspective, and that “it may prove to be the most challenging year that the health services in this country will have experienced over the last twenty years.” The possible HR challenges in 2009 are listed as including “redeployment/reassignment of administrative and clinical staff; greater utilisation of skill mix; maximising employment

levels while focusing on the protection of base pay; adherence to best management practices on travel, subsistence etc.; adherence to agreed annual leave plans; encouragement of uptake of non-statutory family friendly policies (term time, career breaks, and unpaid leave); restriction on locum/agency and replacement cover for all staff; restriction on overtime; voluntary Early Retirement scheme to be explored; completion of Workforce Planning Strategy and analysis of future demand/supply in certain critical professions, and completion of contract negotiations (e.g. NCHDs/European Working Time Directive) and roll out of new Consultant contract.”

The survey revealed significant variation between hospitals in terms of how they resource and manage their HR functions. The voluntary hospitals that took part in the survey had a common approach based on relatively well-resourced internal HR functions, in contrast with a more mixed model in many of the statutory hospitals of shared service HR coupled with varying degrees of in-house HR capabilities. Even in relation to protocols and strategies agreed at national level by HSE and unions, there is evidence of a lack of consistency in their adoption and implementation by hospitals.

- **HR Model:** HSE statutory hospitals have a range of models for HR management, with HR shared services coupled with a modest level of internal HR resources. 12 HSE statutory hospitals utilise shared services, and 10 of the HSE statutory hospitals involve the General Manager’s office in the HR function. In contrast, none of the 8 voluntary hospitals used shared services, each had their own dedicated HR resource, and none drew on the resources of the CEO’s office
- **Workforce planning strategy:** 9 hospitals reported having a formal workforce planning strategy in place, while 15 did not. Voluntary hospitals were more likely to have a workforce planning strategy than statutory hospitals, underlining the greater level of autonomy enjoyed by statutory hospitals in this regard
- **Equality and diversity:** 18 (75%) of hospitals had adopted a formal policy on equality and diversity. Of the 6 (25%) that had not adopted a formal policy, all but 1 were HSE statutory hospitals

- **Bullying and harassment:** All hospitals had a policy on bullying and harassment at work, for all but one voluntary hospital this policy was the Dignity at Work Policy for the Health Service that was developed by the Health Services National Partnership Forum
- **Flexible working:** 21 hospitals (84%) had a formal policy on flexible working. Of the 4 that did not have a policy, 3 were voluntary and 1 was statutory
- **Team-based Performance Management:** there was patchy evidence of team-based performance management in clinical departments, with 8 hospitals (32%) stating it was not at all in place, 14 (56%) saying it was in place in some departments, with only 3 hospitals (12%) reporting that TBPM was in place extensively
- **Individual Performance Management:** there was very limited evidence of annual appraisals or personal development plans in the majority of hospitals, for all grades of staff
- **Leadership Development:** there was mixed data in relation to leadership development strategy: 12 hospitals had no formal strategy, another 11 had a strategy targeted at senior and/or middle management only, while only one had a strategy for all staff in the organisation.

Chapter 4

High Performance in the Acute Hospital Context: Evidence from Ireland

4.1 Introduction

The previous chapter provides a clear sense of the considerable variability and lack of consistency that exists across the hospital system in relation to participative governance and management systems and practices. This present chapter explores whether the variability that is evident in hospital governance and management systems can explain some of the dramatic differences that are routinely found across a range of performance indicators for quality and safety, efficiency and staff well-being.

Periodic performance monitoring reports from HSE, as well as reports from regulatory and standards authorities such as HIQA and the State Claims Agency, routinely reveal significant performance variations between hospitals in relation to issues such as patient safety, hospital hygiene standards, efficiency levels, staff well-being and so on.

The issue of performance and outcome variation across the acute hospital system is a complex one, and must be examined with care. Hospitals are complex organisational entities, delivering health care through the interdependent functioning of a number of front-end and back-end departments and units, and heavily dependent also on externalities in the health system, such as its interactions with other hospitals in the region and at national level, and its interaction with primary care services and community-based care facilities. A number of important factors must be taken into account when examining why hospitals perform well or poorly across a range of performance and outcome measures. Resource and environmental factors, such as the size of the hospital, the adequacy of its physical infrastructure, its level of financial, human and technological resources, its status as a local, regional, supra-regional or national centre of care, its caseload and caseload complexity, the local community-based healthcare infrastructure, and so on can all have a significant bearing on how hospitals perform.

Nevertheless, it is well established in international literature that, even after taking such factors into account, acute hospitals in the same healthcare system differ greatly in terms of the quality of patient care they provide, the levels of efficiency that they function with, the degree to which they improve performance levels over time, and the quality of the work environment that their staff experience. It is important to question why certain hospitals are more successful in achieving standards and meeting targets than others, and why certain departments or units within a hospital are more successful in achieving standards and meeting targets than comparable areas elsewhere in the same hospital.

The reasons for this variability are complex to examine at the statistical level. Our analysis does not in any sense attempt to establish direct causality between management policies and practices and performance outcomes. The practical benefit of the research lies in pointing policy makers and those in positions of leadership at all levels towards areas within the hospital organisation that are amenable to change and improvement, including the governance and management of strategic human resources, employee involvement and engagement, shared governance, teamworking, and workplace partnership.

The fact that an analysis using relatively limited data can elicit a series of relationships that are both intuitively meaningful and statistically significant raises the prospect that future developments of this approach can support a more sophisticated model of performance management, innovation management, continuous improvement and operational excellence in the health sector. It suggests that comparative information on performance and outcomes should become a routine agenda for dialogical engagement at local facility level between stakeholders including management, staff and unions.

4.2 Methodology

The original research brief was to examine high performance in relation to three broadly-categorised issues:

- Patient care outcomes (outcomes for patients in terms of health outcomes, patient satisfaction, etc.)
- Hospital efficiency (the extent to which hospitals are providing efficient services)
- Staff outcomes (outcomes for staff including staff satisfaction and quality of working life).

The project team established an ad-hoc Expert Liaison Group (Appendix C) comprising a network of personnel from various units within the HSE and from a number of outside agencies, which supported the project team in identifying and accessing appropriate data on hospital performance. Data for the reference period July – December 2007 was obtained from three primary sources:

- Hospital performance data was obtained from the HSE. This data is provided on a routine basis by hospitals both directly into the HSE and via the National Hospital In-patient Enquiry (HIPE) database.

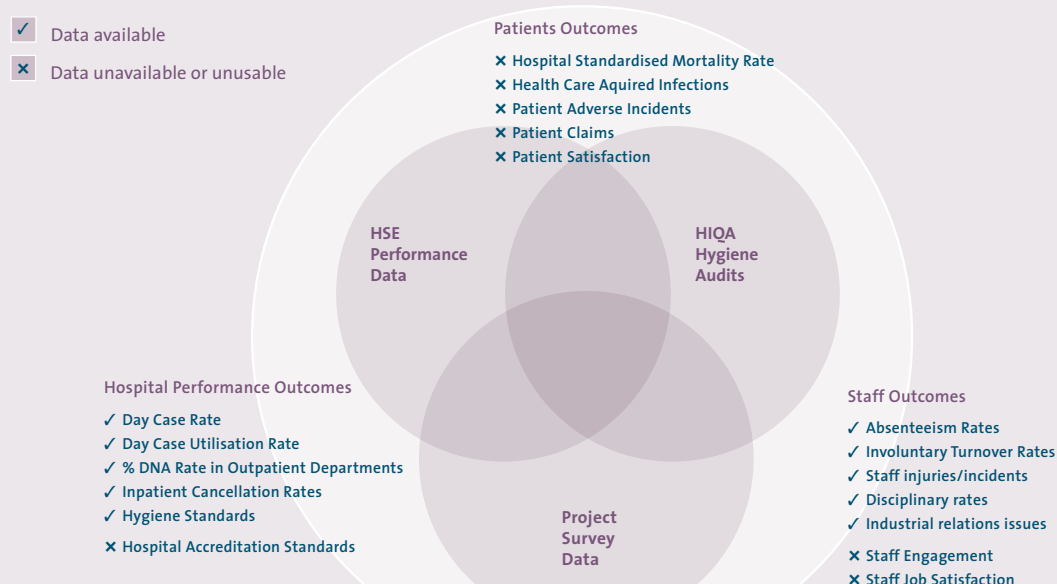
- Data was provided by the Health Information and Quality Authority (HIQA) relating to their audits of hygiene standards in the acute hospitals

- Data was obtained directly from hospitals, based on a questionnaire designed by the project team.

Figure 10 highlights the range of data that was available across the primary research domains. As has been extensively highlighted elsewhere,² reliable data in relation to patient outcomes and risk management was notably unavailable, a fact which impinged on the potential analyses, but more importantly represents a fundamental and serious deficit in terms of risk management and quality improvement at local facility level, and strategic planning at central level.

As more reliable data becomes available in relation to measures of risk, quality of patient care, patient satisfaction, standards-based hospital accreditation and licensing, staff engagement, staff well-being, and so on, the analytical approach used here can be built upon extensively for planning and performance management purposes.

Figure 10 Data Sources, Performance Domains and Key Indicators



2. Including Building a Culture of Patient Safety ("Madden Report") (Department of Health and Children, 2008), and the National Health Information Strategy (Department of Health and Children, 2004)

4.3 Patient Outcomes

4.3.1 Introduction

There is a significant body of international literature on the association between participative governance and management systems and patient care outcomes. This evidence lies at the heart of the decision-making underpinning current reforms of health services in Ireland. The development of the clinical directorate system, the reconfiguration of hospital services (including the move to greater integration with primary and community care, and the move towards regionalisation of services with a development of centres of excellence) are driven by statistical and case evidence of the impact that organisational capability and culture can have on patient care.

International literature on adverse events estimate that between 4% and 16% of patients admitted to hospital experience one or more adverse events, of which up to half are preventable. The cost of this level of problem with patient outcomes, both for individual patients (and their families), and for the Irish health system, is enormous. In economic terms, in 2008 the Government's Clinical Indemnity Scheme, which covers only clinical claims arising from the diagnosis, treatment and care of patients, made settlements totalling €500 million. In the United States, the Institute of Medicine estimates that medical errors resulting in injury cost \$17 to \$29 billion each year (Kohn, Corrigan and Donaldson, 1999).

Due to a lack of reliable system-wide data, we were unable to examine many of the key issues in relation to patient care outcomes, including patient mortality rates, patient satisfaction rates, patient complaint rates, rates of reported adverse incidents, rates of patient compensation claims, hospital-acquired infection rates. As standards, measurement and reporting capabilities improve in the Irish hospital system, it will be important to utilise such data for the purposes of examining the underlying factors that are associated with poor patient outcomes.

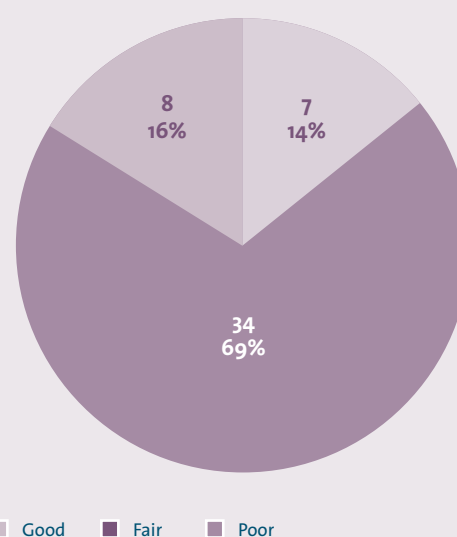
Due to challenges in obtaining reliable hospital-level data on patient outcomes for the reference period, we have based our analysis on two important proxy indicators of patient outcomes for which data was available: **hygiene standards** and **patient involvement**.

4.3.2 Hygiene Standards in Acute Hospitals

We conducted detailed analysis on data from the HIQA Hygiene Services Quality Review (2007)³ and our own survey data. The HIQA data on hygiene standards is the best available proxy indicator of patient outcomes, where it is accepted that hygiene standards are associated with outcomes such as levels of healthcare acquired infection rates.⁴

The variability in hospital hygiene standards is illustrated in Figure 11, revealing that arising from the 2007 Hygiene Standards Audit no hospital had achieved the top rating ("Very Good"), 14% (7 hospitals) had been rated as "Good", 69% (34 hospitals) had been rated as "Fair", and a further 16% (8 hospitals) were rated as "Poor", or in other terms, represent an immediate and significant threat to patients/clients, public or staff.

Figure 11 Overall Hospital Ratings
(source – HIQA 2007
Hygiene Services Audit)



3. The HIQA data contains a total of 56 variables which contribute to the assignment by HIQA of an annual rating for each of 50 acute hospitals. The data is collected based on the most extensive audit of corporate policies and procedures and management and workplace practices ever undertaken in Ireland. It focuses on two main areas of hospital performance: Corporate Management and Service Delivery. Future iterations of the Hygiene Services Quality Review will be incorporated into the planned licencing system for acute hospitals.

4. Recent estimates by the European Centre for Disease Prevention and Control suggest that across the EU, hospital infections directly kill 37,000 people annually, contribute to a further 110,000 deaths, resulting in an additional 16 million days of hospital stays costing €5.5 billion per annum.

4.3.3 Analysis

Clearly, the capacity of a hospital to manage its hygiene services effectively does depend on the hospital having relevant policies and procedures in place. But given that such policies and procedures are well-known in the health care sector in Ireland and internationally, why is it that there is so much variability between hospitals?

We examined the data further to identify those underlying factors related to governance and management systems. A factor analysis technique⁵ revealed that the best indicator of the

impact of hospital personnel on hospital hygiene standards was what we termed the "Continuous Quality and Risk Improvement" (CQRI) index (see Table 1). The CQRI index includes 18 items, providing an extensive and in-depth insight into how hospitals govern and manage risk and quality improvement in relation to hygiene services. The auditing rating goes well beyond the question of stated policies and procedures, to seek detailed evidence of the implementation of these in the workplace. The index relates to policies and practices that can be directly improved by changes to working practices.

Table 1 Continuous Quality and Risk Improvement Index

HIQA Criterion	Criterion Description
CM 4.2	The Governing Body and/or its Executive Management Team regularly receives useful, timely and accurate evidence or best practice information.
CM 4.3	The Governing Body and/or its Executive Management Team access and use research and best practice information to improve management practices of the Hygiene Service.
CM 4.4	The organisation has a process for establishing and maintaining best practice policies, procedures and guidelines for Hygiene Services.
CM 7.1	The organisation has a structure and related processes to identify, analyse, prioritise and eliminate or minimise risk related to the Hygiene Service.
CM 7.2	The organisation's Hygiene Services risk management practices are actively supported by the Governing Body and/or its Executive Management Team.
CM 8.2	The organisation involves contracted services in its quality improvement activities.
CM 9.4	There is evidence that patients/clients, staff, providers, visitors and the community are satisfied with the organisation's Hygiene Services facilities and environment.
CM 13.1	The organisation has a process for collecting and providing access to quality Hygiene Services data and information that meets all legal and best practice requirements.
CM 13.2	Data and information are reported by the organisation in a way that is timely, accurate, easily interpreted and based on the needs of the Hygiene Services.
CM 13.3	The organisation evaluates the appropriate utilisation of data collection and information reporting by the Hygiene Services team.
CM 14.1	The Governing Body and/or its Executive Management Team foster and support a quality improvement culture throughout the organisation in relation to Hygiene Services
CM 14.2	The organisation regularly evaluates the efficacy of its Hygiene Services quality improvement system, makes improvements as appropriate, benchmarks the results and communicates relevant findings internally and to applicable organisations.
SD 1.1	Best practice guidelines are established, adopted, maintained and evaluated, by the team.
SD 1.2	There is a process for assessing new Hygiene Services interventions and changes to existing ones before their routine use in line with national policies.
SD 4.7	The team works with the Governing Body and/or its Executive Management team to manage hand hygiene effectively and in accordance with SARI guidelines
SD 4.8	The team ensures all reasonable steps to keep patients/ clients safe from accidents, injuries or adverse events.
SD 6.1	Patient/Clients, families and other external partners are involved by the Hygiene Services team when evaluating its service.
SD 6.2	The Hygiene Services team regularly monitors, evaluates and benchmarks the quality of its Hygiene Services and outcomes and uses this information to make improvements.

5. A series of prospective indices of organisational culture and behaviour were constructed from the 56 variables in the hygiene audit. Independently, a factor analysis was conducted on the data from all 50 hospitals audited in 2007 by HIQA, and the first 5 principal components were extracted. The association between these principal components and the prospective indicators revealed that four of the prospective indicators were independently associated with the first principal component from the factor analysis. These were Continuous Quality and Risk Improvement; Strategic Human Resource Management; Learning Organisation; and Integrated Governance.

Table 2 Independent Samples T-test: Hygiene Standard x Continuous Quality & Risk Improvement

Hospital Hygiene Standard	N	Mean	Std. Deviation
“Poor”	8	39.3	11.0
“Good” or “Fair”	41	33.9	5.6

An independent samples t-test (Table 2) compares hospitals that had a “Poor” hygiene standards rating from HIQA (and deemed to pose a serious and immediate risk to patients and/or staff) with those that had a “Good” or “Fair” overall rating. There is a significant difference between these groups of hospitals in relation to their CQRI score. In other words, hospitals whose hygiene services standards are sub-standard also have a poorer approach to involving their staff in managing continuous improvement in quality and risk.

We analysed the CQRI index to see how it correlated with data collected in the HOTF survey. We found the CQRI score to be significantly correlated with both Workplace Partnership ($p > .05$) and Partnership Practices ($p > .01$). This finding raises the prospect that those hospitals that have succeeded in developing more sophisticated models of participative staff involvement (both direct and indirect) have also succeeded in developing more sophisticated models of risk management and continuous improvement: in both cases the model extends beyond the existence of formal committee arrangements to enabling extensive staff involvement and participation at the front-line.

4.4 Staff Outcomes

4.4.1 Introduction

International research literature identifies a number of commonly used measures pertaining to staff, including levels of staff engagement, staff satisfaction, staff safety and well-being (physical and psychological). Additionally, a number of indicators can be treated as proxy indicators for staff outcomes, such as absenteeism levels, voluntary turnover, levels of disciplinary action, days lost due to local IR issues, and so on.

Planned research initiatives by the HSE (e.g. in relation to staff well-being, engagement etc.) mean that, in future, additional streams of rich information will become available for analysis, and will provide for a much more comprehensive approach to policy analysis, planning and management.

For the reference period, July–December 2007, the availability of comparable data was patchy at best, and our analysis is limited to data collected by our own survey of hospitals.

Table 3 describes the indicators included in the present analysis of staff outcomes, which were gathered by the HOTF survey.

Table 3 Staff outcomes – key indicators

Indicator	Description
Voluntary Turnover of Permanent Staff	The levels of voluntary turnover of permanent staff were measured, for each category of hospital employee.
Sickness Absence	The levels of sickness absence during the reference period were measured, for each category of hospital employee.
Staff Safety	<p>The following measures were examined as stand-alone items, and also were collectively compiled into an index of staff well-being:</p> <ul style="list-style-type: none"> ■ Reported incidents of needlestick and sharps injuries ■ Reported incidents of moving and handling injuries ■ Reported incidents of slips, trips or falls ■ Reported incidents of exposure to dangerous substances ■ Reported incidents of work related stress ■ Compensation claims

4.4.2 Voluntary Turnover of Permanent Staff

The rate of voluntary turnover of permanent staff is a measure of how successful the hospital is at retaining personnel. International literature would suggest that lower voluntary turnover is associated with higher levels of employee engagement and job satisfaction, a high quality of working environment, and ultimately impacts on quality of patient care and hospital budgets. Higher retention rates are associated with reduced costs in terms of recruitment, training, and contract cover staff. They are also associated with higher levels of patient care.

In US hospitals, nursing turnover has been reported to range from 15 percent to 36 percent per year (Hayes et al 2006), with estimates of the cost to replace one medical-surgical registered nurse (RN) ranging between \$30,000 and \$50,000; and replacement costs for critical care nurses are closer to \$65,000 (Kosel and Olivio, 2002). Jones (2005) estimated the total turnover costs of one hospital-based RN in the US to range from \$62,000 to \$67,000 depending on the service line.

Our survey measured the average level of voluntary turnover of permanent staff during the period July–December 2007, for six categories of staff: Medical/Dental; Nursing; Management/Administration; Health/Social Care; General Support; Other Client Care. Analyses reveal a series of statistically significant correlations between participative governance and management practices and voluntary turnover rates for various staff categories. Figure 12 and Figure 13 illustrate interesting correlations between partnership, staff involvement in continuous quality and risk management, and voluntary turnover rates for nursing and health/social care staff.

Significant correlations also exist between voluntary turnover rates for different professional groupings. Where voluntary turnover rates for nursing staff are high, they also tend to be high among management and administrative grades and general support staff; where voluntary turnover rates for health/social care staff are high, they also tend to be high among other client care staff.

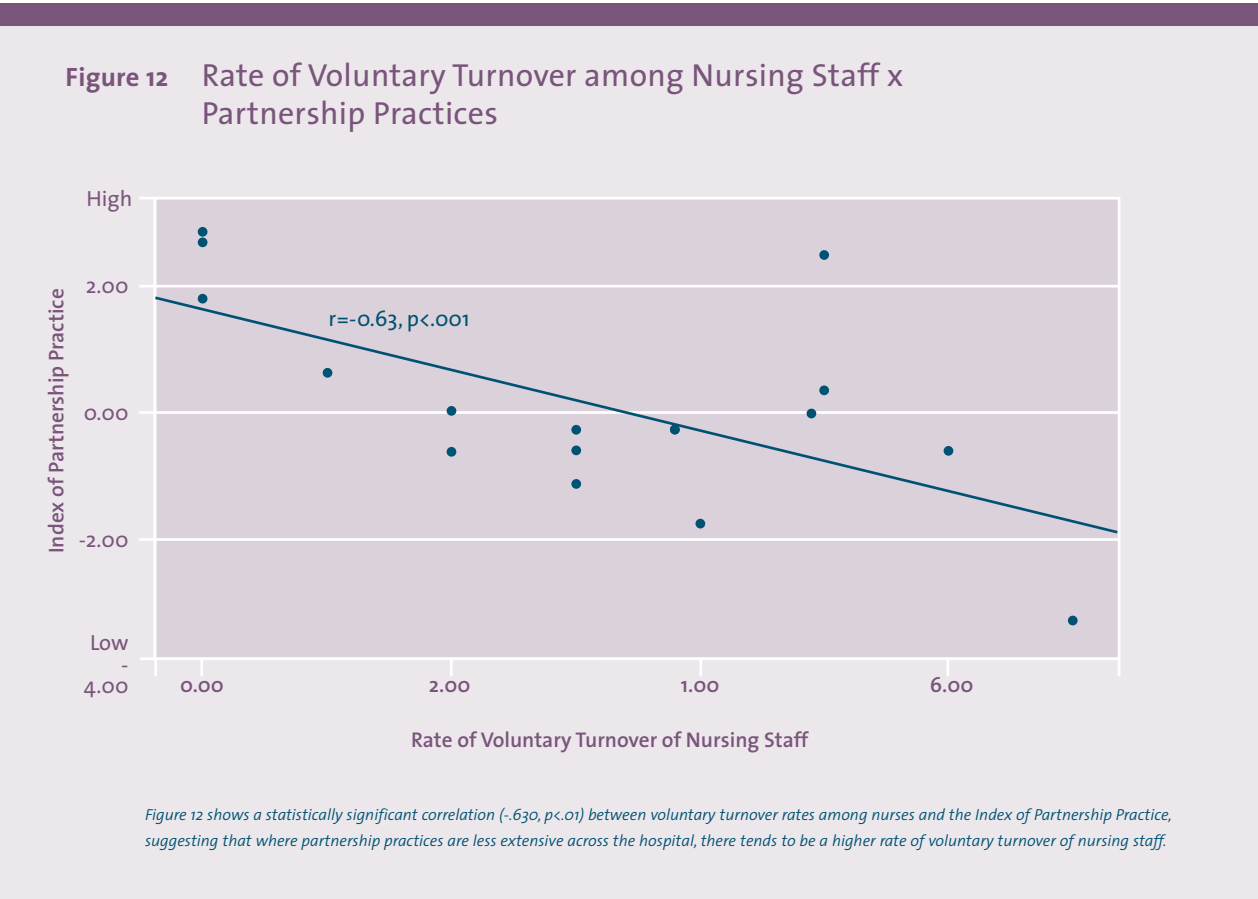


Figure 13 Rate of Voluntary Turnover among Health and Social Care Staff x Staff Involvement in Continuous Quality and Risk Improvement

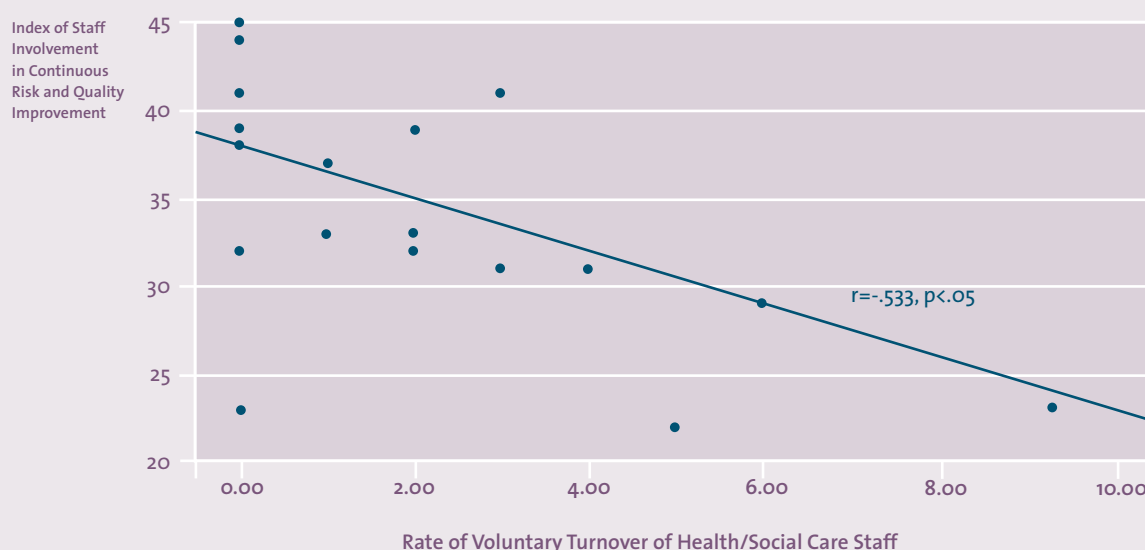


Figure 13 shows a statistically significant positive correlation between the Continuing Quality and Risk Improvement index and voluntary turnover rates for Health/Social Care staff. Where staff involvement CQR is higher, voluntary turnover rates tend to be lower.

4.4.3 Sickness Absence

It is estimated that non-attendance at work costs the HSE in the region of €150 million per annum in replacement staff. The HSE also identifies good attendance as being important in maintaining services and productivity levels, avoidance of work backlogs, maintenance of quality of service, and effective management of work schedules/rosters.⁶

There is evidence of the scope for significant savings and efficiencies to be gained by more effective approaches to managing attendance. Data published by HSE's HealthStat reveal, for example, that the average absence rate for HSE staff in January 2009 was 6.82%, with rates being most elevated for general support staff. Given that the HSE has set a target rate of 3.5%, this offers significant potential for performance improvement and budget savings.

Our analysis, based on limited data, revealed some interesting correlations. For nursing staff, sickness absence levels were correlated with levels of shared governance ($r = -.551$, $p > .05$). In other words, the data

suggests that nurses tend to have higher levels of sickness absence in hospitals where there are lower levels of shared governance. However, a more comprehensive statistical analysis of the factors influencing sickness absence among staff would require more direct and extensive measures such as would be derived from a staff survey.

There is other evidence of the impact of participative management practices on sickness absence. A partnership-supported initiative to address absenteeism rates in the HSE workforce has led to the publication of guidelines on managing attendance, which has been incrementally rolled out at a local level. Our site visits heard several reports from hospital managers about the positive impact on attendance rates following implementation of these guidelines. One hospital reported that it reduced sickness absence among nursing staff by 50% following implementation of the guidelines, enabling it to achieve the level of savings demanded due to the budget constraints imposed in 2007.

6. HSE (2009) HR Circular 002/2009 Managing Attendance Policy and Procedures

4.4.4 Staff Safety

In the absence of reliable data from other sources, our research asked hospitals to report the level of *reported* incidents to staff during the reference period, in relation to needlestick and sharps injuries; moving and handling injuries; slips, trips or falls; exposure to dangerous substances; work-related stress. Data was also sought on the level of compensation claims relating to staff submitted during this period.

No significant association was found between levels of incidents reported by staff and the governance and management system in the hospitals. However, data analysis was limited due to a low response rate to this question. There is merit in exploring these issues at a future point based on more reliable data.

4.5 Hospital Performance Data

4.5.1 Introduction

We selected 6 performance indicators for inclusion in our analyses, in line with the recommendations of the Expert Liaison Group. Each indicator shows significant performance variability across the acute hospital system, and expert evidence suggests that much of the variability for these particular indicators is attributable to the work practices and management approach within the departments and units, which impact on the efficiency of service delivery. The selected indicators cover performance across both inpatient and outpatient care in the hospital environment.

Table 4 Hospital Performance Indicators	
Performance Indicator	Brief Descriptor
Day Case rate	The percentage of the overall number of elective patients admitted that are treated as day cases (excluding outpatients)
Day Case utilisation rate	The number of patients put through the day bed capacity in the hospital.
In-Patient Cancellation rate	This measures hospital-originated cancellation of in-patient treatments
Outpatient Department New: Return ratio	The ratio of new patients to return patients seen by an Outpatient Department
Outpatient Department New Patient appointment rate of non-attendance (%DNA)	The percentage of appointments for new patients at Out Patient department that did not attend (DNA)
Outpatient Department Return Patient appointment rate of non-attendance (%DNA)	the percentage of appointments for return patients at Out Patient department that did not attend (DNA)

4.5.2 Day Case Utilisation Rate

Day Case Utilisation Rate (DCUR) is a measure of the number of patients put through the day bed capacity in the hospital. It is seen as a robust measure of hospital efficiency, and is considerably influenced by work practices. In theory, a highly efficient hospital would have a rate around 200%, or in other words, each day bed in the hospital would be capable of accommodating 2 day case patients during the course of 24 hours. Where rates are significantly lower it can indicate inefficient utilisation of resources.

Analysis

Independent samples t-tests revealed the following:

- A statistically significant difference ($p < .05$) in daycase utilisation rate between hospitals that do and do not have multidisciplinary approaches to improving patient care pathways
- A statistically significant difference ($p < .01$) in DCUR between hospitals where financial issues are discussed regularly at partnership level (“always” or “often”) and where they are less regularly discussed (“occasionally” or “never”).

While an analysis of day case utilisation rates is complex, there are interesting associations between the DCUR and practices such as engagement at partnership committee level on discussions around financial and budgetary issues; also, hospitals which indicated they had specific multidisciplinary approach to improving patient care pathways also had higher day case utilisation rates.

4.5.3 Day Case Rate

A Day Case is defined as “a patient who is admitted to hospital on an elective basis for care and/or treatment that does not require the use of a hospital bed overnight and who is discharged on the same day as scheduled.” Day Case rate expresses the percentage of the overall number of the elective cohort of patients admitted (excluding outpatients), that are treated as day cases.⁷

Benchmarks of day case rates across the OECD highlight that Ireland has relatively low rates of day case care (Figure 14). In line with international best practice, the move to the treatment of more patients on a day-case basis is one of the cornerstones of the HSE’s strategy for the future of health care in Ireland. Treatment on a day case basis is seen to be better for patient care and safety, as well as being significantly more cost-effective.^{8 9} A higher rate can indicate that a hospital is more likely to be up to date on latest treatment techniques and technology innovations (e.g. key-hole surgery). It is more likely to have effective, joined-up management systems for administration and clinical governance, with more whole-systems approach to patient care. It is more likely to have efficient systems for speedy turnaround of diagnostics, good linkages with local GPs, and effective protocols for referral and admission of patients on a day-case basis.

Figure 17 illustrates HSE data that shows the variability between hospitals is also considerable, and demonstrates that there is significant room for improvement within the Irish acute hospital system.¹⁰ While HSE targets have been set so far for certain specific specialities, there is a general expectation that hospitals achieve daycase rates in the order of of 70%-75%.

Analysis

Analyses of the differences between hospitals in the three performance bands for day case rate (high-performing, on-target and below-target hospitals) revealed clear evidence of the impact of both direct and indirect participative systems on performance levels.

An independent samples t-test on 43 Casemix 1 and 2 hospitals (excluding the maternity hospitals) reveals a statistically significant difference between below-target hospitals and others (on-target performers and high performers) in terms of their score on the Continuous Quality and Risk Improvement (CQRI) index (mean difference=7.325,

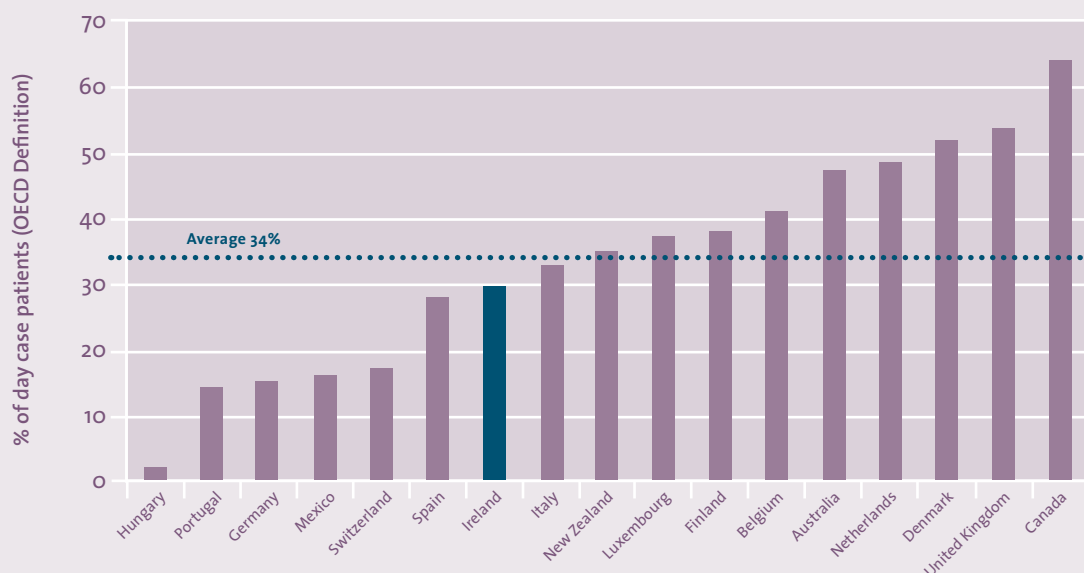
7. Overall Day Case Rate = Total number of day cases / (Total number of inpatients + total number of day cases)

8. The PA Consulting report (2008) Acute Hospital Bed Capacity Review: A Preferred Health System in Ireland to 2020 estimated the differential in the daily operating costs, at 2007 figures, for an in-patient bed and an out-patient bed to range from 29% (in a major regional hospital) to 48% (in a major teaching hospital)

9. “There is clear evidence to show that patients who have day surgery have an overall better experience, improved clinical outcomes and less risk of hospital acquired infections.” - NHS Modernisation Agency - 10 High Impact Changes.

10. Some hospitals attain day case rates as low as 15%, while others exceed even Canada’s average with 69% of all patients as day case.

Figure 14 International Day Case Rates
(Source – OECD Health Data 2006)



$p < .01$, $df = 41$). In other words, hospitals with poorer systems for staff involvement in quality and risk improvement also have significantly lower day case rates.

A second independent samples t-test reveals a statistically significant difference between high-performing hospitals and others (on-target performers and below-target performers) in terms of their score on the Patient Involvement index (derived from a principal components factor analysis of the HIQA hygiene audit data). In other words, hospitals with better systems and practices for involving patients in the design and improvement of hygiene services also had on average a significantly better day case rate.

A third independent samples t-test reveals that another important issue appears to be the capacity of the partnership committee to access performance-related information. In high-performing hospitals (with day case rates exceeding 85%), the trade union/employee representatives on the partnership committee enjoy significantly more open access to financial information and performance data ($p < .01$, $df = 21$).

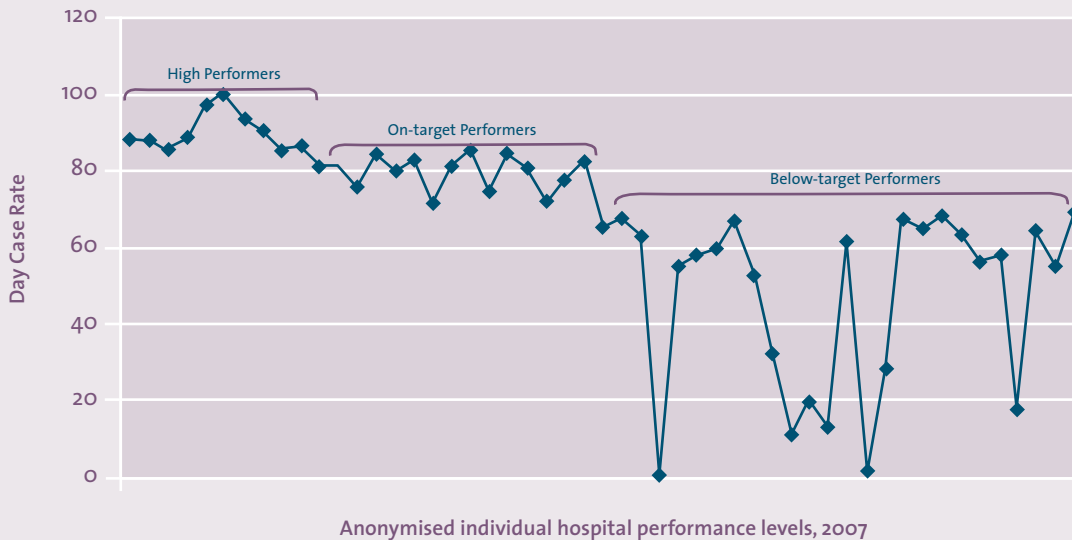
4.5.4 In-Patient Cancellation Rate

The In-Patient Cancellation Rate measures the level of hospital-originated cancellation of in-patient treatments. It is seen as a universal and robust comparator between hospitals. Even though the perceived causes of the cancellation rate can be a source of contention among practitioners and analysts, it is a rate that should be targeted for reduction over time.

Broadly speaking, there are two common perspectives on the reasons for high in-patient cancellation rates. The first is that high in-patient cancellation rates are to be expected in hospitals where there are busy emergency departments, with frequent but unpredictable intakes of emergency cases, which take precedence over elective in-patient work. The second is that high cancellation rates could suggest poor levels of planning, co-ordination and anticipation, and is affected by capabilities in terms of communications, bed management, etc.

Either way, resource issues (e.g. insufficient staffing levels, ward closures, theatre closures) do affect the cancellation rates. For the purpose of our analyses it was assumed that such resource issues are relatively equitable across the hospital system. There is also a view that the type of patient can

Figure 15 Mean Day Case Rate, 2007, excluding maternity hospitals
(source – HSE Performance Monitoring Unit)



determine the extent to which cancellations can be permitted. A patient with a serious illness is less likely to be subjected to cancellation than a patient with a less serious illness.

Analysis

There is clear evidence of an association between in-patient cancellation rates and systems for involvement of staff and patients.

There was a significant negative correlation ($r = -.677$, $p < .01$, $n = 23$) between in-patient cancellation rates and the CQRI index score. In other words, hospitals that had better systems and practices for staff involvement in continuous improvement (for quality and risk) also had significantly lower rates of cancellation.

There was also a significant negative correlation ($r = -.674$, $p < .01$, $n = 23$) between in-patient cancellation rates and the Patient Involvement index score. In other words, hospitals that had better systems and practices for involving patients in the design and improvement of hygiene services also had significantly lower rates of cancellation.

An independent samples t-test revealed that hospitals performing well in relation to in-patient cancellation rates (IPCR < 5%) more frequently involved front-line clinical and/or support staff in service improvement projects ($p < .05$).

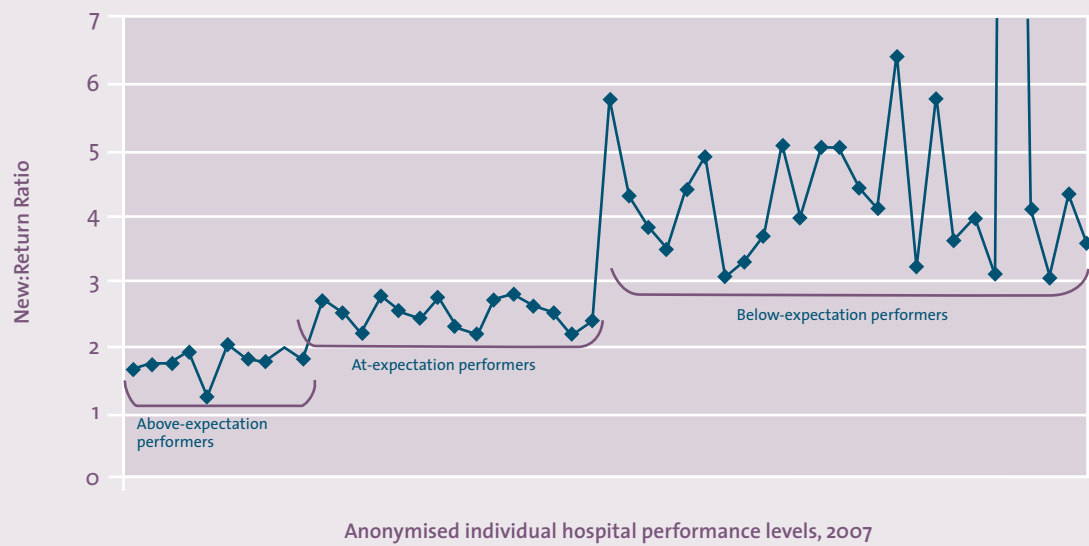
4.5.5 New:Return Ratio in Outpatients Department

This is the ratio of new patients to return patients seen by an Outpatients Department in the acute hospital system. A lower ratio suggests that the hospital is implementing a system that is relatively effective in processing patients efficiently, indicating a more patient-centred approach, resulting in a higher throughput of new patients and, all other factors being equal, a consequentially shorter waiting list for access to the service.

A lower ratio, and certainly a ratio that shows longitudinal improvement, would suggest evidence of continuous service improvement, potentially underpinned by effective clinical governance, communications, multidisciplinary teamworking, whole-system cohesion, joined-up clerical administration and effective records management. In this respect, it can be considered a valuable indicator of performance levels in Outpatient Departments.

This ratio can be expected to vary according to hospital type. For example, the mean ratio will be different for maternity hospitals than for Casemix 1 hospitals, and again for Casemix 2 hospitals. However, after controlling for this distinction, there is clearly considerable variability in the ratio across hospitals.

Figure 16 New:Return Ratio in Outpatient Departments



Analysis

We found a significant negative correlation between New:Return ratio and partnership practices ($r = -.499, p < .05$), indicating that better use of partnership practices is associated with better new:return ratios.

We also found a significant negative correlation between New:Return ratio and the Collaboration and Teamworking Index ($r = -.628, p < .05$), indicating that better levels of teamworking and collaboration are associated with better New:Return ratios.

Figure 17 New:Return ratio in Out Patient Departments x Partnership Practice Index score

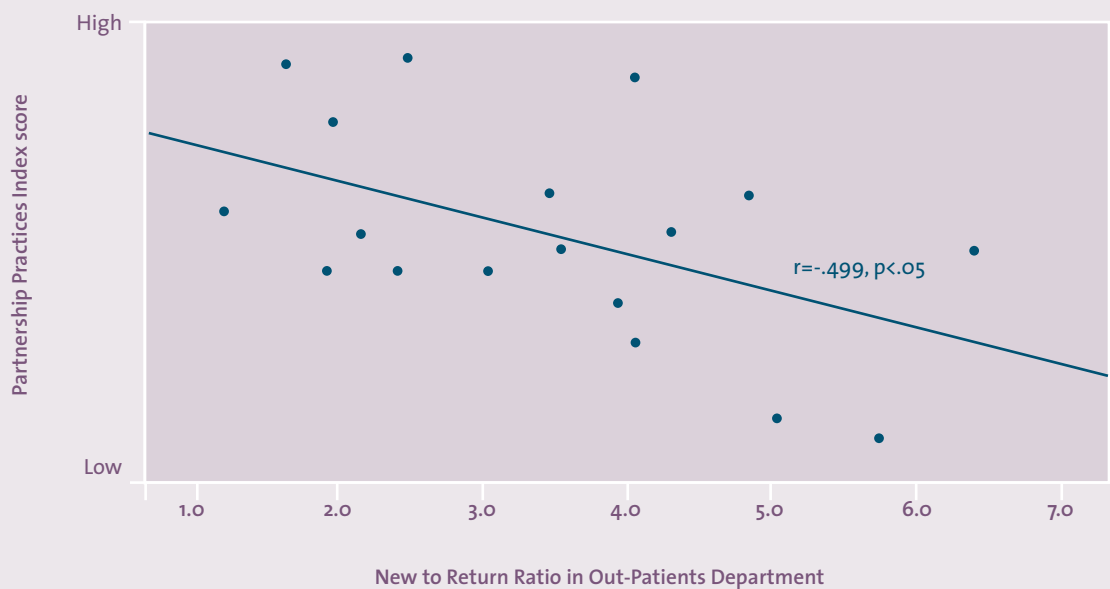
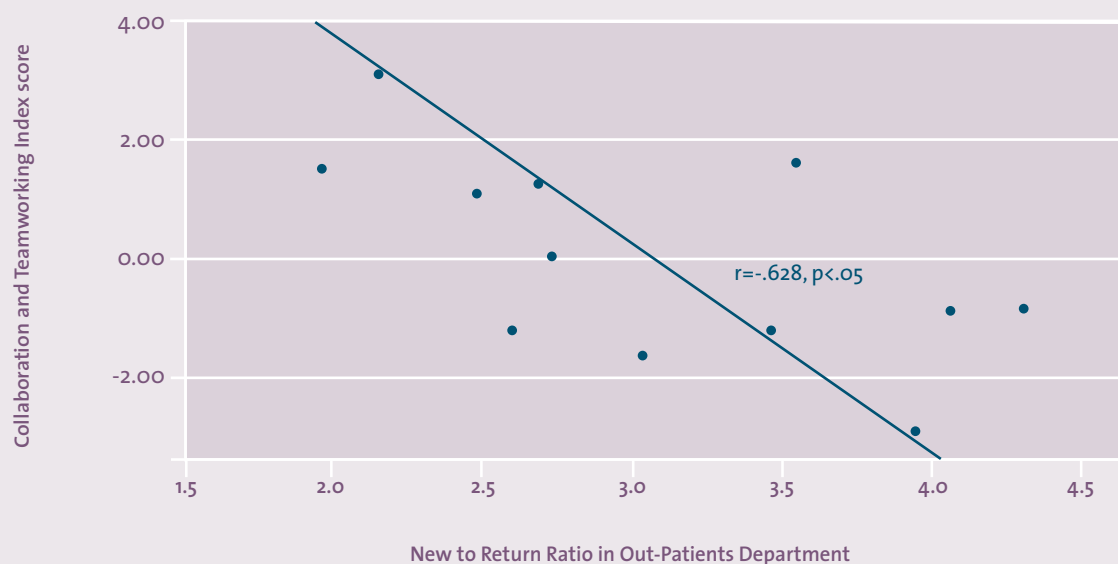


Figure 18 New: Return ratio in Out Patient Departments x Collaboration and Teamworking Index score



4.5.6 Missed appointments for return patients at Outpatient Departments

This measures the percentage of appointments for return patients at Outpatient departments that did not attend (% DNA). This is a robust indicator of performance for all hospitals, with no compelling reason for variance other than performance. At its most basic, the ratio can be viewed as a direct indicator of waste, which should be a target of immediate redress. It is also an indicator of process efficiency. A lower rate would suggest that the hospital is implementing a system that is relatively effective in eliminating missed appointments by return OPD patients.

A lower rate, and certainly a rate that shows longitudinal improvement, would suggest evidence of continuous service improvement, potentially underpinned by good HR systems, effective patient-

focused processes, good clinical governance, communications, multidisciplinary teamworking, whole-system cohesion, joined-up clerical administration, effective records management, and, potentially, good ICT systems. It would be reasonable to expect that a good clinical manager would be aiming to lower the rate. It would also be reasonable to expect that lower DNA rates relate to higher levels of patient satisfaction in their dealings with the OPD. Figure 19 highlights the performance variability across the acute hospital system.

Analysis

Analysis reveals a significant negative correlation ($r = -.507, p < .05$) with the Direct Staff Involvement index, suggesting that hospitals where front-line staff are more routinely involved in service improvement also have more joined-up and efficient Outpatient Departments.

Figure 19 % Missed Appointments in Outpatient Departments (return patients)

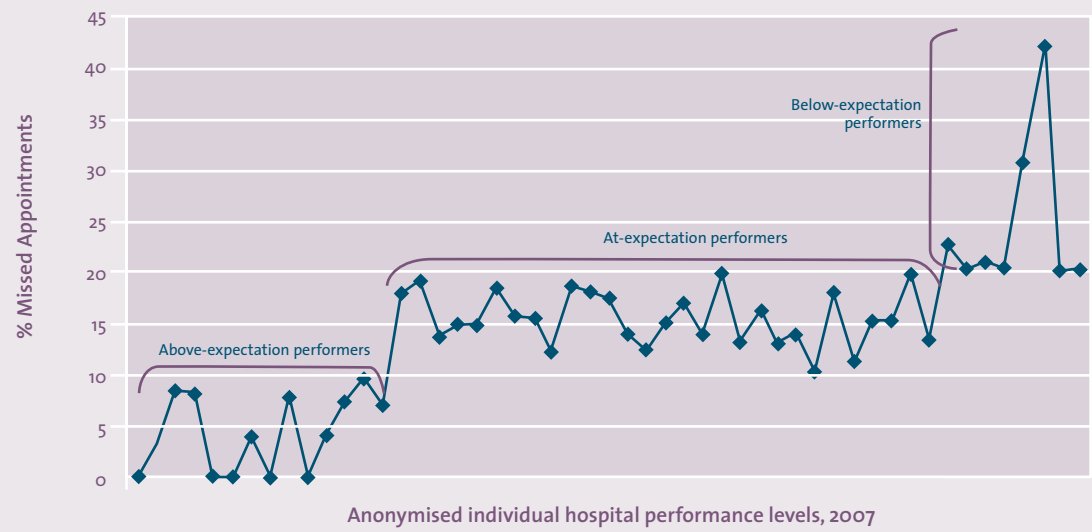
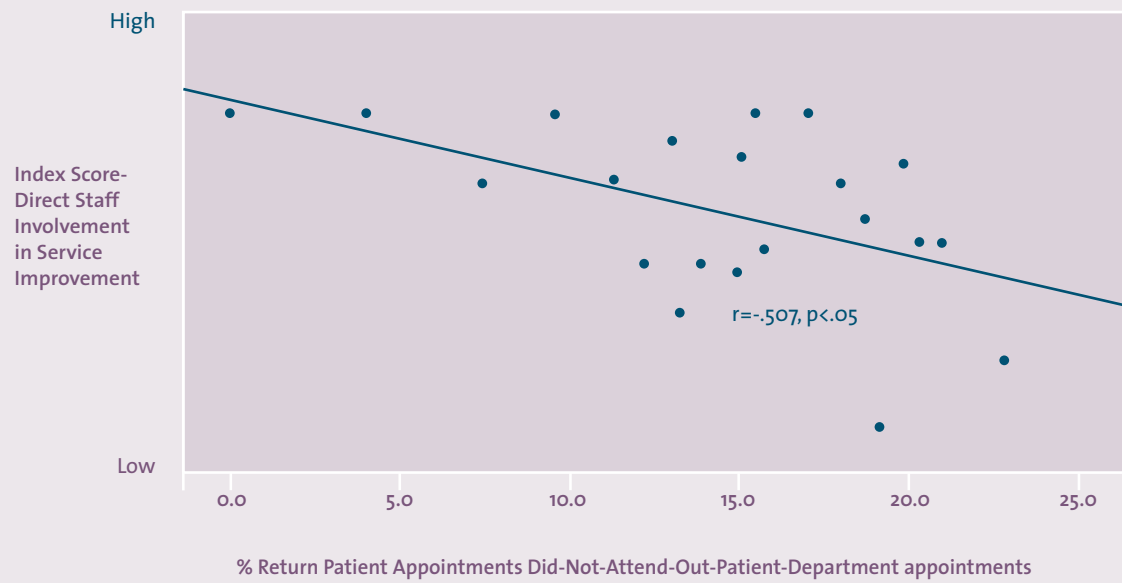


Figure 22 Current State of Participative Governance and Organisation: macro-system factors



Part C

Part C examines the relationship between participative governance and performance further, drawing on detailed evidence from study visits to seven acute hospitals. It then draws on the combined evidence from the international literature and the research in the Irish acute hospital system to operationalise the conceptual model. The final chapter presents the conclusions and recommendations.

Chapter 5

Participative Governance in Practice: Evidence from the Front Line

5.1 Identifying the conditions for excellence: seven hospital visits

The literature review described in Chapter 2 provided the research team with a strong indication, if one was needed, of the complexity of the relationship between organisational practices on the one hand and organisational performance on the other.

It was clear from the outset that making sense of the relationship would also entail in-depth qualitative investigation, and this took the form of visits by the research team to seven acute hospitals. These visits sought to identify “what works” in enabling staff to make a full contribution to effective governance and quality improvement – and to identify the obstacles to that goal. Critically, the methodology was designed to ensure that the resulting picture was multi-voiced – that it captured the points of divergence and convergence between the perspectives and experiences of actors in different parts of the hospital system.

In selecting the seven sites for the hospital visits, the Project Steering Group was actively concerned to ensure that it achieved a sensible balance both between large teaching hospitals and smaller regional or local hospitals, and between HSE-owned statutory and public voluntary hospitals. The sample also achieved a reasonable geographical coverage. Since the principal aim of the visits was to enhance understanding of participation and partnership in the system as a whole, rather than to audit the practices of individual hospitals, it was agreed to maintain the anonymity of the participating institutions. This played an important role in ensuring the open disclosure of information and free access to a wide range of staff.

The *OIL* methodology described above provided the basis for data collection during the visits. Four researchers interviewed members of the Executive team and senior clinicians in order to gain their perspectives on the development of partnership in

the hospital, its impact, and its relevance to other drivers for change such as governance, quality improvement and the emerging financial crisis. Issues arising from these discussions were then explored with line managers and front-line staff. Wherever possible these latter discussions took place in small groups and were facilitated in ways that brought out shared experiences and specific stories including rich descriptions of achievement, struggle and adversity. Detailed evidence was collected from more than 400 people across the seven hospitals.

The research team emerged from these visits with a vast range of data, including notes from interviews and group discussions, policy documents and minutes from partnership meetings. An exhaustive initial analysis identified a number of themes, providing a matrix within which it was possible to categorise most of the data from the seven hospitals. Themes ranged from the role and effectiveness of formal partnership structures to the extent of opportunities for reflection and involvement experienced by front-line staff in their day-to-day working lives. These themes were gradually refined through testing and iteration against evidence emerging from the literature and the survey.

The methodology facilitates the identification of discrepancies between the perceptions of senior personnel and the described experiences of line managers and front-line staff. We make no judgement about “right” and “wrong” perspectives but such discrepancies offer a particularly valuable means of gaining insight into the workings of partnership, participation and communication practices within each hospital, and in particular the obstacles they face. These discrepancies also provide a fertile basis for constructive dialogue between the different actors, both at the level of the individual hospital and at the level of the hospital system as a whole.

Box 3 OIL (Organising, Involving, Learning) Methodology (UK Work Organisation Network)

The OIL approach is based on an audit of workplace culture and practices, involving employees from all levels in identifying the major areas that require attention, as well as the positive and valued aspects of working life and practice. At the heart of the approach is a technique known as Group Recall.

The reality of how an organisation works can be revealed by inviting groups of between six and ten employees to identify and analyse shared experiences – either specific instances that they have all experienced or more generalised aspects of day-to-day work. Rather than asking people to make abstract assessments of how “good” an organisation is in terms of pre-defined categories (often the approach taken with traditional focus groups), Group Recall involves participants in analysing the causes and meanings of issues which arise in day-to-day working life. Anecdotes therefore become an important starting point for uncovering the hidden processes that take place at work. For example, instead of asking a group, “Does this organisation respect the knowledge and experience you bring to the job?” the facilitator would ask, “Can you give me an example of a situation where you felt good about having used your knowledge and experience to make a real contribution to the job?”, or conversely “Can you give me an example of a situation that made you feel that your knowledge and experience were being ignored?” The group is then guided to identify factors which make the difference between the two situations, again grounded in actual experience of working life.

Group Recall will thus reveal immediate priorities for action, as well as less visible barriers to employee motivation and engagement. The methodology typically involves the following stages:

1. In-depth interviews with senior managers, designed to identify perceptions of organisational policies and practice, including awareness of the working life issues experienced by front-line staff.
2. From the analysis of these findings, key “propositions” will be extracted about work organisation, working life and culture in the organisation.
3. These propositions will be tested through Group Recall discussions involving a cross-section of front-line staff. Groups can be recruited to reflect functional, organisational and geographical divisions. Discussions will particularly focus on:
 - experiences that affect working practice;
 - perceived reality of working life and employment in the company;
 - the extent of a shared vision of the company’s future;
 - identifying resources and approaches needed to enhance employee engagement and to support future change.
4. Analysis of findings from stages 1–4 identifies the extent of convergence between corporate intent and managerial perception on the one hand, and the lived experience at the front line of the company on the other. This provides strong insight into outstanding issues and the scope and nature of actions capable of enhancing employee engagement.
5. Findings and conclusions are then presented to management and participating staff, both as a way of checking validity and of providing feedback.

In sections 5.2 to 5.7 below we present the outcomes of this analysis starting with the role of Partnership Committees and moving through to direct forms of participation. This sequence is not intended to convey any sense of an implicit hierarchy in the importance of these practices: rather that the role of Partnership Committees and their impact on the wider organisational climate emerges both from the analysis of existing research and from the survey as a central question.

5.2 What do Partnership Committees do?

In line with the project brief, the research team sought evidence in each of the hospitals of the impact of Partnership Committees on (a) sustaining non-adversarial IR; (b) facilitating major change through the avoidance of IR issues, active participation in design and implementation, and the creation of a positive attitude to change amongst the workforce; (c) instigating proactive SHRM policies; (d) continuous quality improvement and clinical governance; (e) a “partnership climate” throughout the organisation, including management style, a “no-blame” culture, high levels of risk/incident reporting and ability of all staff to contribute ideas for improvement.

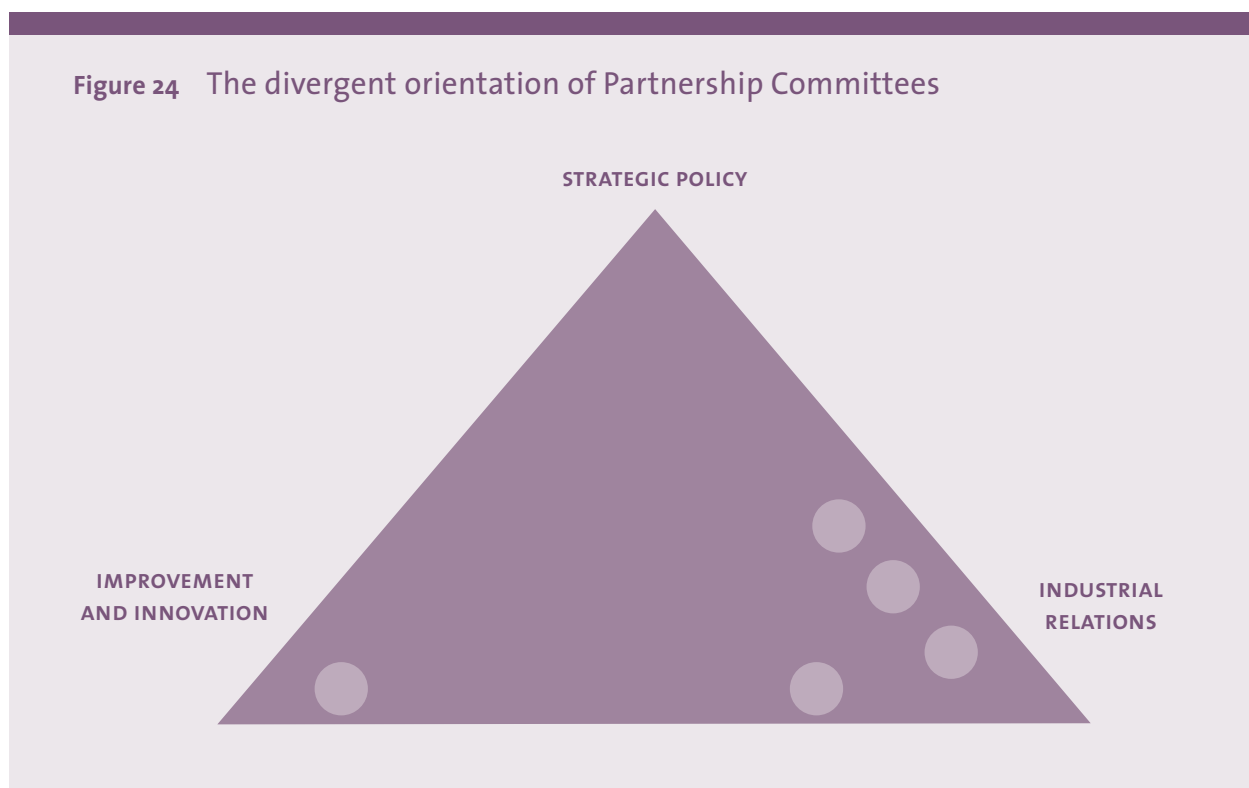
The suggestion that Partnership Committees “need an injection” and a new sense of purpose was almost universally acknowledged – even in

hospitals where formal structures were working relatively well, it was “time for renewal.” Union representatives and managers in one public voluntary hospital considered that the Partnership Committee was seriously weakened by the prescriptive nature of HSE directives, offering little scope for dialogue. The recent IMPACT dispute and the consequent withdrawal of the Union from partnership activities had thrown several Committees into powersave mode. In the worst case the Joint Chair of a Committee described partnership in the hospital as a “shambles” with poor attendance at meetings by management and unions alike. In several hospitals, plans for revival were just starting during our visits so it was difficult to evaluate the potential effectiveness of Committees.

Partnership Committees were found to vary considerably in both their levels and focus of activity, with only a minority close to the heart of hospital strategy. An analysis of Partnership Committee minutes from 12 hospitals confirms that most are failing to deal with strategic issues on a systematic basis, and that there is a heavy emphasis on relatively trivial issues such as smoking, coffee bars and car parking. Excluding the trivia however, the analysis identifies three main strands to the work of the Committees, and these are illustrated in Table 5.

Table 5 Selected extracts from Partnership Committee minutes

Participation in hospital strategy and governance	Building and maintaining co-operative industrial relations and HR	Instigating and supporting innovation and improvement
Guidelines for local implementation groups concerned with service reconfiguration.	How partnership can support the management of change.	Finding practical projects with a start, middle and end that are measurable.”
Supporting “Value for Money” and “Cost Containment” Working Groups in several hospitals.	Communication strategy. Staff meetings.	Modernising the trauma transfer system in the Emergency and radiology Departments.
Quality and Risk reporting framework.	Partnership IR framework.	
Hygiene audit.	Attendance management.	
National cancer strategy.	Staff handbook.	

Figure 24 The divergent orientation of Partnership Committees

As a simple means of demonstrating the variance, Figure 203 locates five of these hospital Partnership Committees in terms of their relative orientation towards IR, strategic policy and innovation/improvement. Note that this diagram is purely for illustrative purposes and does not reflect a scientific weighting of the different characteristics of each Committee.

A proposition that might reasonably be derived from the partnership literature (Farnham, Horton and White, 2003) is that a fully effective Partnership Committee would be located within the centre of the triangle, balancing the maintenance of a positive industrial relations climate with dialogue around strategic policy and the active resourcing of high involvement improvement and innovation. In practice none of the five Partnership Committees came close to achieving this balance.

In each case the existence of the Partnership Committee was credited by unions and management with the avoidance of local disputes and the creation of a positive IR climate in ways that facilitate change. It should also be emphasised that the existence of Committees represents a proactive and usually effective means of compliance with the EU *Information & Consultation Directive*.

In some cases the IR climate had been progressively transformed over a number of years through committed leadership from management and unions, leading to a highly co-operative culture, which transcended the confines of the Partnership Committee itself. Several instances were also cited where mergers or significant restructuring has been achieved without significant IR problems as a result of early and consistent Partnership Committee dialogue. While some managers were critical that partnership procedures slow decision-making, the dominant view appears to be that they enhance confidence by providing a sounding board for proposals and offering the assurance that ideas can be pre-tested for potential difficulties or conflict. One manager described the partnership consultation process as “latently available” – deflecting crises but otherwise lying dormant and awaiting reactivation by situations beyond line managers’ capacity to handle. Arguably this “latent” quality reduces the visibility of Partnership Committees and may lead some actors to underestimate their actual impact in sustaining a positive climate for innovation and change.

Despite the role of Partnership Committees in building a positive IR climate, there is a strong separation between “boxing” and “dancing”

(Huzzard, Gregory and Scott, 2005), in that collective bargaining and representation take place in a different forum from partnership matters. This leads several managers and union representatives to complain that their Partnership Committee “has never dealt with the hard issues yet” and spends its time on “trivia” such as smoking and uniforms. Some respondents also reinforced findings from the UK that HR managers in the health service held a restricted, instrumental view of partnership; they used the partnership institutions to achieve formal policy and procedural changes, irrespective of how remote these issues were from the concerns of most employees, with the consequent exhaustion of union energies in servicing corporate agendas (Tailby, Richardson, Stewart, Danford and Upchurch, 2004).

Thus there is clearly untapped potential for dealing with more difficult matters through partnership but this needs clear commitment from all parties: “What good is it if it doesn’t have the teeth?” Likewise there are suggestions from some managers that unions resort to traditional IR routes too quickly without exploring partnership options thoroughly. One middle manager summed up the views expressed by many that “partnership is a haphazard process” and complained that there were no clearly established rules to decide “what will be considered by whom”.

However in most hospitals “dealing with the hard issues” would undoubtedly require a closer relationship between Partnership Committees and Executive Management Teams (EMTs). The deliberate distancing of Partnership Committees from key policy discussions in most of the hospitals visited came as something of a surprise. In most cases Partnership Committee members do not have access to EMT minutes or to finance and performance data, and were rarely consulted at the earliest stages of key policy decisions. From our limited sample it appears that Boards in the Public Voluntary Hospitals operate with greater openness and inclusion than the management structures in their HSE counterparts. In one voluntary hospital, relatively well-resourced union representatives reported easy access to the CEO and other senior managers, and both parties stressed the importance of informal dialogue and early involvement in dealing with issues that arise.

While most of the hospitals visited were clustered more or less tightly around the IR pole, one stood out from the rest through the evident role that HSNPF Partnership Funding played in its entire *raison d’être*. In this small regional hospital – where the IR climate was described as “passive” – senior managers worked hard to identify projects that would attract HSNPF funding in order to maintain the Partnership Committee’s momentum. The Committee also instigated a staff survey in order to stimulate ideas for improvement and the “Empty Chair” at meetings gave members a chance to hear ideas and experiences from nominated front-line staff. Completely separated from key policy decisions, it appeared that this particular Committee would have no purpose if Partnership Funding dried up: in effect it had become a continuous improvement group rather than a key component in hospital strategy and practice. In another case the Partnership Committee (combined with a degree of direct staff involvement) was used to legitimise the acquisition of HSNPF funding for what might best be described as mainstream decorative refurbishment. While we did find a number of examples where HSNPF funding had been used effectively to deepen and embed partnership practices throughout hospitals (see below), these instances draw attention to the potentially distorting effect that the untargeted use of financial incentives can have on the role of Partnership Committees. In contrast however some Committees were either unaware of how Partnership funds might be used to promote real change or were poorly prepared to use them effectively.

The involvement of Partnership Committees in mainstream hospital quality improvement or service innovation activities is rare; in one example, however, the Partnership Committee instigated an initiative to extend opening hours in the X-ray and radiography department thereby eliminating a 6–8-month waiting list. Staff-related initiatives (such as the establishment of a crèche) have also been instigated directly by Committees. In the one hospital the Partnership Committee instigated proactive HR policies designed to systematise partnership-based approaches to attendance management (generating significant

cost savings) and bullying and harassment (resulting in a significant reduction in grievances).

Most often, partnership involvement in improvement or innovation takes place at arm's length through localised partnership forums (see 5.3 below). This lack of visible involvement in high-profile initiatives clearly weakens the standing of Partnership Committees (a member of one Committee "could not remember a single achievement"), even if it can be argued that they are instrumental in creating the structures and climate for innovation and change at other levels of the organisation. This is, in part, a case for more effective internal PR and communication: partnership as a systemic activity (in contradistinction to the activity of the Partnership Committee) was rarely publicised.

The near-universal disengagement of clinicians from formal partnership structures has already been noted. Critically there is also a strong sense of disconnection between partnership and emerging models of clinical governance in hospitals. Initially this appeared to cast doubt on the ability of partnership per se to engage with "the real business of hospitals" and has been cited by our respondents as a cause of major concern. However, dialogue with clinicians and managers in the seven hospitals enabled us to understand the nature of this issue more clearly. It is certainly true that the major clinically-driven changes required in the hospital sector over coming years will have sustained IR repercussions as well as implications for the direct involvement of front-line staff. Partnership Committees have proven their worth in facilitating effective change and some of the newly appointed Clinical Directors acknowledged the need to engage them in future planning; this provides grounds for optimism that the gap need not be as wide as it often appears. On the other hand much of the partnership process appears remote from the day-to-day concerns of medical, nursing and allied health professional staff alike: "People don't understand what partnership means for them and their role." The next section examines ways in which some Partnership Committees have established specific forums that are "closer to issues of immediate concern" to these groups.

5.3 Beyond Formal Partnership Committees: Spreading participative practices to the front line

According to one General Manager, "the Partnership Committee is a minor part of the totality of Partnership." Beyond the role of the formal Committee, partnership makes a critical impact on hospital performance when it is manifested in high levels of staff involvement and participation at all levels of the organisation, and this is explicitly recognised within the Health Services Partnership Agreement as well as within the work of the HSNPF (see Chapter 1). The negativity demonstrated by several management, staff and trade union respondents during our visits appears to reflect a popular conflation between Partnership Committees and partnership per se: Partnership Committees appear relatively ineffective therefore partnership itself is a dead duck.

However, we also found substantial support for the view that Partnership Committees themselves could play – and sometimes were playing – a key role in disseminating "partnership behaviours" to clinicians and line managers throughout the organisation. It is important not to neglect the intangible dimension of this process – managers talked about the way in which "the very existence" of formal partnership arrangements influenced their own way of working with staff even when they had no direct contact with the Committee itself. At the same time we also tried to find evidence of deliberate strategies by Committees to bring partnership to the front-line. Such evidence turned out to be sporadic.

The most effective way of spreading partnership "culture" and practice appears to be through the creation of "local" partnership forums, which encourage direct staff involvement by focusing on people's day-to-day concerns – as the Health Services Partnership Agreement points out, these can sometimes be targeted on professions, on departments, and on specific areas where improvement is needed. In one hospital separate forums for nursing, allied health professionals and other groups play a key role in engaging front-line staff and union stewards in quality improvement and risk management, while also providing staff with an opportunity to voice issues of immediate concern. Elsewhere, Multidisciplinary Committees

representing all grades are established across one hospital to deal with a wide range of issues; these Committees regularly employ the services of the Partnership Facilitator who “partnership proofs” the handling of particular issues, advising on involvement and communication. In another hospital, Local Implementation Groups (LIGs) targeted principally at specific occupational group were established to deal with issues raised by management, unions or the regional HSE structure. Both unions and management are asked to identify areas of concern or opportunities for improvement to their respective LIG.

Box 4 Local Implementation Groups

LIGs are playing a valuable role (notably in relation to porters and laboratory staff) in helping to manage rostering and work patterns in the context of growing staff shortages. According to one middle manager “It’s worrying how often the guys have a better idea than yourself”: LIGs offer a “chance of doing it right this time.” In the case of laboratory staff this led to upskilling as a means of enhancing flexibility and reducing pressure on certain roles. LIGs have succeeded in “bringing people in to partnership – making them feel involved.” However, there is no medical representation on LIGs at that hospital, though the Director of Nursing participates regularly.

Weiner and his colleagues (1997) show that targeted physician participation in formally organised quality improvement teams is positively associated with improved patient safety outcomes. However, involvement by medical staff in these devolved partnership structures was, on the whole, unusual. While some were highly proactive, doctors in each of the seven hospitals appear to be under no sustained pressure to participate in multidisciplinary forums concerned with quality improvement, innovation, risk, untoward incidents, patient safety or patient care. This presents a challenge both to partnership and to the emergence of clinical governance. In one Public Voluntary Hospital, partnership forums were

planned as part of each of the proposed clinical directorates and could play a simultaneous role in disseminating partnership principles to the front line and in the creation of a participative model of clinical governance.

Bach’s (2004) research in the UK found that the scope to develop effective employee participation was greatest among the nursing workforce, and the establishment of alternative approaches to staff involvement was championed by the Directors of Nursing in some of the seven hospitals. These approaches were grounded in the particular occupational concerns and aspirations of nurses and were of greater direct relevance to these staff who were more engaged in extended involvement.

Regular ward or team meetings can provide the most tangible expression of partnership in day-to-day working life for the majority of front-line employees. Partnership Committee representatives and senior management alike in all seven hospitals acknowledged the importance of such meetings for engaging staff in improvement and governance, as well as in maintaining effective communication and high morale. However, while we found a minority of cases where some progress had been made towards establishing regular ward or team meetings as the norm, in none of the hospitals was there an unqualified and systematically reinforced expectation that line managers must organise such forums effectively and on a regular basis. Even where meetings do happen, many front-line staff remain sceptical about the commitment of managers to partnership: some ward meetings were described as “useless” and it is clear that front-line staff are sometimes demotivated by the discrepancy between participation rhetoric and actual experience.

Yet while senior management can be very committed to the success of devolved partnership forums, individual staff members and union representatives continue to report little support from immediate line managers in securing time away from duties for partnership activities. This clearly inhibits the ability of partnership and participation to harness the full range of staff knowledge and experience in quality improvement, but it also draws attention to the line-management dilemma. This is explored further in Section 5.7 below.

5.3.1 *Using and not using the Protocol on Handling Significant Change through Partnership*

The *Protocol on Handling Significant Change through Partnership* was agreed nationally as a means of embedding win-win principles in change processes at hospital level. In many ways the protocol successfully incorporates the principles of high-involvement innovation within a codified and essentially practical set of recommendations. According to the HSE:

The aim of this protocol is to help managers, trade union representatives and employees working through partnership in the Health Services to handle significant changes with confidence. The protocol lists the types of issues that managers and trade union representatives have identified as being important to address through partnership in the interests of improving services to the public and the quality of working life of managers and employees. The protocol sets out a framework within which managers and union representatives may raise significant issues and agree on appropriate mechanisms for handling them.

HSE (2008) Protocol on Handling Significant Change through Partnership

It was notable that while the smaller hospitals visited in this study tended not to make explicit use of the protocol, its essential principles were understood by the key actors and have been soundly embedded within major change initiatives. For example, staff, unions and management in one hospital reported positive experiences in the move to a new building through the active participation of staff in each department during planning and transition stages. Partnership Committees in the larger hospitals were more likely to have customised and adapted the protocol to local circumstances (in one case amalgamating it with procedures adopted as part of the hospital's response to the EU *Information and Consultation Directive*).

5.3.2 *High involvement innovation: an underused dimension of partnership?*

A critical dimension of partnership-based practice lies in the involvement of front-line staff and unions in identifying, designing and implementing innovations in ways which capture

both their knowledge and commitment. High involvement innovation (Schroeder and Robinson, 1991; Boer, Berger, Chapman and Gersten, 1999) is characterised by the expectation amongst managers and front-line staff alike that change will be inclusive and developmental.

The research team found a number of examples of high-involvement innovation in the seven hospitals. In each case these were linked to the Partnership Committee directly (in the sense of being instigated or overseen by the Committee) or indirectly (in the sense that they could be directly attributed to the partnership culture and practices promoted by the Committee).

5.3.3 *Patients, hospitals and staff: evidence of win-win-win innovation?*

The most systemic approach to high involvement innovation amongst the seven hospitals was found in a major Public Voluntary teaching hospital and in a large regional hospital.

In this first case the Partnership Committee is active and includes a strong and well-resourced trade union alliance. Senior management was committed to the dissemination of partnership practices and the Partnership Committee had both adopted and customised the *Protocol on Handling Significant Change through Partnership*. While the Committee operated at arm's length from service improvement activities, it oversaw the establishment and operation of a *High Priority Projects Office*. This focused on the implementation of a highly participative approach to Six Sigma and Lean methods with the full involvement of front-line staff. A project to speed GP referrals through the implementation of Lean techniques was particularly prominent, involving admissions staff and GPs in detailed analysis of processes before identifying opportunities for streamlining and cutting waste. Throughout the hospital some 110 *Green Belts* (staff who have received basic training in Six Sigma) have been trained over 7 years at 2-day workshops. This is potentially a vast resource in a hospital employing some 3000 people, creating a large and well-distributed cadre of individuals capable of leading innovation. However, we received no information on the impact of this training. It appears that no evaluation has been undertaken and it is not clear whether those individuals were

facilitated in their day-to-day jobs to identify or lead innovation. The High Priority Projects Office is high profile throughout the organisation and offers a useful resource for partnership (in its formal and informal sense) to drive innovation.

At the same time, senior management and partnership representatives adopt a pluralistic perspective and are keen to encourage other approaches to flourish alongside Lean and Six Sigma. Ad hoc local working groups were instigated to address specific bottlenecks to patient flow and other areas where the potential for quality improvement had been identified – for example, the introduction of Saturday radiography clinics to reduce waiting lists. Such innovations have obvious IR implications, which generate serious potential for inertia; it is clear that the active partnership structure and culture in this hospital contributed both to the instigation and the implementation of these improvements. In summary this hospital had acquired considerable collective competence in high-involvement innovation, driven and supported by synergies between the Partnership Committee, the trade union alliance and senior management's commitment to both direct and representative participation. However, innovation appears to remain driven by specific problem solving, or by the serendipitous emergence of “good ideas”. This works well up to a point, but there is clear if unrealised potential to use the hospital's accumulated change competence more strategically through the systematic use of process mapping across each patient pathway.

The smaller, regional hospital has begun to adopt this approach through the creation of “Patient Journey Groups”, which involve the Finance Manager, HR and clinical staff. Yet while this suggests the development of a systematic approach to the identification of opportunities for innovation, here there is no consistent approach to the involvement of front-line staff and no direct link with the very much less active Partnership Committee and trade unions. Likewise, the Finance Manager at the same hospital has instigated a “Value for Money Group”, which has proven to be an effective vehicle for engaging middle managers across departments in the identification

of cost-saving measures – but front-line staff and union representatives are excluded and feel disenfranchised from contributing their own ideas and experience.

Comparison of these two hospitals points to the role that a strong Partnership Committee and a well-organised trade union alliance can play in creating the conditions for the active engagement of front-line staff. It also suggests that this engagement is less likely to happen where those conditions are absent, even where strong managerially driven approaches emerge.

Examples of “bottom-up” innovation are not rare, and the research team found several cases in each hospital. The establishment of a bone density scanning facility in one district hospital, which has enabled over 1100 patients to be diagnosed locally rather than travelling some distance to a major regional facility, was led by a radiographer and involved extensive collaboration with front-line staff across a number of disciplines. In another hospital, front-line nursing staff and AHPs were heavily involved in planning a new A&E building; trade unions were also involved at an early stage in discussing consequent changes to working patterns. According to one of the union representatives involved, these issues are “best handled through partnership because people involved in delivering the service can sit down and resolve problems together.” In the same hospital's maternity department, difficulties in midwifery recruitment have led to a partnership approach to work redesign in which neo-natal and paediatric nurses rather than midwives look after premature babies on the ward. It has also created a joint approach to recruitment including fast-tracking and liaison with colleges. In this case a partnership-led approach involved both unions and front-line staff in ways that not only avoided the IR problems resulting from shortages but that also led to creative interventions.

5.4 Contested terrain? Governance as a driver for improvement and innovation

Clinical governance in Irish hospitals remains embryonic and somewhat fragmented in most cases. However, the majority of hospitals have established risk and/or quality improvement committees, although many operate in silos and have little to do with partnership or staff involvement.

There appears to be no national model of clinical governance, although the implementation of the HSE's *Quality and Risk Management Standard* (HSE, 2007) offers the potential for strategic direction and consistency.

5.4.1 Clinical Directorates: common purpose?

The appointment of Clinical Directors is widely seen as critical to the future direction of governance. Indeed, in several of the hospitals we were told that clinical governance was “on hold” until the Clinical Directorate structure was in place. One manager summed up the situation in many hospitals when he said that the Clinical Director’s priority should be to “sort out” fragmented relationships between different parts of the structure.

According to the HSE:

*The appointment of Clinical Directorates represents a milestone in the management and development of health care in Ireland and was a key element of the new consultant contract. Patient outcomes, safety, clinical effectiveness and financial management are likely to be better when there is significant involvement of clinicians in managing and delivering services Clinical Directors will lead and accelerate positive clinical and management change. They will strengthen links within and between acute hospital and community care services, speed up patient access and simplify patient journeys and care pathways.*¹¹

In HSE hospitals, Clinical Directors and clinical directorate structures are likely to play the commanding role in driving innovation and improvement, and it will be interesting to observe the types of relationship that develop between them and hospital General Managers. In Public Voluntary Hospitals, and perhaps elsewhere, there appears to be widespread disquiet at board, senior management and consultant levels about what is seen as the HSE’s “one size fits all” approach. Larger hospitals in particular appear to favour a team-based approach involving three or more clinical directorates, each with responsibility for different functional areas. At the time of our visits however it was unclear about how this divergence of views will be resolved.

Disquiet is also widespread about the likely *modus operandi* of clinical directorates. In some of the hospitals visited we found clear evidence that the new Clinical Directors were firmly committed to multidisciplinary and partnership working. One specialist nurse was anticipating that the Clinical Director would “liberate staff and give them permission to contribute more than at present.” In the best cases, plans were being developed to integrate nursing, allied health professional and partnership representatives within clinical directorate structures and practices, with an explicit focus on fostering front-line staff involvement in governance. However we were unable to find evidence of clear guidance from the HSE – either in terms of actual working practices or in terms of the qualities and competencies required if a Clinical Director was expected to work in this way.

11. http://www.hse.ie/eng/News/National_Tab/Statement_by_Prof_Brendan_Drumm_CEO_of_the_Health_Service_Executive_to_the_Joint_Committee_on_Health_and_Children_shortcut.html; accessed 30th April 2009).

Box 5 Participative design: a bridge too far?

One public voluntary hospital acknowledged that the introduction of Clinical Directorates had significant implications for the working practices of staff by organising an extensive consultation exercise. A series of participative design workshops were instigated which involved a wide section of staff in analysing experience of Directorates from elsewhere and identifying a model appropriate to local conditions. Two of these workshops were focused on senior managers, the other four on different groups of front-line staff, line managers and union stewards. Significantly the Partnership Committee only played an arm's length role in the participative design process but individual stewards were able to support the process using their considerable local knowledge and influence. Consultants did not participate in the process for the first six months, demonstrating considerable scepticism about the value of consultation, but later began to take part.

The resulting model placed considerable emphasis on multidisciplinary working; a nurse leader was proposed for each Directorate and each would have a strategy for regular meetings with staff. A matrix structure was developed to integrate the work of the Directorates with each clinical department and corporate service.

Initially the HSE were supportive of the consultation process and watched with interest. At the time of our visit, the process was on hold following an HSE instruction not to proceed, despite the previous heavy investment. We found that this was having a tangibly demoralising effect on staff and management alike.

It is apparent that Clinical Directors will enjoy considerable discretion in developing their preferred mode of operation. In most of the hospitals we found considerable unease at all levels about the process of introducing clinical directorates and about likely outcomes. Several Nursing Directors were particularly vocal about their exclusion from HSE consultation and planning meetings relating to the implementation of clinical directorates

and feared that this augured the reinforcement of medical dominance at the expense of multidisciplinary working and partnership. These fears were widely echoed by other nursing grades and by AHPs.

Some Clinical Governance managers however pointed to the difficulty that Clinical Directors would have in asserting their authority: there are "two parallel power structures in play – the clinical directorate structure and the traditional *modus operandi*."

In contrast, even amongst newly appointed Clinical Directors there was strong anxiety that their role would become that of "enforcer" of top-down HSE directives rather than harnessing the local engagement and innovative potential of staff in securing quality improvement.

In short, the move towards clinical directorates is welcomed as an opportunity to provide impetus, coherence and consistency to governance and quality improvement, but it opens up a vast and highly significant area of contested terrain both between medical and multidisciplinary and between top-down and bottom-up approaches.

5.4.2 Sustainable improvement? Accreditation, dialogue and continuity

External accreditation of hospital practice and performance has long been a feature of some European countries but has generated evidence that assessment can be a "tick box" exercise leading to quality assurance without quality improvement. Performance measurement *per se* does not automatically lead to high standards or improvement.

On the other hand the assessment process can provide a structured opportunity for critical reflection and inclusive dialogue about opportunities for improvement and innovation. "Bringing bright people together" leads to "collateral benefits" – creating a mutual understanding of what other people do. Likewise, in one hospital an inclusive, partnership-based approach "really made a difference" to the accreditation process, even drawing in contract cleaners as "part of the team." The inclusiveness of the approach helped build trust, communication and the capacity to take stock. Guidelines for

accreditation were linked to local knowledge and this proved to be the key to success. Certainly the research team was struck by the frequency of references by front-line staff to the accreditation process as a positive example of the partnership approach.

However, it is clear that the momentum established by the accreditation process has not been maintained everywhere. The Quality Manager in one hospital admitted that “it was very easy just to tick the box”, and a loss of momentum certainly followed, especially because there were no resources to make real improvements: “Most quality improvements identified haven’t been acted upon.”

Nonetheless, there are clear examples where accreditation has strengthened governance structures, for example through the creation of a Quality and Risk Committee in one hospital; in another a “Leadership and Partnership” group was established after accreditation, as a continuing forum for sharing practice and experience between professions.

5.4.3 *Removing the climate of fear? Incident reporting and risk management*

If a wider “partnership culture” (as discussed in 5.3 above) were to exist in a hospital, one of the clearest indicators would be found in the attitude of doctors, line managers and front-line staff to incident reporting and risk assessment. An approach to incident reporting and learning, which is free from the fear of retribution, as well as the proactive assessment of risk, represent critical ways in which the day-to-day experience and tacit knowledge of front-line staff can be captured as a resource for improvement and innovation.

Several, though not all, of the seven hospitals reported a positive transformation of culture resulting in the steady emergence of a no-blame culture and improved levels of incident reporting. Participants in hospitals that had invested widely in partnership-related training saw this as the major contributor to the change. One hospital had also introduced mandatory study days for managers as a means of reinforcing a no-blame culture.

In a large teaching hospital, an investigation conducted by HIQA of a serious untoward incident led to a significant transformation initiative

in response to the report’s twelve principal recommendations.

It is also important to emphasise the importance of mechanisms that ensure effective learning from incidents. Several hospitals have introduced forums chaired by the CEO/GM, which investigate incident patterns identified by Risk Managers, and the root causes of serious incidents. Feedback to staff, as well as opportunities for collective learning from incidents, clearly play a key role both in quality improvement and in continuing to engage staff. However, such feedback and learning tend to be patchy even in hospitals with quite well-developed risk management capacity. We found a few instances of forums that were embedded in routine ward or team practice, and in which front line staff and managers were routinely able to discuss incidents as a means of learning and improvement. However these were disturbingly rare.

Despite encouraging signs of improvement, the persistence of widespread “fear of career damage and retribution” associated with incident forms was evident in the hospitals visited. Perverse and defensive behaviour by line managers often goes unchallenged by their seniors – “you have a lot of power in your own area.” More surprising was the open admission in one hospital that “doctors don’t do incident reporting”! Indeed, we were unable to find concrete evidence in any hospital to suggest this problem is not more widespread.

Protocols for incident reporting were also poor in some cases and this suggests a legitimate opportunity for early intervention by the HSE to harmonise practice. In one hospital the completion of incident/near-miss forms results in a third copy being left in the risk book for all to read, thereby creating a reluctance to report when other people are involved. In another hospital a simple lack of coding on incident forms prevents individual staff from receiving feedback.

Proactive risk management was also underdeveloped across the hospitals visited. On the one hand we found a hospital where no assessment of patient risk took place. On the other we found excellent examples of inclusive risk assessment involving front-line staff and different professional groups. In one maternity department, weekly education meetings take place involving

consultants and midwives, with mandatory attendance. The focus is clinical and addresses risk, incidents and ideas for improvement. However such examples are not replicated across the whole hospital.

In some cases it is possible to detect the beginnings of a coherent link at hospital level between incident analysis, proactive risk assessment and quality improvement strategy. We assume that the appointment of Clinical Directors will strengthen this virtuous circle, reinforced by the rollout of the HSE's *National Quality and Risk Standard* which is already prompting a more systematic review of current systems and procedures in some hospitals.

Once again the main obstacle appears to lie in a high degree of discretion enjoyed by doctors and managers about whether to opt in or out of a robust approach to risk assessment. Two risk advisors were appointed in one hospital but despite strong senior management commitment to their role they have to "work their way in" to access departments. In the same hospital a high-risk clinical area (maternity) has so far succeeded in resisting the introduction of a risk register.

Many respondents also expressed concern about the lack of specific risk assessments relating to posts affected by the recruitment embargo within the HSE.

5.4.4 *Is there a culture of continuous improvement?*

Systems and processes for the implementation of clinical governance and quality improvement need to be deeply embedded in hospital practice and working life. Strategies for staff appraisal, training and professional development (including for non-clinical staff) and time allowed for planning are seen as vital for quality improvement. Information technology also facilitates good communication and provides easier access to both clinical and non-clinical evidence on which to base practice. It should also enable the standardised and consistent collection of data for audit and similar purposes. Above all, it is the integration of these systems that leads to sustained quality improvement (McSherry and Pearce, 2002).

Front-line staff and union representatives are aware of "what works" and what doesn't on a daily basis, and this tacit knowledge provides a potentially invaluable component of governance as a resource for the improvement of patient care and the avoidance of untoward incidents (Preuss, 2003; West, Guthrie, Dawson, Borrill and Carter, 2006). However, the ability of the hospital to capture such knowledge depends on the creation of time and opportunities for critical reflection – both structured and informal (Boud, Cressey and Docherty, 2005).

Despite the insistence of the HSE's *Quality and Risk Management Standard* (HSE, 2007) on clinical audit as a building block of governance, effective examples are quite rare. It is recognised that clinical audit needs to be at the heart of clinical practice and service innovation, engaging all health practitioners in continuing evaluation and improvement. Clinical audit arguably constitutes the single most important method that any healthcare organisation can use to ensure the quality of the service that it provides. It must embrace and deliver improvements across all aspects of clinical quality, including effectiveness, efficiency, equity, appropriateness, acceptability and access and be well-integrated within the wider approach for enhancing clinical effectiveness (Davies, Powell and Rushmer, 2007).

We found a number of cases where managers attempted to initiate audits of practice in order to meet internal targets, and in some cases front-line staff were involved, but typically in routine data collection with little engagement in dialogue about the potential for improvement and the sharing of sound practice. More seriously, however, these audits were often undertaken in isolation with no apparent link to clinical governance or risk management structures at hospital level. This reaffirms the findings of the Commission on Patient Safety and Quality Assurance which pointed out that:

While clinical audit is being advanced in a number of organisations, it is not generally linked to service improvements, planning or resource allocation (Building a Culture of Patient Safety, 2008).

However, one hospital holds annual events for a wide cross-section of staff, in which each ward presents audit findings and research relating to quality, benchmarking and practice development. Headlined as “Demonstrating Pride and Achievement” this is an innovative example of a strategy to build a learning and improvement culture across the organisation. In another hospital the partnership-based Nursing Forum (see 5.3 above) explicitly sought to provide a direct line of communication between continuous improvement at the front-line and wider hospital policy.

As part of its training strategy linked to the creation of a partnership culture, one hospital trained Clinical Nurse Managers to create front-line working environments conducive to the involvement of all staff in continuous improvement. However, hospital-wide measures to promote continuous improvement culture and practice are rare and most of the striking examples were found in individual departments (such as the Maternity Department weekly education meetings described in the previous section), again with little replication across the hospital as a whole. Team and ward

meetings – where they exist – are often limited to dealing with day-to-day caseload or other pressing matters. This is often a wasted opportunity, and as in the hospital cited above, managers/clinical leaders could be made more aware of how continuous improvement can be embedded into the normal working lives of staff at all levels (Wilkinson, Rushmer and Davies, 2004).

Front line staff such as care assistants and porters often spend considerable time talking to patients and have a great deal of tacit knowledge about what is working and what isn’t. During our interviews we found a considerable willingness on the part of such staff to contribute ideas for continuous improvement but, even where regular forums or team meetings existed, these grades were “never invited to ward meetings – we’re invisible.”

Each ward or clinical team also needs to determine standard procedures and protocols for a wide range of clinical functions. An inclusive approach to the involvement of front-line staff in this process enhances staff “ownership” of the process, while at the same time providing opportunities for identifying “best” practice – perhaps drawing on staff members’ diverse experiences of working in different places (Davies, Powell & Rushmer, 2007). In one hospital policies and standards (such as catheter policy) are developed through the active involvement of front-line staff at ward level in order to ensure ownership by all staff, as well as the capture of good ideas. Elsewhere a nursing-led Policies, Procedures and Clinical Guidelines Group has been established, encouraging proposals from front-line teams of nurses, ward managers and specialists. Once again, however, these participative approaches were driven by individual Nursing Directors with a personal belief in more inclusive ways of working, although it is possible to argue that they were influenced by an overall commitment to partnership in their respective hospitals.

Notably we found little evidence of trade union interest in the potential of continuous improvement to achieve tangible benefits for staff through, for example, job enrichment or enhanced recognition of knowledge and experience. Likewise there was little recognition that trade

Box 6 Continuous Improvement in an Emergency Department

A strong continuous improvement ethos is a notable feature of one Emergency Department where nurses are “hugely” supported by doctors. “All teams are equal within the Department.” The Department is characterised by a strong meeting culture with receptionists and secretarial staff playing a key role (porters are not represented and this is a matter of concern to them – they “communicate via nurses”). Overnight trolley waits have been eliminated due to medical leadership, which is hands-on and strong on communication – this is “instilled in the culture of the whole organisation”. Bed meetings every morning in this Department involve all key actors.

Box 7 Improving catering services from the bottom up

One newly appointed catering manager worked closely with her team to make far-reaching improvements in the level of service to patients. Staff were aware that the provision of a seamless service depended on getting to know the patients and being sensitive to their needs. They also recognised the importance of working closely with ward staff and “being part of the team.”

Changing from a traditional method of work organisation enabled teams of two to take complete responsibility for the preparation and delivery of food to patients in a specific ward. This included preparing food ordered via the menu system for individual patients, trayng it up, transferring it to the allocated ward, heating meals in ward ovens, taking them to the patients and collecting the plates. They know the patients and ensure they are able to eat the food, even by cutting it up when required. However they do not help the patients when eating since this is the responsibility of the ward staff. They liaise with the ward team regarding the patients’ meals and how well they have eaten. They also share information with the dietician. The enhanced role of the catering staff requires a wider range of skills, and this was met through the provision of appropriate training and development.

The catering staff have a real sense of pride in the service they provide. Direct patient contact gives them a high level of job satisfaction and they consider that they can provide a better quality of care. A patient survey was undertaken by the Catering Department, which demonstrated a high level of patient satisfaction with the service provided.

unions themselves have a potentially significant role to play as knowledgeable participants in improvement and innovation, drawing, for example, on the considerable casework experience and “organisational memory” held by stewards.

5.4.5 Do empowered staff empower patients?

The research team sometimes came across the view within the hospitals that there is something of a zero-sum quality to the relationship between staff involvement and patient involvement: what is good for staff is likely to be at the expense of patients and vice-versa. Research and experience suggest the opposite, however (Davies, Powell and Rushmer; 2007). Patient empowerment, consultation and feedback are increasingly seen as a critical dimension of quality in hospital care. Enabling front-line staff to “own” the patient feedback and consultation processes can be an effective means of engaging them in quality improvement, thereby leading to job enrichment.

The Trade Union Alliance in one hospital describes itself as “patient-centric” and it is clear that, over time, the nature of the dialogue with management has begun to focus on “win-win-win” outcomes for patients, staff and the organisation. In another hospital the Partnership Committee itself instigated “Service Users Groups”, in part as a mechanism for identifying improvement projects that might be considered for Partnership Funding. Elsewhere patient forums report directly or indirectly to Partnership Committees and this should certainly be seen as part of the strategic input that they receive.

The absence of a consistent national mechanism for surveying patient satisfaction is notable. Such comparative data would provide a valuable addition to the HSE “dashboard” of performance measures. As in the UK (Healthcare Commission, 2008) it would also permit further investigation of the complex interrelationship between staff satisfaction and patient satisfaction.

5.4.6 *Doctor's dilemma: medical leadership and the elusiveness of multidisciplinary teamworking*

As Chapter 2 points out, multidisciplinary teamworking has become the international standard for the treatment of several major clinical conditions and there is an increasing body of evidence (notably West, Borrill, Dawson, Scully, Carter, Anelay, Patterson, and Waring, 2002) that it is linked to clinical outcomes. Teamwork practices such as multidisciplinary case conferences and combined clinics provide patients with a more systemic view of their diagnosis and treatment, enabling each professional group to contribute fully (Clemmer, Spuhler, Oniki and Horn, 1999). Research suggests that an improved service can be delivered to patients where health care professionals work together in teams (Schmitt, 2001; Rafferty, Ball, and Aiken, 2001).

When a multidisciplinary group of healthcare professionals meets, each member brings only a portion of the knowledge and skills necessary for patient care. For example, physicians contribute their diagnostic and treatment expertise, while nurses and allied health professionals primarily attend to daily patient care and monitoring. Health care professionals must integrate their specialised knowledge to deliver care that results in desired patient outcomes (Clemmer, Spuhler, Oniki and Horn, 1999). In practice, efforts to integrate are challenged by professional socialisation and organisational systems. Each discipline has its own values, approaches to problem-solving, mechanisms for information exchange and reward structure (Garman, Leach and Spector, 2006).

However there appear to be few national drivers for the introduction of multidisciplinary teamworking despite international evidence of its efficacy for patient care and safety. We were somewhat encouraged by the systematic introduction of teamworking that is emerging in a few of the hospitals visited, although we remain acutely aware of the distance to be travelled.

The HIQA investigation at the large teaching hospital cited above prompted the introduction of multidisciplinary teamworking across each of the main clinical areas as part of a major corporate commitment to avoiding risk and enhancing quality. This was a seemingly impressive example of

corporate-level commitment to the improvement of patient care and safety through the systematic introduction of multidisciplinary teamworking, although the quality of teamworking varies considerably. In some areas front-line nurses are excluded from meetings. Some teams are not meeting at all and staff report the accumulation of a long list of agenda items, leading to considerable frustration. These were also the units in the hospital that had notable problems with staff morale and voluntary staff turnover. Moreover, the role of most team meetings is limited to case-related issues and does not cover service planning, governance or quality improvement: this is clearly a missed opportunity for staff involvement (and some hospitals are preparing detailed directives or guidance to enable managers to make the most of team meetings). This reinforces research evidence that points to the need for the continual monitoring and renewal of teamworking to prevent “innovation decay” (Buchanan, Fitzgerald and Ketley, 2006); such a role could well be assumed by an active Partnership Committee where it existed, although that condition was not present in this particular hospital. This case illustrates both the strengths and weaknesses of a regulatory-driven approach. Teamworking was introduced systematically across the whole organisation as a result of an external investigation and recommendations, but the local innovation required to ensure its quality was not adequately supported on the ground.

In another hospital, a highly participative organisational development process was underway, designed to strengthen teamworking at ward or unit level through the introduction of a matrix model bringing together second-level line managers to ensure greater co-ordination between different disciplines on the ground. Such managers are often remote from each other in hospitals and can impose conflicting demands on front-line staff which undermine effective multidisciplinary working (Totterdill, 1995). The approach underway in this hospital appears to have the potential to develop as an exemplary model of patient-centred restructuring.

In one of the general hospitals, multidisciplinary teamworking involving all grades is actively pursued by senior management and the Clinical Directorate as the accepted means of leading

change and improvement. For example, an Integrated Care Discharge Group was established involving nurses, community nurses, AHPs and doctors: “Everybody drives it but the important thing is that consultants actually come to it”. Good examples of clinical teamworking can also be found in Obstetrics and A&E, which are “open to ideas from all levels – people feel valued and the sickrate is less.” Unit meetings and education sessions emphasise sharing knowledge and bringing ideas for discussion; teams also make a formal input to the risk management process in the hospital. A&E nurses are also qualified to prescribe drugs and some have been trained to undertake X-Ray procedures, two examples in which multidisciplinary approaches support the greater integration of patient care through job enrichment.

In other hospitals the picture is more sporadic, and the situation in one of the other general hospitals was fairly typical. An exemplary model of teamworking was developed by a consultant in day-case geriatrics. Likewise interdisciplinary decision-making practices are in place for day case cancer and stroke patients. But elsewhere in the hospital multidisciplinary teamworking is attempted by nursing and AHP staff without the participation of doctors in medical wards (consultants “actively refuse to come to multidisciplinary meetings”). In one case a video fluoroscopy project developed from collaboration between Speech and Language Therapy & Radiology reduced incidences of aspiration pneumonia and readmission – an excellent example of multidisciplinary teamworking but with no consultant participation or support: “the consultant said no.” Hope was expressed by staff throughout the hospital that the Clinical Director would enforce medical participation in other teams. However such expressions of hope only serve to underline the deeply embedded voluntarism that governs the adoption of participative practices in hospitals even where clinical benefits appear to be unchallenged.

Box 8 Staff involvement in Surgical Nursing Care Documentation

Nurses, Allied Health Professionals and medical staff collaboratively developed documentation to improve the quality of communication as a means of enhancing multidisciplinary team-based care for patients. The aim was to standardise and integrate the reports of all professionals within a single booklet from admission to discharge. The new documentation was well received across the hospital and generated considerable interest throughout the Region. However most medical staff do not participate in the use of the booklet as a source of integrated patient notes.

5.5 HR: key player or well-meaning bystander?

Basic HR functions are a prerequisite for any effective organisation, helping to ensure sound employment practice, generating a sense of fair treatment within the workforce and minimising IR risks. A more proactive approach is needed, however, to address problems that are often deep-seated within parts of the hospital sector and that may influence performance, including absence, communication and management competence. One of the key dilemmas for HR in the hospital sector is how to find effective strategies for “mainstreaming” – influencing the behaviour of operational managers and clinicians – otherwise HR policies remain in a silo with little real impact on working lives and performance. HRM activities will only have an impact on outcomes and performance if worker attitudes and, in particular, worker behaviour are affected (Guest, 1997; Purcell, Kinnie, Hutchinson, Rayton, and Swart, 2003).

In the larger hospitals we found strategically focused HR Departments with a clear focus on disseminating partnership principles throughout the hospital (one has won equality and diversity and “Better Place to Work” awards). Such measures appear to be particularly effective when working

with an active Partnership Committee which, as we have seen above, can be proactive in animating HR policies. These may include a portfolio of measures to promote partnership culture and behaviour amongst managers, including training, mentoring, establishing standards of dialogue in team meetings, and proactive approaches to bullying and harassment.

Box 9 Loosening up hierarchies

One hospital's HR Department ran "Dignity and Respect at Work" workshops over a two-year period in order to "loosen up hierarchies" and empower front-line staff to make their voices heard; after participating in these workshops some alumni "wouldn't shrink from meeting with senior managers and directors." Many of these individuals subsequently formed a cadre for front-line staff involvement in major consultation exercises.

Even in these cases, however, HR influence over clinicians and line managers may be limited: union representatives argue that "things that HR thinks are happening aren't happening." Some managers on the other hand complain that HR is "imposed from the top."

In the smaller hospitals, however, reliance on shared HR services seriously inhibits the potential for proactive HRM. This typically prevents proactive measures for management training in partnership principles and methods, or for bullying/harassment and equality and diversity policies. HSE frameworks are perceived to constrain local HR innovation: according to one HR manager "you can initiate stuff within the policy but everything else is driven centrally." No local agreements are possible without the agreement of the national HSE Employment Relations office for fear of setting precedents.

5.6 Equal partners? The effectiveness of the trade union contribution to partnership

Partnership practice can only be as strong as the capacity of trade unions to contribute meaningfully. This relates in part to the internal structures and processes of each union – for example the support to stewards offered by full-time officials and the level of training in partnership provided by the union. Facilities offered by the hospital (time for partnership activities, backfill, office and IT facilities) are also important in building capacity, as is the ability and willingness of unions to meet collectively.

Facilities provided to trade union representatives in terms of leave and office resources differ greatly between hospitals. In most hospitals there is no forum or trade union alliance where trade unions meet together to discuss strategic issues relating to partnership and hospital policy. This appears to leave individual stewards with little opportunity for reflection or dialogue around issues affecting hospital strategy or working life, and collectively the trade union contribution is inevitably fragmented. Where such forums exist, the trade union contribution to partnership processes appears to be much stronger. As we have seen above, such forums can be "patient centric" in their approach.

Local union reps are "unsure of their mandate and incapable of making decisions" according to one senior manager; according to another, union representatives "may not have the vision" and some lack the confidence to contribute effectively in a room full of senior managers. Unions are sometimes perceived to revert to IR procedures rather than use partnership because they feel more at home with the traditional ways of doing things. Some stewards certainly admit that they "don't feel as though they can influence things" in partnership.

Union full-time officials vary in the level of support they provide for stewards in relation to partnership activities. In some cases stewards appear to be excluded from some partnership discussions: one General Manager "prefers to work directly with full-time union officers because union reps are too junior."

There is a widespread feeling amongst managers that messages from national unions about partnership are mixed – the example cited during the period of our visits was the 2007 boycott by the IMPACT union – perhaps because of a fear of losing influence. Moreover, they perceive that positive statements made about partnership by union headquarters are rarely disseminated: “Trade unions may say something nationally but it is never communicated locally.”

It is therefore unsurprising that serious difficulties in recruiting stewards are experienced within several hospitals. Effective partnership clearly depends on the recruitment of able stewards; it has clearly become a significant challenge for unions and hospital management alike to demonstrate that the role is both rewarding and respected in a partnership context.

5.7 The line manager as a barrier reef?

A trade union representative in one hospital summed up the situation in many parts of the sector: “There is an ethos of partnership at senior management level but further down it depends on personality.” Indeed, there is a widespread feeling amongst union stewards that managers need to be better equipped to deal with staff issues and to acquire the skills and motivation to work with unions where necessary.

During our visits to the seven hospitals, a common complaint from line managers themselves is that lack of administrative support inhibits partnership behaviour by managers who are too preoccupied with “firefighting”. Despite exemplary measures in some hospitals, others have no significant partnership training policy for managers. Communication from senior management is “by drip feed” and people rely on rumour. Senior managers are often seen as having low visibility. The HSE is also perceived as poor in terms of the timeliness and clarity of communication, putting extra pressure on line managers responsible for implementation. This, managers perceive, is exacerbated by centralisation and the loss of local autonomy.

Changing management behaviour to reflect partnership values has produced mixed results. Some hospitals have invested heavily in training; others have little or no strategy. For example, one hospital has made significant efforts to create a management culture conducive to participation through extensive training; in total 75% of staff at that hospital received training relating to partnership including 750 people who benefitted from two-day off-site courses in meeting skills designed to enhance management/staff interaction. Elsewhere a hospital cited the participation of management and staff in training to achieve a “Conflict Competent Organisation.”

Yet even where extensive training takes place actual management behaviour varies widely. Staff in hospitals where managers were extensively trained in partnership behaviours and practices continue to report that some managers “go ballistic if you involve the union” in problem-solving and that “management reluctance to get staff involved” in decision-making remains a major issue. Arguably this evidence simply reaffirms the findings of extensive research (Marchington and Wilkinson, 2000; Munro, 2002; Wilkinson, Dundon, Marchington and Ackers, 2004): that training on its own is insufficient and that it must be accompanied by other simultaneous interventions if it is to change behaviour and practice.

Senior management leadership has a clear role to play in changing behaviour. One Assistant Director of Nursing, for example, insists that the line managers who report to her must account in detail for the quality of their communication with staff, and this is regularly audited. In another hospital the Executive Team is instructing line managers to report to their own line managers on how they communicate with their teams. Elsewhere again, senior managers have imposed retraining on intransigent middle managers – “this would never have happened without partnership” – and such actions are reviewed regularly by the Partnership Committee.

5.8 Difficult conversations: communicating in hard times

Management, union representatives and staff in every hospital are anticipating that 2009 will provide a profound test of partnership: “How deep will partnership go, how relevant is it and how appropriate?”

The effects of the financial crisis on staff – and therefore on patients – can be exacerbated by insensitive handling, including poor communication, the perception that decisions are inequitable or counterproductive, and lack of inclusion. Where managers share the problem with unions and staff, including open access to books, they may avoid unforeseen risk and adversarial reactions, and identify breakthrough solutions based on their tacit knowledge and creativity.

Union representatives consulted during our visits were overwhelmingly prepared to play a positive role in managing the crisis: “Nobody has the right to veto – the place has to be managed.”

Box 10 Dialogue as a value for money strategy?

One hospital introduced a scheme to reduce in-patient waiting lists for diagnostic tests by outsourcing MRI scans to a private company. However, the radiographers were frustrated by the absence of any apparent cost benefit because the patient transfer incurred the additional expense of an accompanying nurse, porter and ambulance. The subsequent reports frequently went missing, leading to the referral of patients back to the hospital for a repeat MRI scan. The radiographers argued in vain that the cost of outsourcing could be better used to employ an extra radiologist and support staff, using the adequate diagnostic facilities in-house.

On the basis of our evidence, partnership does not appear to be weathering the crisis well. Difficult decisions such as ward closures appear to be bypassing partnership structures even though major changes have to be made through the Partnership Framework Agreement. Many staff feel that the “pain is not being equally shared” but Partnership Committees remain either silent or uninvolved.

Middle managers report that “goodwill is running out” at all levels; they experience a lack of clarity from the top and they are not given enough timely information either to plan cuts safely or to involve staff effectively. While being instructed to make cuts without affecting the quality of patient care, they are given no practical guidance on how to do so.

Communication appears sporadic. There are reports that in some hospitals “Town Hall” and briefing meetings are constantly being deferred while senior managers decide on the appropriate messages or await clarification themselves from the HSE. Front-line staff depend on line managers “cascading down” information, but even where such information is available, “a far more robust and accountable structure needs to be put in place.” In the words of one steward, “morale is lower than the carpet” with inadequate communication and unions having no involvement in decisions.

Chapter 6

Participative Governance and Partnership: Towards a Way Forward

6.1 Making sense of the evidence

We can report that the “second generation” model of partnership prefigured in *Towards 2016*, embodied in the Health Services Partnership Agreement and realised in the work of the HSNPF remains as relevant as ever. Its core message – that partnership creates and sustains the means for all healthcare staff to become directly involved in quality and efficiency improvement – is becoming embedded in thinking and dialogue at many levels of the hospital system.

Findings from our extensive survey data and in-depth interviews clearly confirm the importance of various, and especially integrated forms of staff participation in animating, resourcing and sustaining plans for change and improvement. It is encouraging that there have been significant, and often successful, efforts to embed representative partnership through the supports and resources provided through the HSNPF. Moreover, there are exemplary cases of such participative innovation and improvement in a significant number of Irish hospitals.

However, our findings show that the translation of the model into everyday practice is problematic and that results on the ground remain patchy. The challenge of systematising the culture and practice of staff involvement and participation throughout the acute hospital system has barely been addressed at a strategic level, and there is a great deal more work to be done.

Before making specific recommendations to address this gap in Chapter 7, the following sections pull together the diverse strands of evidence from the qualitative data and the survey to reach broad conclusions about the nature of the challenges faced by key stakeholders in the hospital system. It tests evidence about the current “state of the

art” of organisational practice in the sector against the model of participative governance developed in Chapter 2. In particular, it examines the extent to which “partnership”, both representative and in the broader sense of direct staff participation, plays a significant role in supporting and informing emerging systems of quality improvement and governance.

6.1.1 Valuing partnership for what it does

The overall picture that emerges from both the survey and qualitative study evidence is that if partnership did not exist it would need to be invented. Just because partnership is not highly visible to every actor all of the time does not mean that it is not playing a key role – at the very least as a “hygiene factor”¹² that may not necessarily lead to change in its own right but provides a level of assurance that unnecessary problems can be avoided. As section 3.2 demonstrates, even where Partnership Committees themselves have been somewhat moribund, the existence of partnership as a *modus operandi* helps to build and sustain trust-based relationships: “You can actually talk to unions rather than having a slanging match.” In some hospitals partnership structures have managed to transcend this background role to become key enabling mechanisms for strategic change, but as we have seen such cases remain relatively unusual.

Moreover some Partnership Committees have gone very much further than others in bringing partnership to the front line. Local partnership forums, high-involvement innovation structures, large-scale “partnership behaviour” training programmes and proactive HR interventions provide necessary – but by no means sufficient – conditions for effective and sustainable staff engagement in quality improvement and efficiency improvement.

12. To adapt Herzberg, who used “hygiene” to describe job factors that can cause dissatisfaction if missing but do not necessarily motivate employees if increased.

What are the missing elements that would provide “sufficient” conditions for a participatory approach to quality improvement? The following sections review the evidence.

6.1.2 *We have seen the future and it works – but it’s meeting some stiff resistance*

In Chapter 2 we analysed evidence from existing literature and from our survey about the ways in which the staff contribution to hospital performance can be maximised. Section 2.7 consolidates this evidence in the form of a conceptual model of organisational practice in hospitals focusing on the three arenas of partnership and involvement, job design and teamworking, and knowledge as a resource for innovation and improvement. This model is useful both as a means of understanding that the relationship between partnership and participation on the one hand, and hospital performance on the other, is both complex and multilayered. Organisational practices are heavily interdependent: not only does the success of practices such as

multidisciplinary teamworking or risk management rely heavily on structures, policies and cultures at all levels of the organisation, but their individual impact is hard to separate from what goes on in the hospital as a whole.

As we have argued above, there is little evidence of systemic transformations enabling staff at all levels to use and develop their competencies and reflexive capabilities to the full. However, we have also noted the emergence of an archipelago of innovation throughout the hospital system. Sometimes these islands of good practice are founded on a strong senior-level commitment to partnership and/or participative ways of working as a means of enhancing patient care, sometimes they emerge from the bottom up in response to identified needs – though too often, perhaps, in the face of resistance, from management, clinicians, or indeed union representatives.

Figure 22 summarises the current state of the art in terms of participative practices in the hospital sector against the conceptual model.

Figure 21 Current State of Participative Governance and Organisation: the three arenas

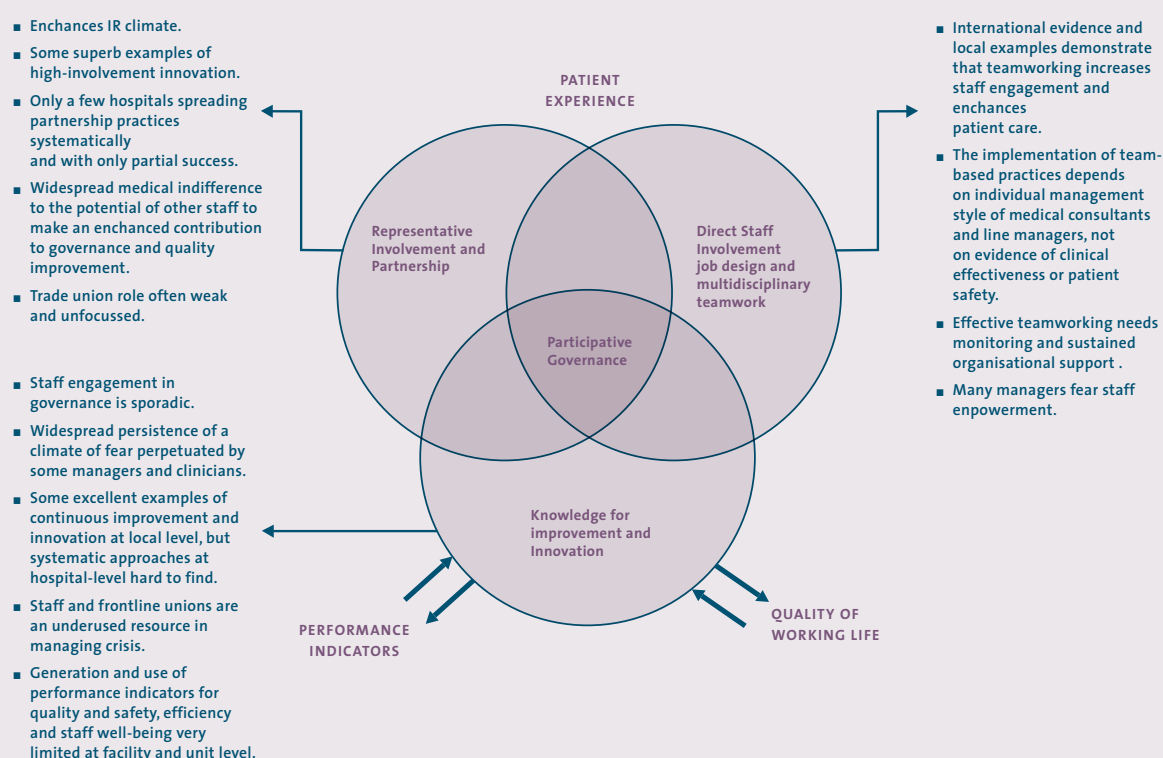
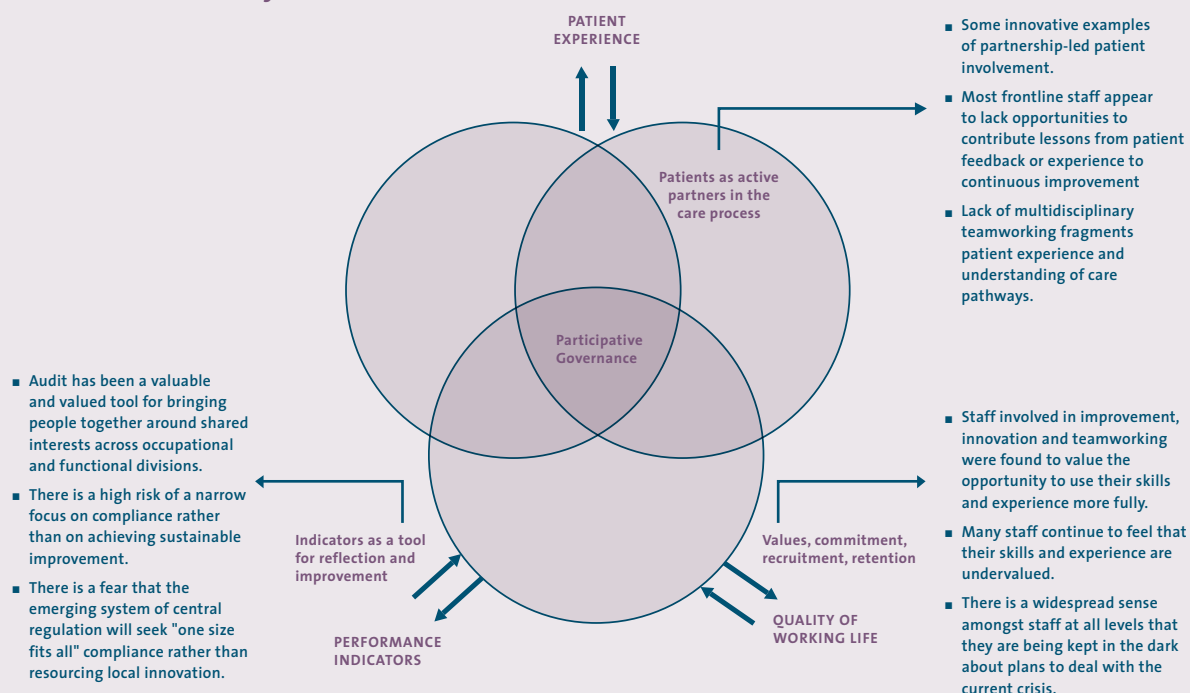


Figure 22 Current State of Participative Governance and Organisation: macro-system factors

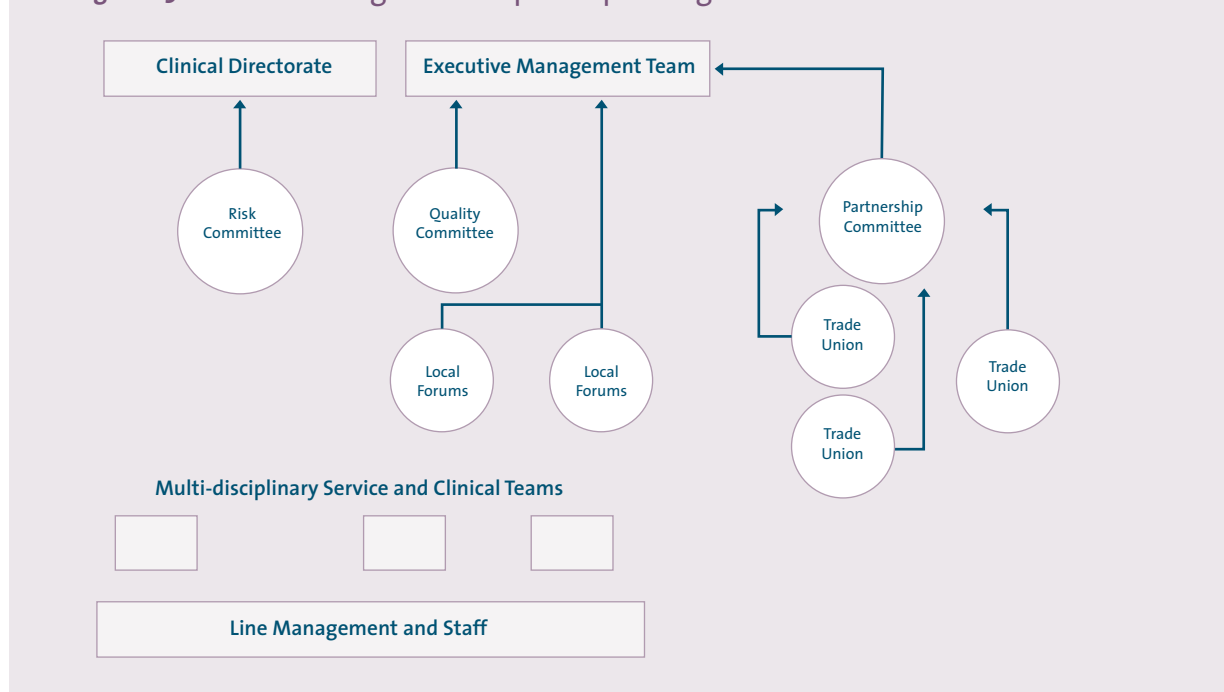


6.1.3 Governance as the emerging driver for innovation

As in the rest of Europe, the concept of governance is emerging as a principle driver of improvement, innovation and change in Irish hospitals. Ireland's relatively late entry into this arena offers the advantage of being able to learn from what has worked – and what hasn't worked elsewhere.

This report has argued (sections 2.7.2 and 3.4) that effective and sustainable approaches to governance are those which engage staff at all levels and across all occupational groups. Our evidence demonstrates that where doctors take the lead in innovation and improvement it can lead to remarkable outcomes for patients and staff alike. Likewise the involvement of even the most junior staff can reveal problems and opportunities that are invisible to others. However, situations in individual hospitals where some doctors effectively opt out of governance procedures by refusing to take part in continuous improvement and incident reporting, or where porters and care assistants are excluded from contributing their tacit knowledge and experience both pose clear risks to patient safety.

Most hospitals appear to have created elementary governance structures (such as the appointment of Quality and Risk Managers and/or the establishment of committees to deal with these issues) and these have undoubtedly achieved some tangible gains. However there is a widespread sense that progress towards establishing integrated systems of governance has been in suspension pending the appointment of Clinical Directors and the creation of Clinical Directorate structures. This makes sense in that Clinical Directors will, potentially, become powerful figures in the battle for safer and more effective healthcare. However, as we suggest in 3.4.1, it raises key questions about future direction: will Clinical Directors consolidate medical dominance or will they embed multidisciplinary working within hospital practice? Whether or not the HSE has yet established a detailed vision, many of those to whom we talked justifiably see the emergence of governance and Clinical Directorates as a decisive contest in which the future of staff involvement and partnership will be shaped.

Figure 23 The dis-integration of participative governance.

6.1.4 Working in silos: the fragmented hospital

In each of the seven hospitals most of the elements of participative governance and management, including direct staff involvement and representative partnership, were in place. Figure 23 provides a simplified representation:

The striking feature lies not in the absence of organisational structures within the hospitals but in the weakness, or absence, of interrelationships. Hospital practice is defined to a significant degree by “walls and ceilings”: organisational and cultural barriers which prevent dialogue, knowledge sharing and collaboration between different occupational groups, departments and grades (den Hertog, 2009).

Although governance is set to become the principal driver of quality improvement and organisational change, it has at best only a tenuous relationship with the partnership structure. In some cases even quality and risk exist in unconnected silos. At the clinical front-line, multidisciplinary teamworking is sporadic, and team dialogue is rarely connected either to governance or partnership. Even the contribution of trade unions to partnership is fragmented and uncoordinated given the absence in most hospitals of an independent forum in which the different unions meet together.

6.1.5 The effectiveness of the trade union contribution

Evidence from each of the hospitals identifies some of the challenges faced by unions within a partnership agenda, not just in terms of bargaining for the necessary resources of time and support but also in building internal capacity and competence. More research is needed on the nature of these challenges but it is clear that they raise some fundamental questions about union practices and culture.

Local trade union representatives are often largely untapped as a source of professional knowledge and experience at both front-line and strategic levels. Stewards can be a valuable resource in overcoming obstacles to the implementation of strategic policy objectives, and in finding solutions that lead to a convergence of interests between the organisation and its employees. Their role of representing and supporting union members extends to ensuring the equitable implementation of hospital policies such as flexible working, equality and safety for all staff. Often issues and incidents affecting clinical risk and quality of patient care are initially raised with the local steward, compensating for the lack of an approachable manager or an effective teamwork environment in which they would be addressed

through dialogue and reflection. Moreover union representatives constitute a significant part of an organisation's memory at a time when the tendency is for managers to move increasingly frequently in pursuit of career development.

There are three major constraints on the ability of union representatives to contribute effectively to partnership at hospital level:

1. The Steward's lot is not a happy one. Becoming a Steward in an Irish hospital is more likely to be seen as career-limiting than career-enhancing. Stewards gain considerable responsibility both for their members' immediate welfare and for contributing to partnership agendas at the wider level of the hospital, but few are given adequate time, training or resources either by their union organisations or by their line managers. Moreover many stewards are remote both from Partnership Committees and IR structures, leaving them with few points of contact with the wider organisation. Clearly this limits the ability to recruit able and committed people to these roles.
2. The absence of Trade Union Alliances in most hospitals means that representatives are often poorly equipped to deal with complex issues. Where such Alliances exist, union representatives use them effectively to explore issues and options in depth before engaging in the formal proceedings of the Partnership Committee.
3. Full time officials sometimes by-pass Stewards in discussion with management, and this is highly disempowering. Officials need to play an active role in mentoring and informing Stewards, but recognising that the latter possess unique tacit knowledge of "what works" and what is failing at the front-line.

Trade unions also need to address the changing health landscape more thoroughly. The Irish Hospital Consultants Association's advocacy of its members' participation in incident reporting and governance is to be welcomed. However healthcare unions as a whole ignore the rise of governance in hospitals at their peril. Emerging as the principal driver for change, governance at all levels offers

potential job enrichment opportunities for staff by enabling them to contribute their ideas and experience to improvement and innovation, and to achieve greater recognition. Yet as we have seen the development of a participative model of governance cannot be taken for granted. Unions should be alert to the danger that medically dominated clinical directorate structures could seriously damage the quality of working life, status and motivation of their members in nursing, allied health professions and support roles.

6.1.6 Changing behaviour: mainstreaming partnership and participation

In complex organisations such as hospitals, policy implementation processes deserve much greater attention than they have traditionally been given. Evidence from all seven hospitals reinforces findings from previous research in drawing attention to the persistence of management resistance to direct and indirect forms of staff involvement. This resistance can take the form of conscious actions to limit the scope of trade union and staff engagement in traditional areas of management prerogative, but it can also be deeply embedded in organisational structures and cultures.

As the hospital managers cited in Chapter Two argue, lack of consistency and direction from above results in lack of understanding and concordance at other levels. This inevitably leads to uncertain outcomes. But it is also clear that many line managers are not getting the message about participatory management and staff involvement. Moreover senior managers and Partnership Committees appear, in the main, well aware of this and we have seen that some are investing significantly in appropriate measures. However the absence of co-ordinated responses in many hospitals suggests that they have yet fully to understand the negative impact which such recalcitrant individuals can have on perceptions of staff involvement, and particularly on the perception of partnership – an impact which was made very clear to the research team in its discussions with front-line staff.

6.1.7 The emerging picture

Data from the seven hospitals paints a fascinating picture of the challenges facing health service modernisers, both in Ireland and in Europe as a whole. The picture is one of uneasy co-existence between three different narratives:

- government intervention driven by the need to meet public demands for greater accountability in securing consistent and improving healthcare quality;
- partnership as a potential vehicle for improving industrial relations, facilitating change and harnessing employee engagement;
- the traditional voluntarism that privileges the right of clinicians and managers to exercise considerable autonomy in the design and delivery of services with minimal scrutiny even from peers.

The voluntarist tradition, in Ireland as elsewhere, is clearly under attack both because of clinical scandals such as that at Lourdes Hospital and because of the increasingly visible gap between high and low performers. Yet the emerging terrain is highly contested. Government incentives for real innovation at service level in ways which created a new role for workplace partnership would build an inclusive approach to clinical governance and quality improvement, harnessing the tacit knowledge, experience and creativity of all staff. There are encouraging signs that the emerging regulatory structure recognises the interrelationship of governance and organisational culture; this is expressed most clearly in the HSE's *Quality and Risk Management Standard* (HSE, 2007). However many of those interviewed within this study predicted the inexorable rise of "one size fits all" standardisation from the centre, the emergence of clinical directorates as bastions of medical power at the expense of other professions, and the steady marginalisation of partnership.

The *Hospital of the Future* study has accumulated considerable evidence that participative approaches to quality improvement and governance work. Yet the conditions for systematic transformation are absent. All stakeholders require a new

conceptual model of participative governance and management, one which integrates direct participation and representative partnership to transform standards of patient care, cost effectiveness and quality of working life.

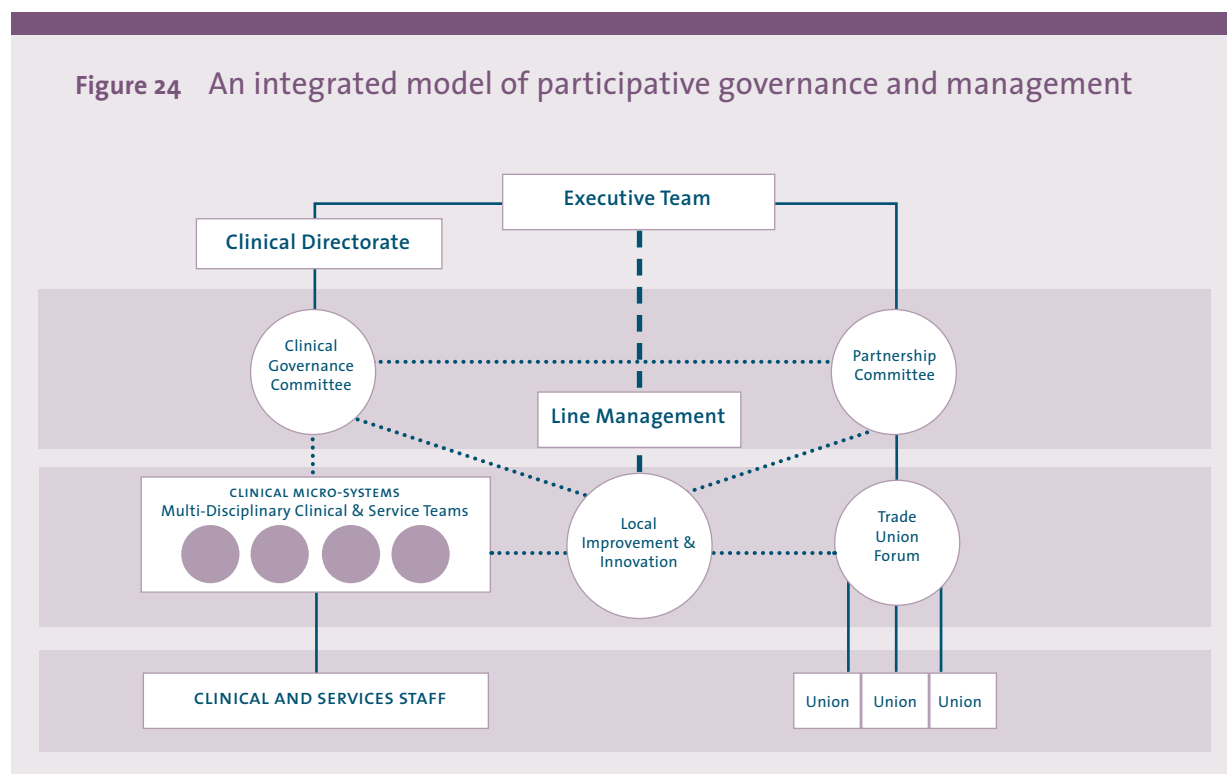
6.2 Challenges and opportunities for staff involvement in hospitals

6.2.1 Beyond the fragments: an organisational model of participative governance at hospital level

The Hospital of the Future study draws attention to the restrictions on and the potential of both direct staff involvement and representative partnership as drivers of quality and efficiency improvement. In its current manifestation, formal partnership in hospitals provides a means of avoiding or containing local IR disputes and we have found evidence that this facilitates positive change. However formal partnership is disconnected from the emerging structures of clinical governance that are becoming the major drivers of change. On the other hand examples of participative approaches to governance and quality improvement are beginning to emerge throughout the hospital system, but often in isolation and without any central strategy for support or wider dissemination. The need is to reinvent the model of staff involvement in quality and efficiency improvement in ways which bridge the gap between representative partnership and direct participation, not least to create a model of *Participative Governance*.

What would this model look like in practice? Sections 2.6 and 2.7 draws on a wide body of literature and experience to outline a conceptual model of participative governance. Findings from the hospitals participating in this study enable us to ground this model, identifying both the components and the relationships which translate it into tangible organisational form. In short, a systematic organisational framework can be constructed within the parameters of our conceptual model by integrating examples of effective practice and innovation observed in different hospitals. This is represented by Figure 24:

Figure 24 An integrated model of participative governance and management



At strategic level the model revolves around interaction between the Executive Team, Clinical Directorate, Clinical Governance Committee and Partnership Committee, aligning the organisation as a whole to strategic demands and opportunities while engaging the tacit knowledge, experience and commitment of staff at all levels as a resource for inclusive and informed decision-making. The quality of this interaction is reinforced by guarantees of participative, team-based approaches to day-to-day clinical and service delivery. Embedded mechanisms in working life for critical reflection, continuous improvement and innovation, such as the local improvement and innovation forums described in Section 5.3, further reinforce participative governance practices.

The Twelve Challenges

From this representation, participative governance hinges on a number of structural and behavioural characteristics, all of which were either identified in one or more of the seven hospitals or arose during dialogue within those institutions. These present the following challenges to hospital management and trade unions:

1. The personal commitment of the General Manager or Chief Executive to high levels of inclusion and participation should be a key measure against which the performance of the postholder is evaluated.
2. The Executive Team must be proactive in breaking down silos through an insistence on multidisciplinary working in both clinical and developmental work wherever possible.
3. The Partnership Committee must strive to become literate in clinical governance and quality improvement, enabling it to engage in coherent dialogue with the Clinical Directorate.
4. The Partnership Committee is the guardian of direct involvement, insisting on the widest possible participation of all staff in the delivery of clinical services, service planning, continuous improvement and organisational change. In particular, the Committee will actively stimulate participation in the Local Forums, ensuring that staff at all levels receive adequate cover to enable them to participate freely. The Committee will frequently monitor and evaluate the quality of participation throughout the hospital, and

will have the power to call for remedial action where there are persistent deficits. An important resource in this context is the ability of the Committee to champion the implementation of the staff survey, and to become involved in enabling, driving and monitoring effective and appropriate responses.

5. Clinical Directorates are the driver for improvement and innovation at all levels of the hospital, and achieve this through a multidisciplinary management structure in which the Clinical Director is *primus inter pares* with the Director of Nursing and senior AHP manager.
6. The Clinical Governance Committee takes a systemic overview of factors affecting quality, risk and safety at all levels of the hospital. It engages in active dialogue with the Partnership Committee on ways of achieving the highest levels of staff participation and engagement with clinical governance practices and culture.
7. Local Forums provide the most visible meeting point of partnership and clinical governance. Forums are diverse in character, dealing with a wide range of routine and developmental issues; however all engage clinicians because they address the day-to-day issues with which they are most concerned. In essence, Forums bring partnership ways of working to clinicians rather than expecting clinicians to participate in formal partnership structures.
8. Clinical Directors drive the reorganisation of services throughout the hospital based on multidisciplinary teamworking and clinical microsystems as described in section 2.7.4. In part, as we argue in Chapter 7 this should reflect the implementation of National Care Standards in key clinical areas, but more immediately it should reflect the interest of Clinical Directors in ensuring best evidence-based practice consistently throughout the hospital. Existing resources such as the Team-based Performance Management System offer a potentially valuable means of reinforcing collaborative behaviours.
9. Line management is a positive resource for improvement and innovation through staff involvement. Managers do not, on the whole, start to involve staff because they are invited to do so by HR or Partnership Committees. Rather they do so because the culture and practice of involvement is deeply embedded in the organisation's DNA, and because they will be judged as managers on their effectiveness in securing involvement. This means that hospitals must employ a systematic approach to the implementation of training in partnership and participative management, to performance management, to systematic measurement and monitoring of staff engagement and involvement, and to the use of sanctions, where necessary to break intransigent patterns of behaviour. Empowering front-line teams with responsibility for service planning also offers the potential to flatten management structures.
10. Staff work in an environment free of fear, characterised by a positive approach to incident reporting and constructive questioning of established practices. All staff enjoy routine involvement in planning and decision-making, as well as regular and properly resourced opportunities to take part in work-based learning, productive reflection and continuous improvement.
11. The Trade Union Alliance offers a reflective space in which all union representatives can analyse relevant issues from the front-line, organise effective consultation and communication with staff across the hospital and explore constructive means of engaging with management proposals. In particular, it enhances the effectiveness of trade union participation in the Partnership Committee by giving representatives the ability to examine and to consult on issues in greater depth.
12. Individual unions make strenuous efforts to clarify their commitment to partnership working at hospital level, actively aiding the recruitment of competent stewards, providing relevant training, and ensuring that regional officials empower and resource them appropriately.

6.2.2 *The bigger picture: regulation and animation*

We have seen in this study that external regulation can play a central role both as a driver for change and in securing effective governance. While being critical of an overemphasis on centralised performance management at the expense of bottom-up innovation, both the literature and our experience from the seven hospitals show that under the right circumstances externally imposed targets can be effective in unlocking energy and imagination at the front line. External regulation has a key role to play in, as one respondent put it, “raising the hurdle.” However we have also seen that regulation is by no means a sufficient condition for real transformation: compliance is not the same as improvement. External regulation alone cannot be effective in creating or sustaining the workplace culture on which the quality of hospital workplace practices depends.

What role can regulators and policy-makers play in creating the conditions for real transformation? Evidence from this study points to three factors:

1. Clear expectations

Staff engagement is too important to be left exclusively to HR strategies. Participation and multidisciplinary working need to be embedded in mainstream HSE directives and statements relating to performance, clinical governance, quality improvement and cost-effectiveness. Chief Executives, General Managers and Clinical Directors should be judged on their ability to mobilise all staff, supported by effective systems for measuring levels of staff engagement and involvement.

2. Smart regulation

Qualitative targets are helpful but on their own they can be misleading. HIQA accreditation and the proposed system of hospital licensing need to go well beyond the *Quality and Risk Management Standard's* relatively terse guidance (HSE, 2007). In particular, they should take into account the experiences of front-line staff, establishing “what really happens” in terms of, for example, incident reporting, risk management and quality of care. Partnership Committees themselves can draw on the tacit knowledge and experience of staff and Stewards to make an important contribution to the validation of hospital accreditation data.

3. Incentives to innovate

Central policy-makers have an important role to play in creating the conditions (both through financial incentives and directives) that motivate managers and clinicians to establish spaces within which real innovation can be discussed, planned and implemented. Target setting and strict cost control can actually detract from performance and efficiency by perpetuating dysfunctional ways of working. The capture and dissemination of good practice can also be actively promoted through learning networks.

6.2.3 *Driving improvement and innovation: Developing the strategic capacity of the health system*

Authority and capacity for driving improvement and innovation are widely dispersed throughout the Irish health system. This, of course, properly reflects the fact that change and innovation require both a top-down and a bottom-up momentum, and necessitate high levels of direct and representative participation and involvement from management, staff and union representatives at every level. However, the fragmentation that was identified by the OECD Review (2008) in the public service as a whole is mirrored at sectoral level in the health services.

In terms of developing models of representative participation, the HSNPF has made a central contribution to the consolidation and development of partnership in hospitals. Its leadership in the design and implementation of formal partnership agreements and structures has provided hospitals with access to high levels of knowledge, expertise and good practice. Many of the HSNPF's local facilitators are very highly regarded by management and union representatives alike for their hard work and persistence. Moreover, the HSNPF has led the development of thinking about "second generation" partnership in hospitals through its advocacy of direct staff involvement – reflected in, for example, the *Protocol on Handling Significant Change* and the *Action Plan for People Management*. HSNPF funding has provided opportunities for some 8000 staff to participate in improvement activities and projects, though the strategic focus of some of the support drawn on by local groups has been called into question.

In parallel, the HSE has been active in developing its governance and managerial systems and strategies, in areas including human resource management, organisational performance management, quality and risk management, and clinical governance arrangements. External to the HSE, the Health Information and Quality Authority (HIQA) is active in developing standards and accreditation systems for the provision of health care in Ireland.

Clearly, in the context of developing a more complete model of participative governance and management at sectoral and local level, there is a need to build bridges that span the institutional and strategic gaps between partnership, industrial relations, clinical governance and organisational performance management.

Chapter 7

Conclusions and Recommendations

7.1 Introduction

The focus of this report has been to contrast evidence of “what we know works”, as represented by a conceptual model grounded in the literature, with evidence of what is happening in the hospital sector taken from the survey and the visits to seven hospitals. There are striking examples of staff involvement in teamworking, quality improvement, governance and strategy making a real difference to patient care and hospital performance. However, the distribution of such practices is patchy, with the result that many opportunities for quality improvement, cost containment and the enhancement of staff well-being are being lost.

This report is being published at a time when employers, trade unions and staff in the health services are facing an unprecedented set of challenges, as set out clearly in the *Public Service Agreement 2010 – 2014*. While employers and trade unions have once again committed themselves to planning and implementing the transformation agenda in a partnership manner, such an uneven pattern of improvement and innovation is hard to justify. This report highlights many of the challenges that need to be addressed if a collaborative, partnership-style approach is to prove itself capable of delivering effective responses to the challenges set out in the *Agreement*.

The level of innovation and improvement that is demanded by the *Public Service Agreement* depends on effective leadership and entrepreneurial behaviour. Our research has illustrated how this emerges when enlightened individuals, clinicians, managers or front-line staff identify a need and mobilise sufficient momentum to make change happen. We have also seen how, sometimes, partnership structures and culture facilitate entrepreneurship by creating a climate in which change is no longer treated with foreboding by managers, unions or staff, and in which greater staff involvement is actively valued at senior executive level.

Sometimes, however, those leading change have to do so in the face of major organisational inertia or resistance from key managers or clinicians. In many other cases this inertia or resistance, actual or merely anticipated, is sufficient to block the emergence of innovation and improvement. Neither partnership nor accreditation has been successful in systematically addressing these “walls and ceilings” in order to ensure the consistent application of evidence-based organisational practices. The result is a highly sporadic pattern of innovation and improvement.

Even where we found high levels of participation in the achievement of accreditation, improvement teams were disbanded once the process was completed – even before many of the promised changes had been implemented. Moreover, Partnership Committees were typically silent on such failures.

The key challenge is not therefore to discover “what works” in the cost-effective improvement of patient care, because there is ample evidence of this from the literature and from this study. Rather the task is to discover how to implement evidence-based practice in a consistent and equitable way throughout the hospital system. Effective and sustainable change occurs when the wider strategic framework drives system-wide change, but does so in ways that engage local actors in the creation of local solutions. Unlike the “one size fits all” sledgehammer that has characterised health policy in some European countries, this can ensure both local ownership of change and “goodness of fit” to conditions on the ground.

7.2 An integrated model of change

Chapter 6 identifies an interconnected series of twelve challenges for the reintegration of hospital organisational structures and for the reconfiguration of the wider regulatory and policy environment. Critically it is the cumulative effect of actions across all of these arenas that will

produce sustainable enhancement of patient care and hospital performance: a systemic approach that generates mutually supporting processes of improvement and innovation.

Likewise it is the concerted action of all of the key stakeholders that will create a critical mass of change. These recommendations are therefore addressed to stakeholders at two levels:

- Institutional stakeholders at government level including relevant departments and State Agencies.
- Institutional stakeholders at sectoral level, including health sector unions, the HSE (specifically directorates including the Office of the CEO, National Director of HR, Quality and Clinical Care, Integrated Services, Population Health, Finance), other health sector employers, the Health Services National Partnership Forum, HIQA, the State Claims Agency and other health sector organisations.
- Stakeholders at regional and hospital level, including Executive Management Teams, Clinical Directors, clinical directorates, regional union officials, shop stewards, front-line managers, and staff.

7.3 The intervention matrix

The challenges identified above are not susceptible to single, linear interventions: each involves a combination of actions at different levels to achieve systemic and effective innovation and improvement. Our proposals comprise three principal recommendations which balance hospital-level innovation with wider system change:

- Actions by government and the HSE to create a policy and regulatory environment conducive to transformation, including system-level capacity to animate and sustain innovation and change.
- A programme to create exemplary practices at hospital level, the lessons from which will stimulate innovation across the system through thematic learning networks.

The *modus operandi* will be bottom-up, building network capital throughout the system. It will stimulate learning and innovation by bringing unusual combinations of participants together

to address intractable problems; it will use a wide portfolio of participative methods including action-learning and action research. It will capture examples of successful innovation, not to codify them into “best practice” blueprints but to stimulate critical reflection and learning elsewhere.

7.3.1 Recommendation One: Transforming the wider policy framework

Strand 1A

Rethinking partnership: a new type of dialogue between Health Service Employers and Unions

Health Service employers and health sector unions have a key role to play in creating a wider environment conducive to transformation at hospital level (and elsewhere in the health sector) through the formulation and implementation of a new strategy for participation and partnership, to facilitate significant innovation and change within the framework of integrated, participative governance described above. The *Public Service Agreement 2010 – 2014* provides both the agenda and the imprimatur for the development of such a strategy. However, the detail must be developed in consultation with key stakeholders including the Health Services National Partnership Forum, NESC, LRC and national and regional Clinical Directors, to ensure that the final outcome is owned by all key actors and exerts a significant influence on organisational behaviour at national and local levels.

Existing funding and other resources for managing change and transformation in the health services should be strategically targeted to support the new Strategy, and to ensure the effective and systematic implementation of the recommendations contained in this report, and related dissemination activities. The findings of this report suggest that targeted investment will have a measurable effect in achieving cost containment as well as quality improvement.

Health sector unions and employers will have a particular responsibility to ensure that local partnership agreements and practices are closely aligned with the new strategy for participation and partnership, and that in particular they build an effective bridge between partnership and participative governance.

The disconnection at hospital level between partnership and the forces such as integrated governance, which are becoming the principal drivers of innovation and improvement, has emerged as a key theme in this research. Yet we have also seen that the qualitative impact of those drivers is weakened by the sporadic nature of staff engagement in activities such as teamworking, incident reporting, risk management, continuous improvement, cost control, and the planning and implementation of change. We have therefore proposed the development of a participative model of governance based on an expectation that staff at all levels, including doctors, will participate in such activities as a core part of their jobs, and that appropriate protection and resourcing will be made available for them to do so. Formal partnership agreements and Partnership Committees have an important role to play in enabling such participation and in assuring its quality and effectiveness (see for example the Kaiser Permanente Partnership Agreement, 2005; see also Exton and Totterdill, 2004).

Key actions required to achieve these changes in culture and practice include the following:

- Embed the right and obligation of all staff to contribute to quality improvement and cost containment through sound governance in all aspects of the hospital system including training, contracts of employment and high-profile policy statements by hospital management and the HSE. It also needs to be reinforced through messages conveyed to members by trade union officials and stewards, and by active and visible support for whistle-blowers. The standards-setting and accreditation role of HIQA can provide a regulatory framework to support this.
- Develop a strategy for employee engagement and participation which establishes targets, measures progress and benchmarks against agreed norms relating to both direct and representative forms of participation.
- Expand the standard performance management framework available to HSE and health-sector unions to include performance measures for staff well-being, patient well-being and organisational efficiency along the lines articulated in this report.
- Expand the existing performance management systems (such as HealthStat) to provide easier access to performance benchmarks and further cascade responsibility to local level, including to partnership groups, department and unit teams.
- Local partnership agreements to be more explicit about the role of partnership and direct staff involvement in integrated governance and quality improvement, and about the importance of active collaboration between partnership structures (Committees and Local Forums) and Clinical Directorates.
- Provide Partnership Committees with a formal role in signing off quality assurance statements, enabling them to comment on the quality of staff involvement in risk, incident reporting, continuous improvement and teamworking, and the extent to which patient safety and corporate performance are compromised by obstacles to participation. This reflects the intention of the existing Health Services Partnership Agreement, which refers to Partnership Committees playing “an important role in the performance verification process under national agreements”, and could constitute an important element of the proposed hospital licensing procedure.
- Require Partnership Committees to compile periodic statements on incident reporting and front-line staff involvement in risk assessment, based on regular reports from stewards; Clinical Directors to be required to demonstrate that these reports have been taken into account in preparing their clinical governance action plans.
- Require the HSE to provide clearer direction on the implementation of the multidisciplinary working conditions contained within the new Consultant Contract.
- Clear elaboration by the HSE of how direct and representative staff involvement, including multidisciplinary working, is to be embedded in the role and operation of Clinical Directorates. This will include the requirement for senior Nursing and AHP staff to share in the management of Clinical Directorates, and for nurses and AHPs at all levels to play a key role in every aspect of clinical governance.

- Establish a national agreement on facilities and resources for local trade union representatives to include:
- the establishment of trade union alliances where they do not currently exist in order to enable representatives to make a more reflective and informed contribution to governance, quality improvement and hospital strategy;
- regular inter-union training and time out sessions;
- enhanced rights for union representatives to take part in partnership and participative governance activities;
- appropriate learning opportunities for union representatives relating to governance;
- national and regional union structures to play a more active role in supporting the ability of stewards to contribute to governance, quality improvement and hospital strategy.
- HSE to implement good practice methods throughout the hospital system to ensure high levels of incident and near-miss reporting.
- Embed multidisciplinary training within the curricula of medical, nursing and AHP education, both at entry level and through CPD.

Strand 1B

Values and focus: establishing leadership

There are inevitably grey areas between the formulation of healthcare policy by government, and its implementation in practice. It is not a simple, linear relationship, and executive agencies such as the HSE are required to use considerable judgement and interpretation. During the course of our research in 2008 and 2009, we found little evidence from the front-line of hospitals that the spirit of social partnership and workforce participation embedded in national agreements and protocols (described in Chapter 1 of this report) is being actively and enthusiastically championed. Evidence from the several hundred managers, doctors, nurses, AHPs and support staff we met during the study spoke of an all too obvious confusion of values and priorities between government, the HSE and hospital management,

leading to day-to-day uncertainty and disillusionment. The ratification of the *Public Service Agreement 2010 – 2014* provides an important opportunity to set out once again a leadership commitment to championing and effectively implementing partnership-based approaches to managing change.

Government clearly has a leadership role to play in setting and reinforcing values and standards of practice within its executive agencies if social partnership is to become a truly effective and sustainable driver for innovation and improvement. Employers have a particularly important leadership role to play in translating the values that underpin government policy into practical action. Equally, there is a need for clearer leadership from senior trade union officials to create a strategic buffer between the industrial relations problems being addressed at national level and the ongoing potential of workplace partnership.

Strand 1C

Smart regulation

We have argued that any regulatory structure based on performance management runs the risk of quality assurance without quality improvement. External regulation has a valuable role to play in creating the conditions for sustainable improvement and innovation but it needs to focus on measures and indicators that will stimulate the underlying processes through inclusive involvement and knowledge-sharing rather than simply on headline outputs.

Verification and accreditation methods are also critical. The experience of the *Improving Working Lives* initiative in the UK's health service demonstrates the importance of direct dialogue with staff in identifying the quality of performance – 75% of the accreditation was based on group discussions and interviews and only 25% on the “paper trail.” This approach could be expected to work well in several areas in which output quality is closely linked to levels of staff involvement, for example incident and near-miss reporting, risk assessment, and the design of clinical protocols.

Key actions will include:

- Standardised collection throughout the healthcare system of performance data covering key clinical and organisational and workforce outputs. At a very minimum the following indicators are required:
- Hospital Standardised Mortality Ratio
- Admission times from referral by GP
- MRSA/C Diff infection rates
- Emergency readmissions
- Return to theatre for subsequent unplanned procedure
- Incidence of bedsores
- Level of medication errors
- Hygiene and cleanliness
- Patient satisfaction
- Incidence of staff fraud
- Incidence of patient litigation
- Staff indicators such as turnover, grievances and sickness absence
- HIQA to work with employers including HSE, and health sector unions to ensure that the national standards frameworks for clinical areas (such as cancer, CHD or obstetrics) reflect international evidence on the role of participative governance and management systems, including the use of multidisciplinary teamworking and the development of clinical micro-systems. The HSE Quality and Risk Management standard should also be revised to reflect international evidence of the impact of organisational practices such as teamworking on clinical outcomes.
- Identify measures that will enable the proposed hospital licensing procedure to embed the role of representative and direct staff involvement in building quality improvement and sound governance.

Strand 1D:

Building Operational Capacity: Integrated Transformation Teams

Both the survey findings and the evidence from our visits to the seven hospitals have demonstrated a substantial gap between leading edge practice and common practice in the organisation and delivery of patient care. This gap exists *between* different hospitals and *within* individual hospitals. Current institutional arrangements contain many of the elements necessary for driving improvement and innovation systemically throughout the hospital system. Yet the current arrangements lack the cohesion and synergy needed to achieve a systemic model of organisational excellence.

We propose that health service employers, including the HSE, and health sector unions develop radical new institutional arrangements to maximise the strategic and operational capacity to drive both continuous improvement and transformational innovation in the sector.

The new arrangements should have a specific capacity to promote organisational learning and participative innovation systematically throughout the health care system. The aim is to produce tangible improvements in quality of care, cost-effectiveness, risk management and staff well-being at the level of the health care organisation.

Bespoke multi-disciplinary teams, responsive to the particular needs of each hospital, will include HSNPF Facilitators and key HSE personnel including Organisational Development staff and Transformation Development Officers, plus those with responsibility and expertise in the implementation of integrated governance and HR strategy. These new teams should be supported within a unified operational framework by existing resources and capabilities for performance monitoring (HealthStat, Population Health Atlas, Performance Monitoring Unit etc.). They should also work in close collaboration with regulatory authorities and performance verification groups to respond to performance and improvement issues. The aim is rapidly to establish a culture based on knowledge-sharing and synergy rather than reflecting the silos that currently exist in the healthcare system.

In particular, the provision of unit and department-level performance indicators in relation to quality of care, cost-effectiveness, risk management and staff well-being should inform the work and progress of these teams, as well as becoming routinely available to front-line management, staff and unions.

Of particular concern are those cases, whether at hospital, department or unit level, which lie at the far end of the "long tail" of underperformance. Often these involve practices or omissions, which are demonstrably dysfunctional but at the same time deeply embedded in culture and tradition; change is therefore often not seen as a realistic short-term option or meets with insurmountable obstacles when attempted. Examples might include hospitals that have consistently failed to introduce patient safety risk assessments, clinical departments where multidisciplinary teamworking is resisted even in the face of international evidence that it reduces mortality rates amongst patients with specific conditions, or persistent "cultures of fear" relating to incident reporting. The combined impact of the recommendations in this chapter will be to reduce significantly the overall length and density of this long tail. However, experience suggests that there will be a number of cases (at hospital, department and unit levels) where the forces of inertia prove resistant to transformation and where internal resources alone will not be sufficient.

We therefore propose the instigation of special measures in cases of persistent poor performance in any hospital or department *where critical issues have emerged which place patient lives or well-being at risk*, where costs have run out of control, or where industrial or employment relations have reached a crisis point. Such critical issues may be revealed by performance data relating to, for example, mortality, emergency readmissions, untoward incidents, litigation and staff turnover, or may be disclosed from local sources including partnership structures, quality and risk committees or individual whistleblowers.

Working closely with unions as well as with Partnership Committees, this team would have a spectrum of remedies at its disposal ranging from the coaching and mentoring of key personnel through to the removal of individual clinicians or managers.

Such interventions are not to be deployed lightly. Rules of engagement will be formulated through rigorous debate with HSE, HIQA and health sector unions, and the team's activities will be closely monitored. The location of the team will also need to be agreed and cognisance given to the requirement for independence and accountability.

7.3.2 *Recommendation Two: Hospital transformation through networked innovation*

This study has argued for a focus on system-level change within individual hospitals, and the clear need is to identify and to demonstrate effective and sustainable means of securing quality improvement at all levels of the organisation. We have seen important examples of innovation in different areas of practice, but distributed sporadically between hospitals. The study has shown that there are no hospitals that are exemplary across all the principal areas of organisational and clinical practice, even though many are exemplary in one or two specific dimensions. This suggests that hospitals have a great deal to learn from each other through the sharing of practices and experience.

The history of public programmes for workplace innovation in European countries is instructive in addressing this challenge. While such programmes traditionally provided support on a case-by-case basis, resources were rarely sufficient to create a large-scale impact. Moreover the knowledge generated in individual organisations was rarely captured or disseminated – a situation also characteristic of the Irish hospital system. However recent developments in innovation theory identify the ability of inter-organisational networks to stimulate and inform change (Alasoini, Hanhike, Lahtonen, Ramstad and Rouhiainen, 2006; Gustavsen, Finne and Oscarsson, 2001). Such approaches offer the potential to create wider ripple effects, so that intervention in one workplace can provide both the momentum and the knowledge required to stimulate change more widely.

Interaction within networks also leads to learning processes, which are at the heart of real and effective innovation (Lundvall, 1992). Typically, this interaction involves the sharing of knowledge and experience, and peer review as an opportunity for productive reflection and as a stimulus for

sustained change. The *New Work Organisation programme* led by the Irish Productivity Centre in the 1990s provides an example of how such network innovation operates in practice (Sharpe and Totterdill, 1999). More recently the ED2000 and VC2010 programmes in Norway created collaborative networks between enterprises as a means of stimulating and resourcing incremental organisational innovations, often taking global models such as TQM and reformulating them in ways that reflected the specific context and gave ownership of the concept to local actors.

We are proposing the use of network-based innovation both as a means of supporting change in a small number of pilot or *Transformation Hospitals* in order to stimulate change more widely through the “ripple effect.”

Recommendation Two comprises three interdependent strands:

Strand 2A

The innovation cluster

While a great deal is known about what works in the delivery of cost-effective patient-centred care, less is known about how to implement such approaches systemically across a whole organisation. An action-research approach, initially focusing on a small group of hospitals with inbuilt mechanisms for wider dissemination, will lead to new practical knowledge about how to instigate sustainable change as well as creating a momentum within the wider hospital system.

Three or four of the most advanced hospitals will be selected to join an intensive 18 month programme that takes them beyond sporadic improvement into system-wide change. This “innovation cluster” will focus on three interdependent themes, although it is expected that the list will evolve and expand as a result of the learning process:

- Embedding Integrated and Participative Governance as a means of achieving quality improvement through staff engagement.
- Establishing integrated patient pathways through organisational redesign and new ways of working.

- Enhancing the role of representative participation in securing greater cost-effectiveness and patient satisfaction.

A key criterion for selection is that each hospital will have secured the full support of the HSE as well as its Executive Management Team, Partnership Committee and trade unions. It will also need to establish effective mechanisms for securing the involvement of a wide cross-section of staff at all levels, including consultants, in different aspects of learning, innovation and improvement. The aim is not to force all stakeholders to participate in an imposed “partnership” structure but rather to grow a diverse range of arenas that are responsive to specific needs and groups and yet networked to each other.

Activities in each hospital will be grounded in discursive methods for large scale change well established in many parts of Europe and North America (Alasoini, Hanhike and Ramstad, 2004) including a connected series of interactive “dialogue conferences.” Involving large diagonal slices of staff in intensive, short-term events linked to a large-scale strategic change programme has been effective in achieving sustainable organisational redesign with high levels of stakeholder buy-in. Such methods will provide a particularly useful tool for the design and implementation of integrated patient pathways, including integration with the PCCC sector. Immediately following the conferences, representative working groups with close accountability to senior management are established to drive the changes forward.

Critically, the proposal involves collaborative learning and innovation between a wide cross-section of participants from the different hospitals. Regular cluster-wide dialogue conferences will provide a means of sharing knowledge and experience, peer-reviewing initiatives and proposals, and benchmarking the process of change.

Experiences from each of the participating hospitals will be captured, analysed and used as part of a learning resource for other hospitals (see Strand 2C below).

Strand 2B

Learning Networks

The problem with pilot approaches to the promotion of organisational innovation is that insufficient thought is often given to the ways in which the knowledge and experience gained can be used to stimulate and inform change in the wider system. Learning networks have gained increasing attention as a mechanism for stimulating large-scale change (Bessant and Tsekouras, 2001; Docherty, Huzzard, de Leede and Totterdill, 2002) and recent evaluations suggest that they can be a valuable tool for policy-makers (see for example Ramstad, 2009). Learning networks typically involve interaction between organisations, but in so doing they can also build bridges between people within different parts of an organisation. They offer an increasingly important method of stimulating real innovation rather than emulation: they are not about transferring existing knowledge but about creating new levels of knowledge through the active exchange of experience and through experimentation.

We propose the establishment of a learning network with the participation of all acute hospitals including representatives from Clinical Directorates, HR and Partnership Committees. The Network will become a vital driver for knowledge-based improvement and innovation by enabling practitioners to share knowledge of “what works”, to identify solutions to intractable obstacles, to build bridges between research evidence and practice, and to peer-review proposals for innovation in individual hospitals. Network programmes will include both multidisciplinary activities and meetings for specific groups such as trade union representatives and management in order to embed learning as effectively as possible.

The Network will initially meet three times over the course of 12 months. It will also generate thematic groups on the three key issues identified in the previous section (integrated and participative governance; integrated patient pathways; the role of representative participation in securing greater cost-effectiveness and patient satisfaction). Using approaches such as action learning these thematic

groups can support the emergence of a cadre of change entrepreneurs able to lead strategic initiatives in every hospital.

We recognise the risk that competing pressures will undermine the willingness and ability to participate in Network activities, and would expect strong leadership from the HSE to ensure active engagement. This might include linking evidence of active participation in the Network’s shared learning and improvement initiatives to the hospital licensing process.

Learning from international experience can also be important in the process of innovation, and this will add a further dimension to the Network. We propose the establishment of an *International Hospital Forum* comprising selected clinical and research institutions from across Europe and beyond with established track records relating to Participative Governance. Forum activities will include peer-review visits and seminars on topics of mutual concern with a focus on bridge-building between academic research and practice.

Strand 2C

Creating actionable knowledge

While there is considerable knowledge and experience relating to internationally established practice, this is often not in a form that is readily accessible to practitioners. There is a clear need to provide usable tools and resources, including an interactive website and DVD material, relating to the introduction of practices such as multidisciplinary teamworking, integrated patient pathways and the different components of participative governance. These resources will provide a valuable complement to regulatory drivers for workplace innovation in hospitals by establishing clear benchmark standards relating to, for example, team effectiveness, shared learning and continuous improvement. They will also provide a vehicle for capturing and distributing knowledge and experience generated by the proposed activities described above.

7.4 The process of implementation

Throughout this report we have emphasised the need for inclusive approaches to innovation and change, matched by robust systems for leading, learning, monitoring and evaluation. These requirements apply equally to the implementation of the recommendations outlined above, and this section describes the mechanisms which will be put in place to secure anticipated outcomes.

7.4.1 Oversight of the Implementation Process

We recommend that the health sector unions, the HSE and the Department of Health and Children develop Steering Committee arrangements to provide for effective oversight of the implementation of the recommendations outlined in this report. The Steering Committee should be supported by a Secretariat drawing on expertise from the HSNPF and other resources.

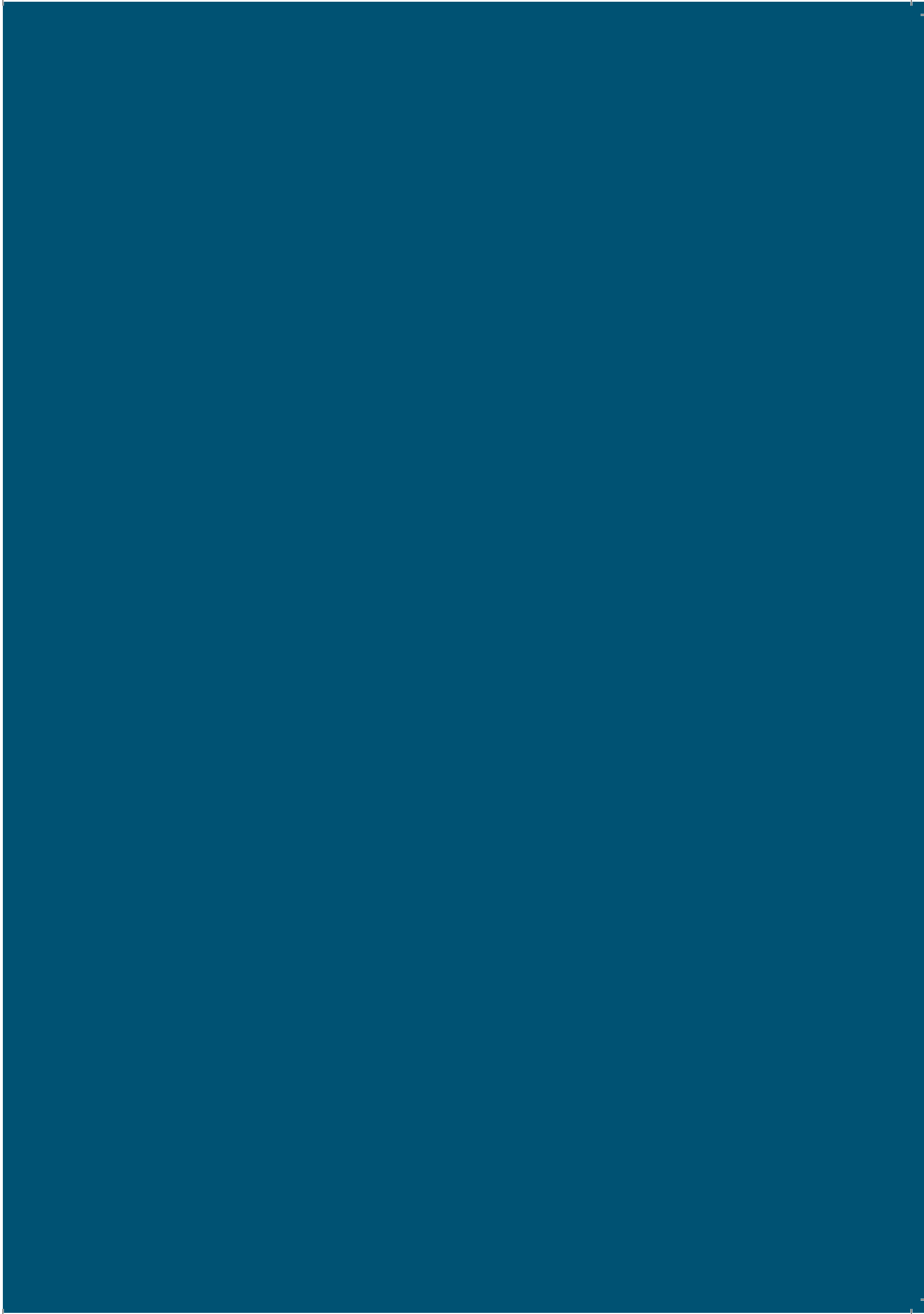
7.4.2 Resourcing and Managing: A Strategic Engagement and Innovation Initiative

The recommendations described earlier in this chapter will constitute a *Strategic Engagement and Innovation Initiative* explicitly focused on realising the aspirations for the healthcare sector outlined in the *Public Service Agreement 2010 – 2014*. Critically, the Steering Committee should establish and monitor a robust yet realistic timeframe for the delivery of the recommendations, with an emphasis on fast-tracking action by the HSE and health sector unions designed to create a macro-level environment conducive to sustainable and deeply embedded transformation at hospital level. The Committee will act as, or establish, a clearing house with a remit to resolve problems and obstacles arising from the initiative, including inter-organisational conflicts or partnership-related issues. The Steering Committee will also manage the strategic allocation of funding to support the initiative.

An important part of the Steering Committee's remit will be to ensure that the initiative achieves a high profile amongst the public, health service management and staff. Such a profile will play an important part in creating an environment conducive to transformation, both within the pilot hospitals and more widely within the sector. In particular the public profiling of the project should be designed to enthuse and empower clinicians, front-line staff and union representatives to engage with the initiative whenever possible.

The Committee will also ensure the wider dissemination of learning from the project:

- by reinforcing the importance of participation in learning network activities (Recommendation 2B) by senior hospital managers and clinicians and by union representatives;
- by ensuring that this participation is linked to active improvement measures in each hospital through an appropriate combination of 'carrot and stick' methods;
- by ensuring that the emerging regulatory and licensing framework relating to quality and risk reflects insights generated by the initiative.



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Appendices

Appendix A

Steering Committee

Dr. Ruth Barrington, Chairperson

Mr. Kevin Callinan, IM PACT

Ms. Ann Doherty, Health Service Executive

Mr. Donal Duffy, Irish Hospital Consultants Association

Ms. Lucy Fallon-Byrne, National Centre for Partnership and Performance

Mr. Jack Kelly, SIPTU

Mr. Eddie Mathews, Irish Nurses and Midwives Organisation

Mr. John McAdam, Health Service National Partnership Forum

Mr. Moss McCormack, Health Service Executive

Mr. Sean McGrath, Health Service Executive

Mr. John McPhilips, St. Vincent's University Hospital, Dublin

Mr. Matt Merrigan, SIPTU

Ms. Colette Mullin, Irish Nurses and Midwives Organisation

Mr. Finbarr Murphy, Irish Medical Organisation

Dr. Larry O'Connell, National Economic and Social Development Office

Mr. Christy O'Hara, University College Hospital, Galway

Mr. Cathal O'Regan, National Centre for Partnership and Performance

Dr. Damian Thomas, National Centre for Partnership and Performance

Ms. Sheila Treacy, IBEC

Mr. Larry Walsh, Health Service National Partnership Forum

Appendix B

Technical Working Group

Mr. John McAdam, Health Service National Partnership Forum

Mr. Moss McCormack, Health Service Executive

Mr. Cathal O'Regan, National Centre for Partnership and Performance

Mr. Larry Walsh, Health Service National Partnership Forum

Ms. Valerie Whelan, National Centre for Partnership and Performance

Appendix C

Ad-Hoc Expert Liaison Group

Mr. Cathal O'Regan, National Centre for Partnership and Performance

Mr. John Billings, Health Information and Quality Authority

Dr. Ciaran Browne, Health Service Executive

Ms. Carmel Cullen, Health Service Executive

Ms. Rosemary Exton, UKWON Ltd.

Mr. Howard Johnson, Health Service Executive

Mr. Eric Koorneef, Health Information and Quality Authority

Ms. Libby Kinneen, Health Service Executive

Mr. John McAdam, Health Services National Partnership Forum

Mr. Derek McCormack, Health Service Executive

Mr. Moss McCormack, Health Service Executive

Ms. Karen Robinson, Clinical Indemnity Scheme, State Claims Agency

Mr. Peter Ross, Insight Statistical Consulting Ltd.

Ms. Rosemary Ryan, Irish Public Bodies

Mr. Pat Savage, IPC Consulting

Dr. Damian Thomas, National Centre for Partnership
and Performance

Professor Peter Totterdill, UKWON Ltd.

Mr. Mark Turner, Health Service Executive

Dr. Cathal Walsh, Insight Statistical Consulting Ltd.

Appendix D

HSE Performance Indicators

Public Inpatient and Day Case (Discharges and Waiting Lists)

- a) Number of Public, Adult, Elective:
 - i) Inpatient Discharges
 - ii) Day Case Discharges.
- b) Number of Public, Child, Elective:
 - i) Inpatient Discharges
 - ii) Day Case Discharges.
- c) Number of adults waiting for:
 - i) Inpatient treatment
(Public Waiting List Only)
 - ii) Day Case treatment
(Public Waiting List Only):
- d) Number of children waiting for:
 - i) Inpatient treatment
(Public Waiting List Only):
 - ii) Daycase treatment
(Public Waiting List Only):
- e) Adult Patients Waiting
 - i) over 6 months as % of Public Elective
Discharges in Reporting Period.
 - ii) over 12 months as % of Public Elective
Discharges in Reporting Period.
- f) Child Patients Waiting:
 - ii) over 6 months as % of Public Elective

Discharges in Reporting Period.

Delayed discharges by type.

Delays associated with a patient returning home Emergency Department Waiting Times

Average monthly numbers based on totality of 2007 Average per day YTD

Average per day YTD

- a) average number of patients on trolleys in EDs
nationally per month following decision to admit,
recorded at 2pm daily
- b) average waiting time for patients in EDs
nationally per month following decision to admit,
recorded at 2pm daily, broken down as follows:

Average daily numbers based on totality of 2007

Average per day YTD

Average per day YTD

Elective / Non Elective and Public / Private Discharges (PI) Number of patients discharged in reporting period

- a) Inpatient Outpatients
- a) No. of outpatient attendances (total)
- b No. of outpatient attendances (new)
- c) No. of new DNAs
- d) No. of outpatient attendances (return)
- e) No. of return DNAs Births No. of births
Emergency Department
- a) No. of emergency presentations
- b) No. of ED attendances
- c) No. of emergency admissions PI / Measure
- Ambulance Response Times (PI) Pre-Hospital
Activity:- Emergency Calls Urgent Calls Non
Urgent Calls Community Transport*

PI / Measure

Infection Control

- i) 20% reduction in HCAIs,
- ii) 30% reduction in MRSA infections
- iii) 20% reduction in antibiotic consumption

MRSA

MRSA bacteraemia notification rate per 1,000
admissions by hospital network.

PI / Measure – Cancer Services Procedures (PI)

a) Number and direct age-standardised procedure rate per 100,000 female population for the following procedures: (with a primary diagnosis of breast cancer)

1. 'Local Excision of Lesion of Breast' (ICD-10-AM 31500-00, 31515-00)

2. 'Mastectomy' (ICD-10-AM 31524-00, 31524-01, 31518-00, 31518-01)

b) For surgeons conducting ANY of the above procedures: average total number of procedures conducted by all surgeons, by Network area.

c) Percentage of consultant surgical staff conducting > 50 of listed procedures, by hospital network.

Table 6 Data Types relating to Hospital Performance (source – HealthStat)

Measure	Number of Categories
Whole-time equivalent staffing numbers (WTE)	6
Bed Days Lost	1
Bed Days Available	1
Number of discharges per hospital	42
Elective Surgery Waiting Times	16
WTE	40
Monthly Admissions	1
Monthly Attendances	1
Total numbers waiting at 2pm in each category each day during month	1
Breakdown of monthly operating cost	1
Uncertified Absences	6
Certified Absences	6
Long term Absences	6
Number of Staff Hours Available	6
Volume activity	39
GP able to submit direct referrals	3
GP request to hospital time to next appointment	6
Consultant able to submit direct referrals	3
Consultant Days to next appointment	6
Number of Consultants Over 30 days	14
Count of Consultants	7
Did Not Attend	7
Nb of New Patients	7
Clinic	16
Average Length Of Stay	34
Total In-patients	34
Day case Rates	14
Total Day case Patients	14
Surgical Discharges	8
Number of Cases	8
Finance	2
Inappropriate admissions	2
Total Number of beds	1
Number of daycase beds	1
Number of inpatient beds	1
% Public beds	1

Health Performance Indicators

Access	Integration	Resources
Adult Elective Procedures Wait times	Day Case Rates – Procedures	Staff WTE Variance from Staff Ceiling
Child Elective Procedures Wait times	Day of Procedure Admission Rate for Elective Inpatients	Percentage of Staff Hours Lost Due to Absenteeism
Acute Admission (Emergency Department)	Inpatient ALOS adjusted for complexity and age	AHP Hospital Activity (number of encounters per WTE)
GP to Hospital Referral Wait Times for Physio	Overall ALOS (inpatients and daycases)	Number of New Patients per WTE Consultant
GP to Hospital Referral Wait Times for Diagnostics	Percentage of Cases Entered into HIPE	Consultant Clinic DNA Rates
Consultant to Hospital Referral Wait Times for Physio	Appropriateness of Admission and Care, discharge plans in place	Public vrs Private Split of Activity
Consultant to Hospital Referral Wait Times for Diagnostics		Variance from Budget
Percentage of Clinics with wait time over 90 days		
Average Wait Times for OPD Consultant Led Clinics		

