PARTNERSHIP AND QUALITY OF WORKING LIFE AT NOTTINGHAM CITY HOSPITAL

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Background

The study grows from the collaboration of the two authors in 'Improving Working Lives' (IWL), a UK government initiative to enhance quality of working life for staff in the National Health Service (NHS). IWL, especially in its implementation 'on the ground' demonstrates both the potential and limitations of centrally determined regulation as a means of stimulating organisational innovation and change. The case study is based on a reflective account of workplace innovation, combining the perspective of an active trade unionist and clinical midwife in the Hospital with that of a researcher concerned with dialogue-based organisational innovation. The study also draws on a review of current thinking about partnership undertaken as part of a UKWON project supported by the Department of Trade & Industry's *Partnership at Work Fund*, involving interviews and dialogue seminars with several leading actors (Dawson, Hague, Knell & Totterdill, 2002).

The aim of the case study is:

- to test the proposition that workplace partnership can provide an effective context for the design and implementation of 'win-win' approaches to organisational innovation;
- to examine the potential for trade unions to negotiate a balance between direct and representative participation in the workplace in ways which strengthen their influence while providing individual employees with opportunities for control over the day-to-day working environment;
- to explore the extent to which workplace partnership offers local trade union representatives the potential for an enhanced role as knowledgeable participants in organisational innovation.

It is recognised that concrete outcomes from such changes may be hard to identify and that the benefits are relatively intangible. Our concern is principally to evaluate the process involved in IWL implementation in one hospital and to identify the extent to which it creates the conditions for sustainable improvements in workplace partnership and staff involvement. We believe that these lessons have significance for organisations well beyond the boundaries of the NHS.

While IWL is concerned with all aspects of working life, this case study will specifically focus on its role in driving staff and trade union involvement and participation. Staff involvement as the focus of the case study is central to effective governance in hospitals. Involved and fully engaged staff provide an indispensable vehicle for the identification of clinical and organisational risk and the maintenance of quality, build-

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ing a culture in which openness and dialogue are recognised as key assets. The study suggests that staff involvement needs to take place at all levels of working life, and that management-employee partnership at the strategic level needs to drive highly participative approaches to multidisciplinary teamworking at the front line. Teamworking, it can be argued, is only sustainable when developed and nurtured within a wider organisational context, which values and resources, dialogue and inclusiveness. By providing opportunities for employees to utilise the full range of their knowledge and experience, staff involvement also facilitates continuous improvement and innovation in patient care. Staff involvement is also a key dimension in building *an inclusive, integrated organisation*, and the IWL measures described in the case study provide employees at all levels with a voice in policy, practice and change. Finally, the study's focus on staff involvement begins with the 'Improving Working Lives' initiative, specifically designed to create attractive and rewarding workplaces as a means of motivating, recruiting and retaining skilled employees.

This case study provides a rare example of 'bottom-up' organisational innovation in which trade union stewards and front line staff play a central role in designing and driving the development of workplace partnership.

PARTNERSHIP & WORKPLACE INNOVATION IN THE NHS

The limits of performance management

New approaches to governance have become the foremost driver of innovation and change within the NHS, reflecting government measures such as risk management, clinical effectiveness, patient involvement and enhanced professional competence. Its practice is largely defined by the controls with which government requires hospitals to regulate their activities. Hospital Boards have to account to external, government-appointed auditors for performance against some 400 indicators including mortality rates, bed occupancy and the quality of patient food. These targets play a powerful role in directing the focus of managers' attention. Arguably they induce reactive management cultures, stifling innovation and preventing the ability to build sustainable change. The fulfilment of short-term targets has become almost the sole preoccupation of politicians and health service managers with worrying consequences for the reflexive and innovative capacity of the NHS. Over-emphasis on targets may lead to quality assurance but is unlikely to secure real, sustainable quality improvement (Moss & Totterdill, 2002).

Whilst the regulation of hospital activity reflects aspirations and standards widely accepted amongst NHS employees, this paper argues that it is not sufficient to ensure the reflexivity and organisational innovation required for effective hospitals capable of delivering safe, patient focussed care. Governance must be based on a more strategic vision, laying the foundations for long-term learning and adaptation in an increasingly unpredictable and turbulent environment. There is a need for a significant shift in management focus, one in which the delivery of targets is achieved as the by-product of wider and sustained improvements in service quality (NHS Confederation, 2002). Such a shift from short-term target chasing to building the organisational com-

petencies associated with adaptive, innovative organisations would represent a radical transformation of the NHS.

An approach to governance in which health service organisations do indeed achieve external targets as a 'by-product' of their inherent organisational competence and values might be characterised as the 'high road'. The defining characteristics of the high road lie in the creation of organisational spaces and the liberation of the tacit knowledge, experience and talent of the entire workforce in ways which achieve a dynamic balance between service and process innovations (Totterdill, Dhondt and Milsome, 2002). Crucially the high road seeks to reunite job satisfaction and patient satisfaction. In contrast the 'low road' – arguably the dominant mode of governance for most NHS hospitals in the present environment - is driven by cost, performance measurement, punishment and reward. For NHS staff it frequently results in deterioration in the quality of working life (Meadows et al, 2000) which purely remedial HR initiatives cannot redress. Apart from increasing problems with recruitment and retention, this failure to involve staff at all levels of service provision represents a lost opportunity for innovation and improvement.

Yet performance measurement cannot be exclusively associated with the low road. This study demonstrates that appropriate target setting and appraisal can be an important (if not necessarily sufficient) stimulus for bottom-up innovation by addressing many of the traditional barriers to staff involvement and the improvement of working life.

Improving working lives through partnership, involvement and participation

At a time when the health service struggles to rise to the challenge of staff recruitment and retention, the *NHS Plan* (DoH, 2000a) announced the government's commitment to enhance the quality of working life of staff. The 'Improving Working Lives' (IWL) initiative launched in 2000 is designed as:

". . . a blueprint by which NHS employers and staff can measure the management of human resources. Organisations are kite-marked against their ability to demonstrate a commitment to improving the working lives of their employees." (www.dh.gov.uk).

According to the Department of Health this is part of a strategy to transform the NHS into no less than a "model employer", defined as:

"A management style that is both involving and facilitating (which) will result in NHS staff feeling more valued, (and) which benefits patients in turn" (www.dh.gov.uk).

In the same mode, *Shifting the Balance of Power: securing delivery* (DoH, 2001a, p24) argues that:

"A real shift in the balance of power will not occur unless staff are empowered to make the necessary change… Staff need to be involved in decisions which effect (sic) service delivery. Empowerment comes when staff own the policies and are able to bring about real change."

Thus although IWL identifies itself principally as a human resources initiative, there are strong implicit links between improvements in quality of working life, effective governance and enhanced patient care. The IWL Standard (DoH, 2000d) states that NHS employers should:

- recognise that modern health services require modern employment services;
- understand that staff work best for patients when they can strike a healthy balance between work and other aspects of their life outside work;
- accept a joint responsibility with staff to develop a range of working arrangements that balance the needs of patients and services with the needs of staff;
- value and support staff according to the contribution they make to patient care and meeting the needs of the service;
- provide personal and professional development and training opportunities that are accessible and open to all staff irrespective of their working patterns;
- have a range of policies and practices in place that enable staff to manage a healthy balance between work and their commitments outside work.

The Improving Working Lives Standard follows seven areas of good practice which, the Department of Health argues, are integral to the successful implementation of modern employment practices (Table 1):

TABLE 1 - *Improving Working Lives* key indicators

Human Resources Strategy and Management – ensuring a range of policies and practices that support national targets, including a workforce development plan linked to the redesign and improvement of patient care and outcomes, effective measures to enhance staff retention, and partnership working practices
Equality and Diversity – fairness and equality for all staff irrespective of ethnicity, culture, religion, sexuality, age, gender or employment status.
Communication and Staff Involvement - awareness and application of IWL principles through effective two way communication, staff involvement and participation, demonstrated through effective partnership working.
Flexible Working – developing a range of working patterns that balance the needs of the service with the needs of staff, including team-based, employee-led rostering.
Healthy Workplace – providing a supportive, healthy and safe working environment.
Training and Development – providing personal and professional training opportunities that are accessible and open to all staff.
.**Flexible retirement, childcare and support for carers–** active pension awareness and planning for retirement, accessible and affordable childcare, and support systems for staff who are carers.

Source: DoH (2000d)

In 2002 *HR in the NHS Plan* was published by the Department of Health (DoH, 2002a). Restating the significant contribution that HR management can make to patient care, the report outlined the benefits for both staff and patients from ensuring that

staff and trade union representatives are fully involved in developing and implementing model employment practices. Three stages of IWL accreditation were introduced: "Pledge" (to be achieved by April 2001), "Practice" (by April 2003) and "Practice Plus" (by 31st March 2006), each based on an external assessment process. This is seen as part of a continuing journey to becoming a world class "Model Employer".

In stage one each organisation made a public "Pledge" to improve working lives by putting in place the necessary policies procedures and plans. In stage two ("Practice Standard"), organisations were required to provide a portfolio of evidence relating to policies and procedures that demonstrated their commitment to the IWL Standard outlined in Table 1. Critically however this portfolio only accounted for a maximum of 25% of the total score in the Practice Standard assessment. Evidence collected from interviews on quality of working life with a cross section of staff accounted for the remaining 75%.

In stage three, the *Improving Working Lives National Audit Instrument for Practice Plus* (DoH, 2002b) challenges NHS employers to prove not just that policies are in place but that they are making a measurable difference to the working lives of most staff in all groups. This is a joint self-assessment and peer review in close partnership with staff and staff side representatives. An external Validation Team endorses the self assessment evidence and its evidence will be moderated to ensure consistency between different organisations.

Finally evidence from each organisation is submitted to an Accreditation Panel comprising key local stakeholders who will submit the process to rigorous quality assurance thus advancing the organisation to stage four: Model Employer status.

It was intended that NHS organisations should not be able to achieve Practice Plus without demonstrable evidence supported by staff, trade union and staff representatives of real culture change, designed to ensure that "most staff in all staff groups" enjoy the benefits of modern working practices that actively improve working lives. The remainder of this paper therefore focuses on staff involvement as the principle driver for achieving the IWL Standard and for securing the wider clinical and organisational benefits associated with an engaged workforce.

While IWL represents a significant innovation, senior NHS managers and trade union representatives often recognise that the difficult task is not to design the appropriate policy framework but to make sure it is implemented equitably across the service and the different staff groups. There is evidence that many middle managers interpret and apply their hospital's policies in arbitrary ways (Exton 2002). The IWL Standard has the *potential* to highlight the uneven application of human resource policies, areas of poor communication and insufficient staff involvement. More positively it can demonstrate areas of good practice and service innovation. To be sustainable, IWL principles need to become embedded in all areas of hospital management and practice and not treated as yet another set of short term performance targets. IWL will only be successful if it effectively engages and involves frontline staff, providing the opportunity for them to develop their professional, service and working conditions. Involving staff at all levels through the IWL initiative potentially empowers them to make a difference

within their hospitals, shaping future health services and thereby leading to improved retention and recruitment.

This represents a massive change from the traditional way most staff work and such changes don't happen without a struggle. Even when hospital Boards are fully committed to improving quality of working life there is no guarantee that effective changes will be realised at workforce level.

IMPROVING WORKING LIVES AT NOTTINGHAM CITY HOSPITAL

Nottingham City Hospital is a large acute teaching Hospital providing a wide range of in-patient, out-patient and day care services for a local population of 650,000 people. The Hospital also provides specialised services to a wider population of two million people. It occupies a 90-acre site and first opened to patients in 1903. Many of the original buildings are still in use, though an extensive capital investment programme is underway.

Approximately 5,800 people work at the Hospital, which also enjoys the support of more than 800 volunteers. There are 1,000 beds, and the Hospital cares for 75,000 in-patients and 22,000 day patients. More than 250,000 out-patient appointments are held each year.

Over the next few years Nottingham City Hospital will see major changes taking place as it plans the redevelopment of services and infrastructure to modernise the care it provides. Effective change management and service planning will become even more central to the ability to improve quality of patient care. However it has been recognised at senior level that much more needs to be done to involve trade union representatives and staff throughout the Hospital in developing the future of the service – from the broad strategic direction of the organisation to day-to-day decision-making.

The consortium of sixteen trade unions at NCH is collectively known as “Staff Side”, with an elected Chair and Secretary. The local trade union stewards and staff representatives are elected by the members of their own unions and professional organisations and are formally recognised by the Hospital. These are voluntary roles but line managers are supposed to allocate reasonable time away from clinical or service duties for trade union activities. Local stewards liaise with their full time regional officers and invite them to Hospital meetings where complex issues require further professional expertise.

Management-trade union relations in the Hospital have rarely been adversarial. However the nature of the dialogue between the two sides was somewhat restricted to traditional industrial relations issues and formal consultation on changes which had a direct bearing on employment. Trade union representatives enjoyed an established position within the organisation but were not closely involved in management thinking on strategic issues. Information on new initiatives was often shared only after decisions had already taken shape. Both sides recognised that a more dynamic, partnership-based approach needed to be developed to meet the challenges of the future albeit - as subse-

quent developments were to demonstrate - with different perceptions of the nature of partnership.

At the outset of the IWL process, it was evident that several examples existed of workplace innovation at service and clinical levels based on participative teamworking and staff involvement. However these examples were sporadic: there was no 'good practice' map of work organisation across the Hospital and no overall guidelines for involvement and participation.

The IWL initiative was first discussed with the trade union representatives at joint meetings with management as early as March 2000. Formal endorsement of the Hospital's commitment to IWL had already been agreed at senior management and trade union level but, echoing Munro's contemporaneous study of employee involvement in the NHS, it was clear that different participants in the process had different understandings of its meaning and potential (Munro, 2002). While the management narrative about IWL was initially dominated by the need for compliance with external audit requirements, it became clear to trade union representatives that they had much to gain from an initiative that offered a new mechanism to influence Hospital decisions affecting working life. In particular this suggested the possibility of a more proactive union role, one that could seek to instigate change rather than simply reacting to a management agenda. The Hospital unions were, however, conscious of possible conflicts between direct and indirect participation, fearful that management would use the involvement of individual staff members to marginalise the role of representatives. Yet a louder staff voice would also support union efforts to raise the profile of working life issues within the Hospital.

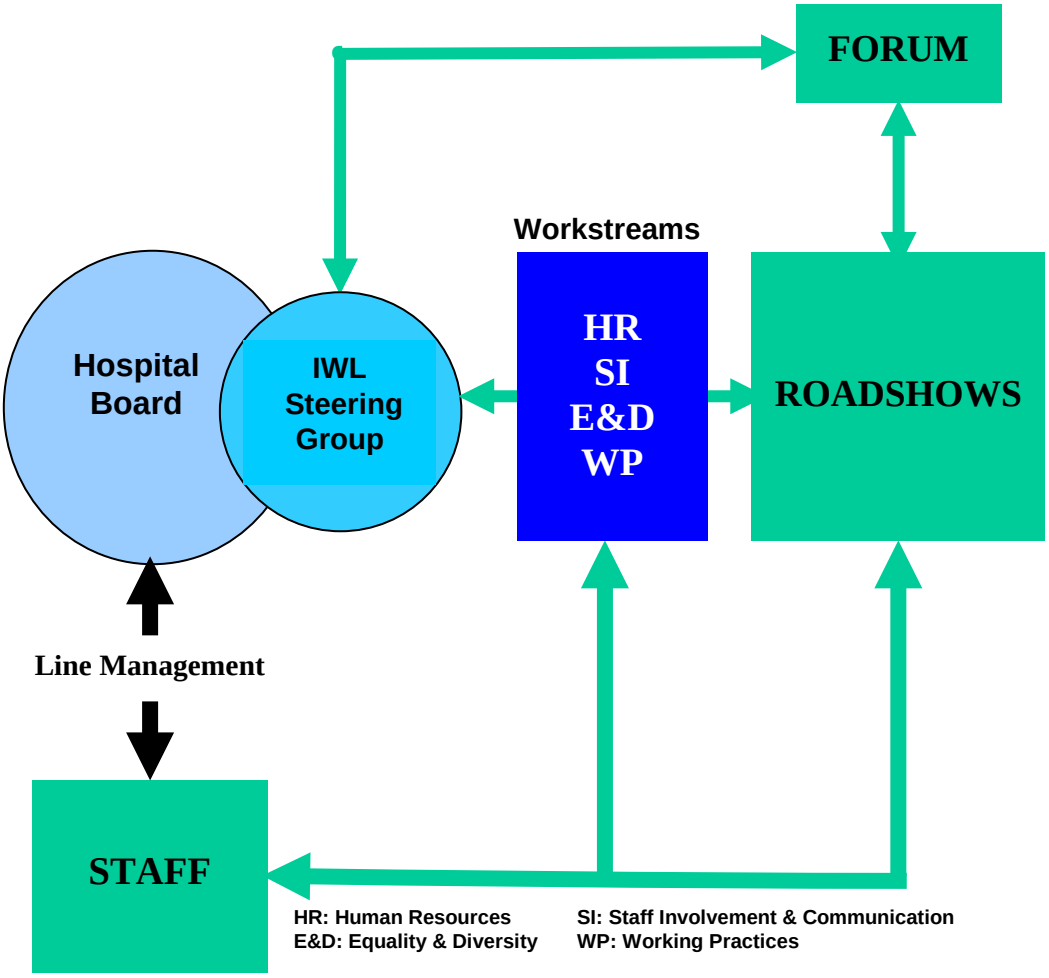
Union stewards were also aware that any initiative to generate involvement seen by staff to be management-led and driven by the need to meet external performance measures would be treated with widespread scepticism by staff. The Practice Standard assessment process based on direct interviews with staff ensured that the Hospital would not be allowed to treat IWL merely as a paper exercise. Real staff involvement leading to recognisable improvements in working life had to become a key Hospital objective bringing issues championed by union representatives over a number of years to greater prominence.

The IWL approach at Nottingham City Hospital

In January 2002 members of Hospital trade unions were invited to join with Executive and Non-Executive Directors, and a representative group of clinical staff and managers at a time-out morning to develop a framework for the implementation of the IWL initiative. Union representatives perceived this as a notable milestone in the development of effective involvement. Trade union participation at this meeting undoubtedly added insight to the discussion, drawing on knowledge of management and working practices across the Hospital. Union representatives identified examples of good management practice and teamworking, but also drew attention to the arbitrary interpretation and implementation of Hospital policies by some middle managers. They recognised that the IWL initiative provided them with a new resource with which to address many issues of concern to their members including the application of flexible working, equality and diversity, and involvement of staff in service planning and change.

The HR Director presented the meeting with a draft framework for the achievement of IWL Practice Standard that placed line managers as the main channel of two-way communication. However the trade union representatives argued that this was not appropriate, firstly because employees would simply dismiss IWL as yet another management-led initiative, secondly because many managers would not be sympathetic to greater staff involvement. An alternative framework based on much wider staff involvement was proposed by the trade unions at the time out and was subsequently adopted (see Figure 1, below).

FIGURE 1: IWL Staff Involvement at Nottingham City Hospital



IWL Steering Group

Following the time-out session a Steering Group was established, chaired jointly by the HR Director and a Non-Executive Director. The Chair and Secretary of Staff Side were invited to join the Steering Group, together with managers from each clinical directorate plus human resources and other service departments. Higher management representation from each clinical division on the Steering Group was included in an attempt to secure a communication pathway through the traditional line management structure. However, as predicted by trade union representatives at the original time out,

dissemination through traditional line management often proved ineffective resulting in poor local support and understanding of IWL.

Inclusion of lead trade union representatives at the strategic level was a clear acknowledgement that the Hospital considered their involvement essential to the success of the IWL initiative. However there was little appreciation at the early stages of the volume of work that would subsequently be required to achieve 'Practice Standard' by 2003, or to undertake the self assessment process preceding validation for Practice Plus in 2005/2006. This was to place considerable strain on the time allowances granted to representatives for trade union duties and involvement in Hospital-wide issues. The individuals concerned struggled to balance the huge demands on their time imposed by IWL with their clinical and service support commitments. Trade union representatives continued to bring this problem to the attention of management but with little success. Even where the issue was recognised by corporate management it did not improve the willingness of some line managers to cover the absence of trade union representatives when faced by a lack of resources in their clinical and service areas. A letter was sent to all managers from the Steering Group urging active support for the participation of trade union representatives in IWL. Managers who felt unable to do so were invited to complete a form in which they could explain to the HR Director why they were unable to release a representative from clinical or service commitments. While it is clear that this measure did not entirely solve the problem, it created some discussion within the Hospital on the need to provide the space to enable trade unions to play a constructive role.

The Steering Group was created initially to set the direction for achieving IWL Practice Standard, but gradually acquired a continuing responsibility for encouraging wider change within the organisation. It provided regular reports to the Hospital Board, which monitored progress towards IWL accreditation as part of its performance management role. The Steering Group attempted to ensure that initiatives were co-ordinated and communicated across the Hospital, and was responsible for agreeing the work programmes of four thematic Workstreams (see below) and managing their performance. Responsibility for ensuring effective responses to staff suggestions also lay with the Steering Group.

IWL Workstreams

Four Workstreams were established to address key organisational issues:

- Human Resource Strategy and Management including training and development
- Staff Involvement and Communication
- Working Practices including flexible working
- Equality and Diversity.

Membership of the Workstreams initially comprised representatives of the Steering Group, including two Non Executive Directors, HR managers, trade union representatives and a cross section of hospital management. This was altered at the suggestion of the trade unions, who expressed serious concerns that membership was weighted towards the management perspective. More involvement from all grades of staff across the Hospital was sought, and over 70 staff members were eventually included in these Workstreams. Workstream action plans included assessment of the Hospital against

the IWL Practice Standard, the evaluation of Hospital policies including the effectiveness of their implementation, and the active engagement of staff at all stages of the process. Discussion within the Steering Group quickly led to agreement that capturing views of staff across the Hospital and that responding effectively was a key priority.

For many trade union stewards this was their first experience of meeting with management outside the usual consultative and negotiation forums. The expectation that the stewards would take on active and leading roles within IWL in the absence of training or extra time to be released from service or clinical commitments was daunting. Many felt ill-prepared and often intimidated during meetings, and unlike many managers, were provided with no secretarial support to help deal with copious emails and paperwork. Some even had difficulty in physically accessing emails from the shared terminals at their workplaces.

There were also indications that some union representatives and individual employees had subsequently been challenged by their managers about issues which they had raised during the early meetings. Once these allegations were verified, the Steering Group wrote to the managers concerned to stress the Hospital's commitment to open dialogue free from the fear of recrimination.

Staff involvement at this level also created a new challenge for the leadership of these Workstreams, recognising that the formality of meetings, structured agendas and the presence of managerial and non-managerial staff could inhibit participation. It required openness, trust and familiarity to encourage some staff to attend and speak out without fear of penalisation by line managers. Feedback from one frontline worker attending her first meeting made clear that she felt intimidated by the formal agenda and the format of the meeting, and she subsequently left the group. This highlights the continual struggle that Workstreams face in balancing the need for structured discussions to complete formal business on the one hand with open dialogue designed to capture staff experience of working life on the other. In partial recognition of this problem, individual letters of encouragement and thanks were sent from the Steering Group to staff members participating in each Workstream.

IWL Roadshows

To address the challenge of involving all Hospital staff in identifying opportunities for improvement, the Staff Side Secretary proposed a rolling programme of Roadshows designed to take the IWL initiative out to the workforce at times and venues accessible to all. Cycles of IWL Roadshow events were held during November 2002, July 2003 and September 2004 in two key locations on the Hospital campus. Over 1000 staff attended the first two cycles, representing one of the most successful involvement initiatives ever organised within the Hospital.

The Roadshows were designed as a relaxed informal drop-in forum, with attractive visual displays and a refreshment area where staff can sit and chat. On arrival participants were welcomed with coffee and biscuits, and invited to complete a questionnaire comprising short multi-choice questions designed to evaluate their quality of working life (the results of the questionnaire survey from the first round of Roadshows are summarised in Table 3 below). The questionnaire set the scene for a series of displays

that provided visual explanations of the IWL initiative in ways that were exciting, informative and designed to stimulate comment. Staff were encouraged to share examples of good practice from their areas of work and to write questions and comments about issues affecting their working lives.

Within the traditional culture of the NHS some staff are likely to fear recrimination if they comment openly about working practices. Trade union representatives acted as facilitators at the Roadshow, encouraging and enabling staff to share their thoughts and experiences with the knowledge that they wouldn't be identified. Graffiti wall charts and marker pens proved an effective medium for staff to express ideas and suggestions, and anonymous boxes were available for written comments.

A number of experienced facilitators were asked to lead informal discussions with staff at the events. A space for these informal groups was arranged near the refreshment table, and staff were encouraged to engage in discussions. Posters on the walls prompted the sessions with statements such as *'What makes you feel good about your job?*' *'What does the Hospital do really well… and not so well?' 'How is your knowledge and experience valued at work?*' and *'What stops your job from being rewarding?'* The question *'How can we do things better?*' was introduced throughout the discussion to generate ideas and suggestions. Ideas introduced were tested on other staff members in the group, for example *Would this work elsewhere in the Hospital?* or *How could we make this work across the whole Hospital?* Results were collected on flip charts and collated for review by Workstreams. Many responses were received, covering a wide range of issues (see Table 2 below).

TABLE 2: Roadshow Feedback

Issues identified from comments, graffiti charts and suggestion boxes *(576 participants)*
Work Organisation
Teamwork
Recognition/Empowerment
Management Style
Flexible Working
Access to Training and Development
Inter-departmental working
Communication, Involvement and Partnership
Management attitudes
Need to harness good ideas
Fairness/unfairness in implementing Hospital policies
Access to information
Work Environment
Car Parking
Catering
Leisure
Social
Security
Temperature
Equipment
Space
Health and Safety
Occupational Health

Comments on the potential for greater staff involvement and lack of empowered teamworking recurred frequently amongst responses, indicating a desire for greater partnership both at the strategic level of the Hospital and in day-to-day working life. It was clear from the focus groups that staff saw benefits resulting from closer partnership not just in terms of working life but also in terms of the quality of patient care. Findings from the Roadshow questionnaire summarised in Table 3 strengthened awareness of the need to develop more participative approaches to the organisation of work, and raised real concerns about the inability of many staff to contribute fully towards effective clinical governance by contributing their ideas for improvement and by participating in effective teams:

TABLE 3: Questionnaire responses

Issues identified from Roadshow Questionnaire ***(440 responses)***
• 88% believe that the Hospital does a good job for its patients, though few (1.2%) think it excels; • 80% of staff feel that they work in teams with at least some degree of empowerment and autonomy, though only 20% experience full teamworking; • most staff feel supported to some degree by their managers but more than three-quarters think there is room for improvement; • only 12% of staff experience work as monotonous or boring, while 24% find their jobs completely fulfilling; • 63% think that there is an acceptable level of consultation and involvement by managers in day-to-day decision making, though 80% feel there is at least some room for improvement; • most staff feel able to contribute suggestions for improvements though less than half are confident they will be taken seriously; only a minority (24%) feel that they are actively encouraged to contribute new ideas; • only 6.7% of staff have actively participated during change initiatives, around half consider that they are consulted and informed to a significant degree though • 47% feel that involvement and consultation is poor; • only 26.6% of staff think that the Hospital satisfies all their personal development needs; most feel that these requirements are met to a reasonable degree though there is still a significant minority (26.1%) whose needs are not being adequately met.

IWL Forum

The first Forum meeting was held in December 2002 and sought to examine in greater detail the key issues identified during the Roadshows. The event was well supported, with 41 staff attending from a wide range of professions and areas of the Hospital. Participation in the Forum was open to all employees, and managers from each department were asked to ensure that at least one member of their area took part. Facilitated by members of the Steering Group, each of the issues cited in tables 2 & 3 were discussed in depth. Specific staff suggestions were clustered and peer-reviewed. Conclusions were then refined and tested, eventually emerging as specific proposals to be addressed by the Workstreams.

The Forum meeting spent some time considering the role of middle management and it's potential either to champion change or to block it. A key proposal to emerge from this discussion was the creation of an 'Inquiry' led by a cross-section of managers in which obstacles could be identified and good practice shared, resulting in the production of recommendations for decision-makers at all levels of the Hospital. This is discussed later in the case study.

Improving Working Lives: Obstacles, Reflections and Lessons

Completion of the first cycle of Roadshow and Forum activity provided an opportunity for reflection, leading the trade unions to identify several key concerns and conclusions:

Staff Involvement

Although there were some very encouraging signs that staff involvement and team-based approaches to work organisation had started to become more common, the results from the 2002 Roadshows provided further evidence of the need to strengthen workplace partnership and work organisation at several levels of Hospital practice. Most staff wanted to see better information and consultation at the strategic level. Moreover there was considerable scope to enhance staff involvement in service planning and change management, and to strengthen team practices at the front line of service delivery. There was also a need for greater recognition of the role that staff at all levels have to play in service improvement, providing more opportunities for creativity and innovation. Consistency across the Hospital was a recurrent issue, with wide variations in the quality of staff involvement and teamworking between departments.

Staff and trade union involvement is a fundamental principle underpinning the IWL initiative. One of the key criteria for meeting the IWL Standard is that of evidence to demonstrate real involvement by staff and their representatives throughout the organisation. In reality recruitment and retention problems in some departments led to minimal staffing levels, preventing some employees from being released to attend the Roadshows or becoming involved in new initiatives. Despite sufficient notice of IWL events for line managers to arrange cover and despite requests by the Hospital Board that participation should be encouraged, staff in some areas were not allowed take time away from service and clinical commitments.

Trade union representatives also reported lack of line management support for their participation in IWL events in some areas of the Hospital. The persistence of this issue might well be seen to indicate residual resistance by management to acceptance of the role of trade unions as ‘partners’ in Hospital decision making: controlling the time and resources available to trade unions effectively controls the extent and depth of their engagement in partnership and policy processes. Despite these restrictions the union stewards played a key role in maintaining the momentum of IWL towards Practice and subsequently Practice Plus accreditation.

Visible Outcomes and Actions

To maintain the credibility of the staff involvement process, it was crucial that issues raised by staff through the Roadshows and Forums were seen to be taken seriously and that effective feedback was provided. Hundreds of comments from the Roadshows were processed and addressed by the appropriate Workstreams, requiring a substantial commitment from members. Subsequent Roadshow events cycles provided the opportunity to update staff on resulting actions. To remain credible, IWL needed to ensure transparency and good communication combined with the ability to respond effectively to the issues raised. Once again this presented a resource issue for the Hospital, one

which was not fully addressed even though a small budget was eventually secured by the Steering Group to assist with administration.

Communication

Traditional forms of work organisation and the top-down multi-layered structure of health service management can prevent effective involvement, teamworking and communication. The IWL initiative demonstrated that the traditional organisational approach to 'cascading information down' through the many levels of management is ineffective. There was little evidence of real two-way communication able both to inform frontline workers and to feed their ideas and experiences back into the policy process. This is partly a resource issue - but also a cultural and organisational constraint created by the middle management 'barrier reef' (Exton 2003).

The need to enhance the distribution of information and quality of dialogue early in the IWL process was addressed in part by a comprehensive Communication Strategy. This is based on a multi-media approach harnessing available communication resources to reach and involve staff at every level in ways which are not wholly dependent on the compliance of line managers. In response to comments made at IWL events by staff on the need for improved communication between management and front line staff, the trade union representatives led a group examining the provision of ICT and improved access to communication systems such as email. They also redeveloped the Hospital's IWL intranet site, making it more user-friendly and informative while including new items such as a staff involvement calendar.

Accreditation

Practice Standard was achieved in 2003 after real improvements were acknowledged by staff. For example the Working Practices Workstream reported tangible progress throughout the Hospital in relation to the spread of flexible working patterns, providing clinical staff with more choice about the length and pattern of their shifts.

The award was followed by sustained activity led by the Steering Group and the four Workstreams in working towards the target of Practice Plus accreditation scheduled for 2005. A further three Roadshow/Forum cycles had been undertaken by Autumn 2004 with a varied programme of events and initiatives, together with feedback on the actions which resulted from issues raised by staff at previous Roadshows.

Practice Plus accreditation was eventually achieved during the summer of 2005.

Developing a wider approach to partnership, involvement and participation at Nottingham City Hospital

This paper began with the argument that the significance of IWL goes beyond the achievement of the Standard and needs to place staff involvement at the heart of Hospital procedure. It was recognised at an early stage in the IWL process that terms such as "partnership", "involvement" and "participation" tend to be used almost inter-

changeably. The problem with this looseness of expression is that it confuses the separate levels of relationship sought between staff, trade unions and management in the Hospital's working life.

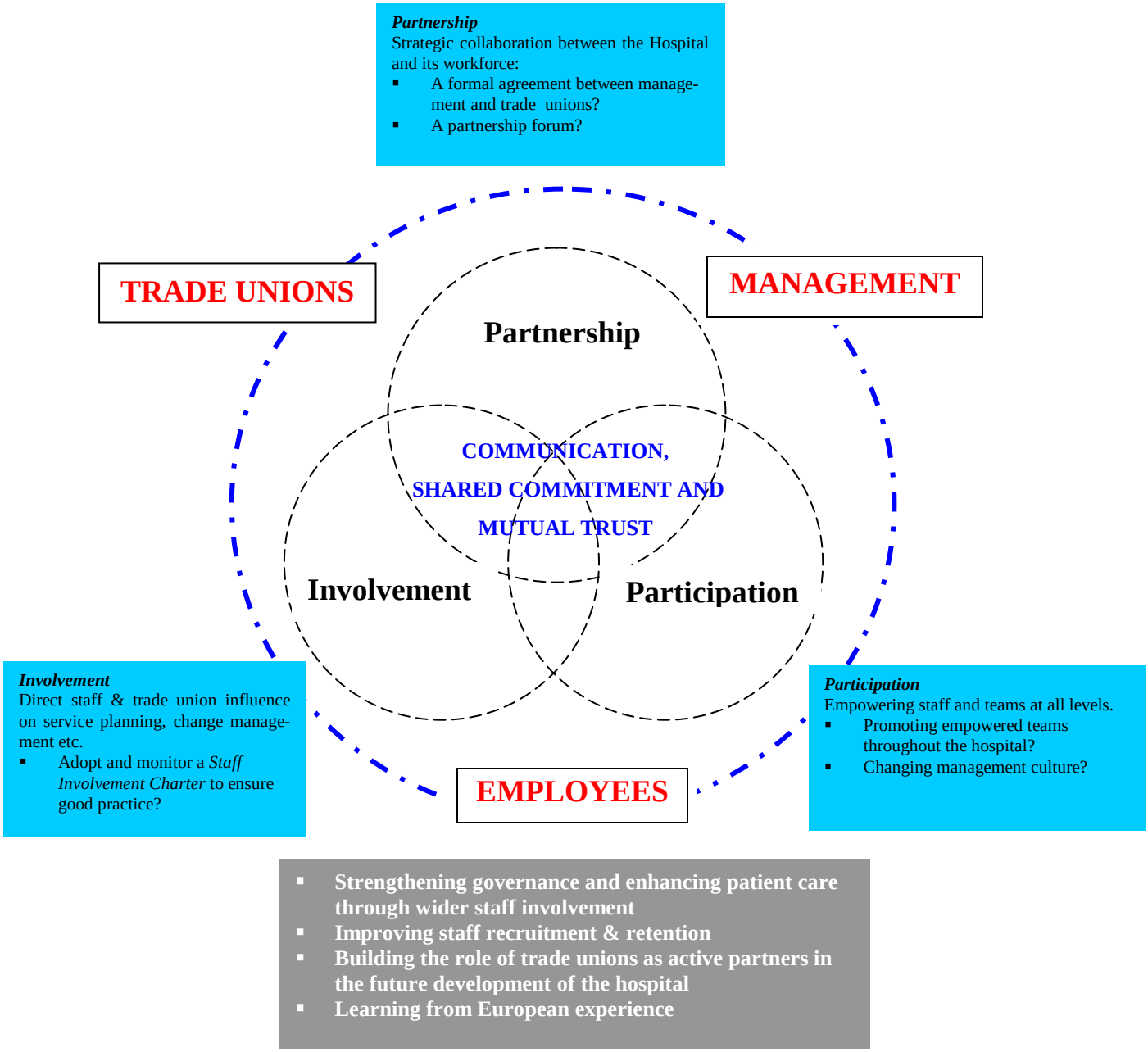
Addressing the issues raised at the Roadshows, the authors of this paper as Staff Side Secretary and Non-Executive Director proposed a conceptual approach designed to transfer lessons and experiences from IWL to the heart of Hospital practice. It drew extensively on current research and experience from several parts of the EU (for example Totterdill, Dhondt & Milsome, 2002). The approach illustrated in Figure 2 focuses on three different but interdependent levels at which staff can contribute more effectively to the Hospital while at the same time gaining more control over their working lives. The three levels are interdependent and, it was argued, need to be built simultaneously if change was to be sustainable. Each level represented an arena in which 'win-win' innovations and improvements could sought and negotiated by stakeholders, searching for potential convergence between improved patient care and improved quality of working life:

Partnership

The partnership circle represents the vision of strategic collaboration between management and the workforce at the Hospital. It proposes a formal agreement between staff, management and unions that seeks to embed partnership working in Hospital culture and is sustainable and workable. Crucially for the Hospital and the trade unions, the scope of partnership must go well beyond traditional industrial relations bargaining. It should guarantee active staff engagement with many Board-level issues including strategic direction, key investment decisions, organisational development, performance management and other aspects of governance. Partnership in this context involves *indirect* staff participation through representative structures. Hence trade unions play a lead role. In this model partnership arrangements monitor and safeguard *direct* staff involvement and participation at other levels of the organisation, and define and promote good practice methods. Increasingly trade unions become champions of both representative and direct staff involvement for their members and non union members of staff alike. Moreover the approach will meet the requirements of the EU's *Information and Consultation Directive* which came into force during 2005.

A Partnership Forum was proposed to ensure the effective engagement of union representatives in the design and implementation of strategy, major policy issues, organisational change and service redesign. Critically it was argued that the Forum should be separate from the existing negotiating machinery established for bargaining purposes, and should be characterised by a less adversarial and more open style of discourse.

FIGURE 2: Towards a strategy for *Partnership, Involvement & Participation*?



Involvement

Staff involvement in decisions affecting, for example, service-level planning, organisational change and continuous improvement will be guaranteed by the partnership agreement and monitored carefully by the Partnership Forum. This level will include trade unions *and* the direct involvement of staff affected by planning or change processes. Involvement should take place at the earliest stages of decision-making, not after key issues have already been agreed, and new mechanisms such as a Staff Involvement Charter are needed to ensure that managers adopt inclusive approaches to planning and change. This requires a change to traditional NHS management culture involving greater openness, dialogue and communication.

Participation

This circle represents staff influence or control over day-to-day decisions affecting their work. A culture of participation also generates innovation and service improvement, drawing on frontline staff knowledge of quality and risk. Principal dimensions include designing jobs in ways which give individuals a high level of responsible autonomy, and empowering multidisciplinary teams to make decisions within their areas of competence without unnecessary referral to line managers even over such issues as budget allocation and recruitment. Multidisciplinary teamworking is the organisational form that, at best, provides a work environment in which health workers from all professions can deploy and develop their competencies to the full. In practice effective care relies on the use of tacit knowledge by staff at every level, the blurring of disciplinary and organisational boundaries, and the personal dedication of health workers to securing good outcomes for patients even where this means far exceeding job requirements. There were several good examples of team-based practice at Nottingham City Hospital (see Figure 3). Yet in all organisations the word 'team' is widely abused and often carries few connotations of dialogue or empowerment. Failure to recognise sound principles of team design and practice damages both personal fulfilment in working life and clinical outcomes, and therefore the propagation of such principles throughout organisations is integral to a systemic approach to staff involvement and partnership.

FIGURE 3 – the Paediatric Renal Team at Nottingham City Hospital

At Nottingham City Hospital the distinction between team-based and non team-based approaches to patient care was clarified in a study of five paediatric renal units in different European countries (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 Nottingham City Hospital in this 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.

Establishing the *Partnership, Involvement and Participation* approach at Nottingham City Hospital

The *Partnership, Involvement and Participation* model was not designed as a blueprint for the City Hospital. Rather it was an attempt to generate reflection and dialogue about the means of embedding IWL principles of staff engagement as a core Hospital value. Hospital trade unions and some managers were particularly conscious of the need to change the perception of staff involvement so that it is no longer relegated to the status of an 'HR initiative' and becomes central to working life and governance at all levels of the Hospital. It was up to the Hospital, its trade unions and workforce to build a model that represented the optimal balance between the expectations of each stakeholder. This required opportunities for experimentation and shared learning be-

tween management, trade unions and staff representatives, drawing on a wide range of experience from both in and outside the healthcare sector.

In 2003 the Hospital's Executive Directors proposed the adoption of three clear objectives for the organisation which imply the active pursuit of convergence between quality of patient care and quality of working life:

- *Improving the Patient Experience*
- *Improving Clinical Outcomes*
- *Improving Working Lives.*

These objectives were subsequently adopted by the Board and it is in this context that staff involvement began to move onto the wider corporate agenda. However in the words of a manager with the senior brief for clinical governance and quality:

"Real staff involvement happens when the organisation is committed to the systematic and routine involvement of staff and their trade union representatives in shaping the service and being part of the decision making which affects their working lives and the delivery of health care."

Likewise some managers raised concerns about the lack of attempt to think through the relationship between staff involvement and patient involvement – separate activities run by different Hospital directorates – and the risk of perceived conflicts between the interests of these different stakeholders. The logic of convergence suggests the need to reduce the locus of 'patient involvement' as a centralised management function, gradually passing its ownership to frontline staff throughout the hospital.

Board-level commitment to achieving this level of convergence between clinical outcomes, patient experience and working lives is a necessary but by no means sufficient condition for change. Involvement needs to be integral to every aspect of hospital policy and practice including risk management, patient consultation and service innovation. For many participants this became the principal test by which the effectiveness and sustainability of the new partnership arrangements at Nottingham City Hospital would be judged.

The Partnership Agreement

Following a period of extensive dialogue, the Secretary and Chair of Staff Side met the Director and Deputy Director of Human Resources, with full support from the Chief Executive, to define the principles of a partnership agreement suited to the needs and culture of the Hospital. The Staff Side Secretary prepared an outline policy statement based on the *Partnership, Involvement and Participation* model that included a discussion of how partnership should operate in the Hospital including its organisational structure and scope. Detailed consideration was given to the need for new protocols and practices relating to partnership including a joint approach to agenda setting, meeting arrangements, the use of inclusive language and the right to attend meetings. The statement argued that partnership principles should be embedded at every level of the Hospital's activity as a means of improving its performance and of improving the quality of working life of staff. In short the paper committed management to openness and inclusive dialogue with staff and trade union representatives but equally acknowledged the commitment of the trade union representatives to work as full partners with man-

agement, pursuing a shared vision of the Hospital as an exemplary provider of patient care and a model employer. This paper provided the basis for a formal Partnership Agreement, subsequently endorsed by management and Staff Side.

Overcoming obstacles

Changing management

The regularly cited tendency of middle managers to inhibit the success of both IWL and workplace partnership was frequently in danger of becoming contentious, and the Steering Group supported the suggestion that an 'Inquiry' be established to report on why Hospital policies relating to staff involvement and working life were being implemented so 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. The concealed intention had been to ensure the inclusion of managers from those parts of the organisation which 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 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.

Moreover managers often felt particularly powerless in the face of resource constraints, considering that senior management 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 participant there was no mechanism for evaluating "the costs of non-investment".

It will be recognised that these managerial concerns reflect those of front-line staff, reinforcing the need for different organisational practices and behaviours at all levels implicit in the model described above in Figure 2. The report's conclusions have quite

far-reaching consequences that will need to be addressed both at Board level and by the Hospital's newly established Partnership Forum.

Building trade union capacity

Until recently local trade union representatives were largely untapped as a source of professional knowledge and experience at both frontline and strategic levels, ignoring their ability to predict likely impact of change. Representatives can be a valuable resource in overcoming obstacles to the implementation of strategic policy objectives, and in bringing about 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 representative, compensating for the lack of an approachable manager or an effective teamwork environment in which they would be addressed through dialogue and reflection.

However, from the earliest stages of the IWL process to the endorsement of the Partnership Agreement, it was clear to all the main actors at the City Hospital that the allocation of time for involvement and participation was not the sole determinant of union effectiveness. A 'time out' event was organised for the Hospital's trade union representatives at Nottingham Trent University in September 2004 as part of this research, and provided an opportunity for reflection on Staff Side strengths and weaknesses in the new context of partnership.

At the event, union representatives reflected on the ways in which Staff Side had changed in recent years. They felt able to celebrate the emergence of a more open and democratic style of leadership in which the Chair and Secretary kept other representatives informed of their discussions involving senior management and included them fully in policy decisions. However it was recognised that in the context of the emerging partnership with management there was still work to do in building an informed and engaged Staff Side team, including strengthening the accountability of the Chair and Secretary to the other representatives. This also meant that the other representatives must accept a more active role, taking part in a wider range of meetings, working groups and activities associated with each of the *Partnership, Involvement and Participation* levels. It was recognised that within partnership working, management would have a legitimate expectation that the different trade unions at local level would be able to speak with a collective voice. Even when national union policy positions are in conflict, hospital representatives need a mechanism through which they can agree a common course of action in working with management. This underlines the growing significance of the partnership role of local union representatives in relation to that of their full time officials.

National union organisations have a critical role to play in supporting the new role of the local representative by educating their membership on the nature of partnership. Their members need to be aware of the skills and behaviours required by partnership if they are to make informed decisions when electing representatives. However, although unions often find it difficult to recruit local representatives, the increased profile of partnership working in the NHS could make their role more attractive (and less career

limiting) to potential candidates, providing increasingly valuable opportunities for personal development. Appropriate training and development is necessary to support effective partnership working with management, not least because there are likely to be many existing stewards who feel ill-prepared and lack the skills to extend their role from that of the traditional union steward into the new challenges associated with partnership working.

Throughout much of 2004 trade union stewards and management were required to prioritise the development of the new NHS pay system *Agenda for Change*, and in responding to controversial government proposals relating to the constitutional status of hospitals. The need to review resources available to buy out staff and trade union time became even more critical in this climate of far reaching change. Senior management commitment was needed to ensure that line managers throughout the organisation recognised the importance of facilitating staff involvement. The inclusion of IWL-related measures in annual performance appraisals for managers was an indication that this barrier is gradually being addressed, but changes in management behaviour will clearly take a long time, requiring concerted action at several levels.

Partnership in a climate of change

Improved working relationships between trade union stewards and management include more comprehensive involvement with Board level issues. The implementation of high priority national initiatives such as *Agenda for Change* was characterised by the mandatory involvement of trade union representatives at key stages of the planning and implementation process, and was facilitated locally by the new commitment to partnership. While the implementation of partnership working remains uneven across the Hospital, the IWL initiative and its aftermath have certainly changed the terms of the debate.

There remains some anxiety within the trade unions that the increased direct involvement of staff could marginalise their role because managers exercise much greater control over the nature and scope of the dialogue. Union representatives continue to argue that managers should embrace a partnership style of working in which indirect forms of involvement involving trade unions can co-exist with direct consultation processes aimed at individuals or teams in the workforce.

There were early tests of the robustness of the agreement at NCH during an extended period of major change that included the fundamental review of the national system of remuneration and significant cost-driven staff cuts. Management sought the involvement of Staff Side to legitimise a challenging cost improvement programme and, in accord with the Partnership Agreement, tried to involve representatives at the earliest opportunity. However they did so in ways which restricted trade unions' access to financial data and which imposed confidentiality restrictions on their ability to consult with members. This created a dilemma for the unions, who were being asked to endorse potential redundancies and job losses with very little ability to influence outcomes. When challenged on the legitimacy of this approach within a partnership framework, management argued for a suspension of the agreement to enable the cost improvement programme to be adopted. The trade union response however saw partnership as indivisible, and made it clear that their involvement in mandatory partner-

ship arrangements such as Agenda for Change were dependent on continuing to work openly with management on reducing the adverse effects of the cost improvement programme.

CONCLUSION

The case study examines the proactive role of trade unions in developing a model of workplace partnership that ultimately seeks to provide an effective context for the design and implementation of 'win-win' approaches to organisational innovation, combining better clinical outcomes with gains in the quality of working life. It suggests that in this proactive role trade unions can potentially scrutinise and negotiate the nature of the cohabitation between representative and direct participation, while building new roles for local trade union representatives as key actors in animating and resourcing workplace innovation. This endorses the view that direct and representative forms of involvement can be mutually reinforcing, creating the potential for real gainsharing.

External regulation plays a central role in this study as a driver for change. While being critical of an overemphasis on centralised performance management at the expense of bottom-up innovation in the NHS, the study demonstrates that externally imposed targets related to staff involvement and working life can potentially be effective in unlocking energy and imagination at the front line. Moreover they can add new legitimacy to the role of local union representatives. However regulation is by no means a sufficient condition for real change: compliance is not the same as improvement.

The study also draws attention to the persistence of management resistance to partnership and 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 can also be deeply embedded in organisational structures and cultures. As the managers involved in this case study report, lack of consistency and direction from above results in lack of understanding and concordance at other levels. This inevitably leads to uncertain outcomes. In complex organisations such as hospitals, policy implementation processes deserve much greater attention than they have traditionally been given.

Finally the study also 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 detailed research is needed on the nature of these challenges but it is clear that they raise some fundamental questions about union practices and culture.

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