



‘Partnership under pressure’
Social Partnership Forum session at the NHS Employers’ Conference held in
Liverpool – November 2011

Case studies

Guastalla Hospital (Italy) - an open and inclusive partnership forum where staff at all levels in the organisation feel free to express their views.

Summary

At Guastalla Hospital, an agreement signed by management in the Reggio Emilia Local Area Health Authority, by the trade union confederations Cgil, Cisl and Uil, and by the doctors’ unions led to a partnership-based process of service appraisal and redesign in order to achieve a better and more efficient service, as well as improved job satisfaction and working conditions. The hospital was also working towards attaining certification from the Emilia Romagna Region as entry regulation to provide services for the Italian National Health Service. Highly participative change methods such as Search Conferences and inclusive task groups enabled the knowledge and experience of staff at all levels to be engaged in the redesign of work organisation and the reduction of hierarchical and professional demarcations. As a result, high involvement work practices emerged which achieved integrated patient pathways as well as enhanced cooperation and mutual learning. Quality of care and patient satisfaction improved while lead-times and inefficiency were reduced.

What they did

Formalised through a local partnership agreement the organisational change was led by a *Contact Group* of senior management and trade union representatives who managed all aspects of the project with external facilitation by the Institute of Labour.

The project was focussed on:

- re-design of work organisation and integration of diverse professional profiles around the same working process;
- improvement of co-operation and mutual learning;
- redesign of work organisation and reduction of vertical hierarchy and segmentation;
- organisation of activities according to patient pathway flows between primary and secondary care;
- improvement of quality of care and service;
- reduction of lead time and inefficiency.

Representation of all levels of staff in working groups ensured participation, involvement and innovation and was fundamental to the development and success of the organisational change. The working group meetings were led by members of the *Contact Group*.

What they achieved

The change project contributed to the certification process through collaboration of all staff and healthcare professionals both within the hospital and the region. In particular it improved:

- Responsibility of service providers in the healthcare process;
- Participation of staff in the decision making process;

- Dialogue among diverse professional profiles.

Examples of improvement and change include:

- A project on *Patient experience* has been developed by improving ICT and enlarging and restructuring the hospital following a review of the patient experience.
- After the start of a *Consultancy in clinical-care profiles project*, a group of professionals began a review on the requests for specialist consultancy, with the aim of optimising the resources available within the Hospital.
- A project on *Involving GPs in specialised care phases* was developed by setting up Primary Care Departments which have consolidated relationships between Hospital professionals and the Region.
- More opportunities for dialogue have arisen between the Hospital and the Region and important projects have commenced on *Care continuity* and *Discharge of patients for care at home*.

Hospital of the Future Project (Ireland) - partnership committee representatives engaging with front line staff and capturing stories which led to improved service provision and patient care.

Participative Governance: An Integrated Approach to Organisational Improvement and Innovation in Ireland's Hospital System.

Summary

This report has been prepared by an international consortium of researchers led by UKWON with expertise in organisational innovation in health care, on behalf of the National Centre for Partnership and Performance and the Health Services National Partnership Forum. It is based on the Hospital of the Future project, conceived in 2007 as a research inquiry into the organisational factors which affect performance in the acute hospital system. Focussing on roles and relationships between management, staff and unions, the report makes an evidence-based contribution to the debates now taking place about the transformation of the health sector at national and local levels.

What they did

The study seeks a better understanding of how workplace change and innovation influences the performance levels of our acute hospitals by improving efficiency, patient care and staff well-being. It provides an account of the functioning of acute hospitals that will be of value to management, staff and unions in their efforts to develop effective approaches to innovation, problem-solving and performance improvement. The researchers undertook an in-depth review of the international literature on the relationship between employee involvement and organisational performance both within and beyond the healthcare sector. They also undertook an extensive survey and statistical analysis of data pertaining to governance, management policies and working practices within acute hospitals, and their impact on the performance levels attained by those hospitals. Finally they conducted extensive qualitative research at seven acute hospitals, including interviews and dialogue with front-line staff, managers, clinical and nursing directors, trade union representatives, and other medical and non-medical personnel including support staff.

What they found out

Both quantitative and qualitative findings from the study suggest that many elements of Participative Governance are in place in the acute hospital sector, and there is considerable evidence that participative practices can lead to convergence between high standards of patient care, cost-effectiveness and quality of working life. However there is little overall coherence or co-ordination between the different elements, and there is often a willingness to tolerate the non-adoption of evidence based practices by managers and clinicians even where these have a direct impact on patient well-being and safety. The overall picture then comprises islands of extremely good practice but set within a sea of opportunities for improvement at both strategic and local levels.

The study suggests that existing representative partnership arrangements within the health service tend to be valuable though underused resources in the modernisation of the hospital sector, not just because they can be instrumental in creating an industrial relations climate conducive to transformation but because they hold the key to engaging the knowledge, ideas and commitment of staff at all levels. In particular they can add real value to clinical governance and quality as key drivers of change by ensuring that staff have the opportunity to contribute fully through participative approaches to team-based care, risk management, patient safety, incident reporting, learning from errors, cost control, service improvement and innovation. Three key elements - the newly formed clinical directorates, representative partnership arrangements and the direct involvement of staff and managers at the frontline - need to be brought together into a virtuous circle of shared learning, dialogue and action aimed at producing better care for patients, better value for taxpayers and better jobs for staff.

The full *Hospital of the Future Report* is available at:

<http://www.ukwon.net/files/kdb/015330f73124a3b83e8910f453e35fba.pdf>

Nottingham City Hospital - work to ensure the 16 trade unions spoke with one voice in partnership discussions.

Background

This case study involved the *Improving Working Lives (IWL)* implementation in one hospital and identifies the extent to which it creates the conditions for sustainable improvements in workplace partnership and staff involvement. While IWL is concerned with all aspects of working life, the focus of this case study is specifically on its role in driving staff and trade union involvement and participation where a partnership agreement between management and trade unions explicitly recognised the role of the Partnership Forum in promoting the direct involvement of staff in quality improvement, clinical governance and patient participation. 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 importance of staff involvement

Staff involvement as the focus of the case study is central to effective governance in hospitals. Involvement provides an indispensable vehicle for the identification of clinical and organisational risk and the maintenance of quality, building 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, providing employees at all levels with a voice in policy, practice and change.

The role of trade unions

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

Partnership, Involvement and Participation model

This model was designed not as a blueprint for the City Hospital, but as 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 between management, trade unions and staff representatives, drawing on a wide range of experience from both in and outside the healthcare sector.

What they did

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 management, 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.

A 'time out' event was organised for the Hospital's trade union representatives at Nottingham Trent University 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.

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 partnership 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.

Summary

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.

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[Kaiser Permanente - use of partnership working to drive cost savings and improve services.](#)

A highly developed example of the nurturing relationship between representative participation and participative teamworking comes from a surprising source. Kaiser Permanente (KP) is the biggest non-profit health care organisation in the US. KP has received a great deal of attention amongst European health services for its high standards and cost effectiveness, particularly in

the integration of primary and acute services. Less widely reported is the high level of trade union and employee involvement that underpins these achievements, driving the introduction of multidisciplinary teamworking and other service innovations.

The role of trade unions

KP's Labour Management Partnership (LMP) involving managers, workers and physicians is the largest and most comprehensive agreement of its kind. The LMP was formed in 1997 after years of labour turmoil within Kaiser Permanente combined with growing competitive pressures in the sector. Two years earlier, 26 local unions representing KP workers had joined together in the Coalition of Kaiser Permanente Unions to coordinate bargaining strategy more effectively. Kaiser Permanente and the Union Coalition created the LMP as a means of transforming their relationship and the organisation as a whole. Today it covers more than 92,000 union employees, including some 20,000 managers and 16,000 physicians across nine states and Washington D.C.

Partnership in Kaiser Permanente

This goes far beyond traditional industrial relations. On a day-to-day basis partnership means that workers, managers and physicians engage in joint decision making and a problem-solving process based on common interests. KP's Value Compass, originally formulated by the LMP to set the direction for improving organisational performance by focusing on subscribing members of the public and patients. The Value Compass is now driving the Corporate Agenda, based on the concept of the balanced score card to maximise performance and so create value:



Workplace social dialogue at KP takes place at three interdependent levels: the strategic and policy level provides a platform for whole systems change and continuous improvement, the meso level is the locus for union representation and management in the day-to-day operation of the business, and the microsystems level comprises Unit Based Teams (UBTs) as the basic building block.

How they work

Unit Based Teams were introduced in 2005 following extensive discussion in the LMP and provide the platform for performance improvement across Kaiser Permanente. More than 90,000 employees now work in 34,000 unit-based teams. A team includes all the participants in a natural work unit or department, including supervisors, union stewards and staff members, physicians, dentists and managers. The team supports the regional business strategy and goals for performance, service quality, efficiency and growth. Because teams increase consistency and standardisation of treatment, they also improve care. A dramatic reduction in sepsis has been attributed to the introduction of UBTs, as has the success of the design and implementation of the integrated IT electronic patient record system.

At UBT level there is an expectation that everyone will contribute to building the vision for the future direction of the business. Unit Based Teams tap the creativity, skills and experience of their members in a process that consistently engages frontline workers in improving performance. The LMP ensures the quality of dialogue and participation at team level through a system of Inclusion Control and Openness. Unions credit the arrangement not only with improving patient care and satisfaction, but in making Kaiser Permanente a better place to work.

Summary

The significance of KP for this study is that it demonstrates the way in which workplace social dialogue can permeate the whole organisation even in a context where partnership is somewhat antithetical to the national system of industrial relations. Representative partnership in the form of the LMP acts as both the stimulant and guardian of direct participation at the frontline with demonstrable benefits for organisational performance, staff and patients.

[The Örjan Network \(Sweden\) - clinical and non clinical staff developing 'one stop' care pathways between primary and secondary care to improve patient experiences.](#)

Summary

The site of the Swedish activity from which experiences of health innovation and renewal is drawn is the West Skaraborg Health Development Project in the Regional Health authority centred on the town of Lidköping in southwest Sweden. The project has entailed a health development coalition comprising diverse actors in the region coming together to generate change and development in the organisation of the region's health care activities. A central aspect of this coalition coming into being was the setting up of the project based on the Lidköping Hospital, the primary care providers in its vicinity, together with the six local authorities comprising the area served by the hospital in concert with a local research and development institute.

The aim of the project

This was to develop health care such that acute care would become the core activity of the hospital with routine care being transferred to the primary care providers and local authorities. In such a way, care delivery would be closer to the patients, who would face fewer referrals and thus receive a higher standard of provision. The main project vision of the regional health development coalition was that it would result in better care from the consumer's (patient's) perspective and needs. It would also lead to improvements in the work organisation and working environments of councils and the regional health authority through close working arrangements across traditional health care boundaries. The realisation of such a vision clearly required new forms of working and inter-level co-operation – and this in turn required organisational change by the care providers and support services.

Trade union and staff engagement

Trade union density and influence are high in Sweden and the West Skaraborg Regional Health Authority is no exception in this regard. Union representatives contributed to the dialogue conferences and group work of the project, and supported the overall project and its aim of introducing patient centred care. Employee participation in the work of the Örjan group in the West Skaraborg Health Project was largely of a direct nature, albeit on an agreed basis by the unions, with some indirect participation in the dialogue at the dialogue conferences with the unions being 'equals' on those occasions with the various other actors from the region who took part on a similar basis.

Improving patient pathways

The aim of the Örjan Network has been to describe and formulate proposals on how to bring about improvements in patient pathways in the form of collaboration between the hospital,

primary care units and the local authorities in the Lidköping area. The pathways concerned are those of patients aged 70 years and over, typified by a fictitious male patient, 'Örjan', from whom the project took its name. The aim to move to 'one stop' care and end the interminable round of referrals between departments and organisations is seen as a main motive behind the project and a clear attempt at local implementation of the national health vision in Sweden for health care to be 'patient focused' rather than driven by the needs of the health bureaucracy. A clear problem has been identified in that communication between the hospital, primary care units and the local authorities only occurs through their respective managers – one of the motivations of the project has been to end this and make such connections more automatic by being undertaken directly by front-line staff. In concrete terms, the group has been guided by a number of long-term principles as follows:

- A patient perspective - Mapping analysing and developing patient pathways
- Broad-based care collaboration
- Long-term process working
- Better communication
- The creation of a permanent network for collaboration.

By way of a message to practitioners elsewhere engaged in similar change efforts, the Örjan group members have identified a number of critical success factors:

- Information about the project to other key stakeholders. This allows the possibility for questions to be asked – in both directions.
- The role of and support from top management and trade unions as well as the nature of the relationship between senior management and those engaged in the change effort.
- Long-term, process thinking about the challenges of change and acceptance of a new, ongoing way of working rather than a 'project'.
- The significance of broad participation and diffusion of one's activities and acceptance of the implication of this on the pace of change and tolerance towards the various stakeholders.
- Motivation and commitment particularly by a dedicated team, but also reciprocation of this in senior management circles.

The outcome of the project

This included a number of proposals from the project groups that suggest changes in routines and behaviour. The project also yielded outcomes of improved competencies and attitudinal change, noticeably the breakdown of territorial thinking across the medical profession. Ultimately, the aim has been for patients to see care provision in terms of one organisation rather than an impenetrable mosaic of clinics, departments, and forms separated in time and space

[Aker University Hospital \(Norway\) - management working with staff to reduce the unnecessary use of physical restraints on patients.](#)

Summary

During the last decade the Norwegian health care has undergone a lot of changes due to reforms and innovation that to a large extent have been driven externally. The case described here was also initiated externally, involving unions both at the national and local level who were asked to participate in the development of the project from the beginning. Thus, drawing on the Breakthrough Series concept, the project had the necessary legitimacy both from the senior management and the unions at the hospital who acted as expert supervisors, which facilitated the founding and implementation of the project at the local level. This case demonstrates a successful story of changing practice, resulting in decreased use of mechanical restraints on an acute psychiatric ward.

What they did

The Breakthrough concept is based on the staff's enthusiasm, motivation for change, willingness to share experience, creating a sense of urgency for change and improvement, valuing creativity and contributions from all participants – hallmarks of effective learning organisations. They established an expert group comprising national experts from various professions within the mental health field, including nurses, psychologists and psychiatrists. This expert group provided the knowledge base and evidence within the selected field of medicine, constituting a "best practice catalogue", and made proposals for changes that they believed would be effective in improving the care. During the project, the expert group supported local improvement teams in the clinical areas who had to create a culture of change in the organisation. The improvement team decided to work along three strategies: information, increase of competence and changing routines, and not at least to involve the staff in the process of development.

Staff involvement in the project

The education was organised at the ward and focused on evidenced based practice, the relational work with the patients, to increase the staffs' understanding of the patients' needs and reactions in situations where compulsory treatment is required. Moreover, ethical and moral questions connected to the use of coercive measures were discussed. The improvement team coordinated the work, but the themes were suggested by the staff, and the ward's own physicians and nurses were responsible for most of the educational program. In this way, the improvement team increased the consciousness of the staff, thereby making change of practice possible.

At the start of the project, most nurses at the ward were not fully aware of the frequency in using mechanical restraints. Nor did some of the nurses acknowledge the need of change, and they were surprised when the baseline numbers were presented. In the interviews they told that during "the process of consciousness", they became more aware of using preventing strategies, i.e., to be one step ahead of dangerous situations that might make them use mechanical restraints. An effect of this was more real teamwork, collaboration across professional borders. Looking beyond the process of consciousness, the nurses emphasised the different kinds of education as important elements to make change and improvement happen. Although the main issue, to reduce the use of coercive measurements, was not chosen by the staff, they influenced the goals on the more detailed level. For example they identified the scope for change by deciding to reduce the hours in mechanical restraints by 30%.

Outcome

By involving the staff at different levels in the process, the ward has become a more inclusive and integrated workplace. The staff was motivated to continue the quality improvement set out by the project, and the project has been of great importance to the staff's working environment. Not at least, the sustained achievements in reducing the use of mechanical restraints are of great benefit to the patients.