

CAN LEARNING ORGANISATIONS SURVIVE IN THE NEWER NHS?

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Abstract

This paper outlines the principle features of a learning organisation and the cultural features it should contain. It moves then to examine the prospects for the application of a learning organisation to sub-systems of the British National Health Service (NHS). In the late 1990s the British government announced its intention to modernise this service. Part of that policy innovation was to encourage learning, innovation and a culture in which lessons from mistakes would be valued. This intention is reviewed in the light of more recent policy changes in the NHS, which provide both drivers and constraints upon the prospect of learning organisations flourishing in British health care.

Introduction

In 1998 the British Secretary of State for Health announced that a central aim of the incoming Labour government was to modernise the NHS. This modernisation included the need to:

‘...create a culture in the NHS which celebrates and encourages success and innovation...a culture which recognises...scope for acknowledging and learning from past mistakes’ (1)

A key plank of this emphasis on learning and innovation was the introduction of a policy of clinical governance. This emphasised the multi-disciplinary responsibility of colleagues working together in a clinical area to manage risk, implement evidence-based practice and learn from errors. This quality assurance ethos, in which all staff were encouraged to participate, seemingly indicated that the government wanted to frame service improvements in systemic terms rather than emphasising individual performance alone.

In 2000, with the above starting point in mind, Davies and Nutley (2) elaborated a relevant organisational development concept, which was already well-known in managerial studies (3), that of a 'learning organisation'. In their paper, they set out some aspirations for, and cautions about, 'developing learning organisations in the new NHS'.

A few years on, how does this policy intention look, especially given that the 'New' NHS is even newer- more reformed, more 'modernised'? Our aim here is not to query the descriptions, aspirations or normative premises set out by Davies and Nutley. Instead, their reflection of the late 1990s period will be placed in the context of more recent health policy and the changed character of the NHS. Our aim in so doing is to interrogate the capacity of a large, politicised, unstable and bureaucratic complex of organisations, the current NHS, to live up to any rhetoric about developing a learning organisation ethos. Elaborating on the scene-setting of Davies and Nutley, we briefly set out, for readers new to the topic, key points about what Senge (4) and other management writers take a 'learning organisation' to be. Then we situate these management theory accounts within recent developments in health policy and NHS management.

Key point one: defining features of a learning organisation

Max Weber used the term 'ideal type' to describe model forms of organisation. In the case of a learning organisation, the seminal text describing the desirable 'ideal type' is Senge's (4). Models of learning organisations are mainly derived from studies of the more adaptive commercial firms (5, 6) and emphasise the following organisational features:

1 *Open systems thinking* entails people in learning organisations seeing the bigger picture and where they and their particular functional or physical setting fit in to that picture (7). The opposite of this is thinking within the closed parochial or professional world of their activities.

2 *Maximising individual competency* is important; each employee must be supported to make the best of their aptitudes and abilities, and to build on them continuously ('life long learning').

3 *Team learning* is important whenever tasks are delivered in teams. This runs against the grain of meritocratic educational structures, from which a professional typically comes into the workplace. They emphasise individual learning and scholastic achievement not collective learning.

4 *Updating 'mental models'* entails people in learning organisations understanding their own assumptions about their work and appreciating their colleagues' assumptions. Team learning and open systems thinking depend upon each person understanding the mental models they hold themselves, and understanding and appreciating those which others hold (8, 9).

5 *Cohesive vision* refers to clarity of unifying purpose in an organisation (7). Learning organisations develop ways of owning a shared vision throughout the workforce. This could emerge from the bottom but is usually engendered from above. For this reason, leadership which champions learning and puts it at the centre of organisational functioning is vital to develop a proper learning organisation.

Key point two: triple learning

Davies and Nutley define three types of learning, using NHS examples. First, 'single loop learning' entails an audit identifying the gap between intended and identified performance and installing corrective action. Second, in 'double loop learning' wider lessons are learned about organisational performance from audits and evaluations and larger adjustments are made to bring about organisational improvement (10). There is a transfer of learning from an example to one or more others. Third, there is 'learning about learning'. This entails people in learning organisations taking stock, not just of the content of organisational lessons, but the process by which this learning took place; a form of reflexivity for the betterment of the organisation. True learning organisations are able to achieve this higher order type of learning or 'meta-learning'; they do not just accumulate single and double loop lessons.

Key point three: negotiating cultural change

Davies and Nutley cite Mintzberg et al's views (11) about which cultural processes should typify learning organisations. They say that learning organisations should: celebrate success; avoid complacency; tolerate mistakes; believe in human potential; recognise and value tacit knowledge and respect work based competence; be open to diverse and flexible ways of sharing knowledge and experience; and engender trust, horizontally as well as vertically in the organisation. Finally, learning cultures should be outward looking not insular.

What would be evidence of a learning organisation?

Some organisational researchers, in particular Snell (12) have tested Senge's ideal type features against attainable best practice. Senge considers that a learning organisation should not only aspire to but also *achieve* his five ideal type features. As Snell notes, this would require a super-human effort for any organisation, no matter how culturally secure and financially well-resourced. Snell offers some less utopian practical guidance from the learning organisation literature. It does not contradict

Senge but it is less conceptual, more descriptive and pragmatic. Snell suggests that learning organisations should show clear empirical signs of the following:

1 A community of learners is evident. People in a learning organisation should show signs of goodwill, solidarity and collaboration with their colleagues.

2 Ongoing collective transformation and self-improvement are evident.

3 Learning leadership is dispersed throughout the organisation. From situation to situation, individuals would move readily between the roles of learner, co-learner, coach, pupil, mentor or teacher. This is not a top down hierarchy, with fixed roles, but a flexible non-defensive culture, which is open to experience and opportunities for learning.

4 People are confident to have an open dialogue about multiple perspectives. A tolerance of uncertainty and contested viewpoints would be clearly present. People would not be fearful of speaking their mind.

5 Employees would accept the need to be flexible and adaptable. Reciprocally, employers would demonstrate a clear commitment to continued professional development.

All the above conditions involve a degree of trust between different occupational groups. Trust, a feature of a true learning culture, takes time to develop. However, organisational structures which are too short lived engender distrust, a point that Sennett has recently emphasised in his critique of transferring the principles of an unstable, rapid turn over business culture to State bureaucracies (13).

From 1998 to 2006: can the current NHS nurture learning organisations?

In the light of the above, can the recently reformed NHS nurture a learning organisation approach in its midst? Among current health policy and management priorities, there are some identifiable positive drivers in this regard.

1 *Improvements in the patient experience* are now at the top of the political agenda and managerial targets. Such improvements can only be maximised if the workforce is well educated and that education is constantly refreshed. According to the theories of learning organisations, this policy imperative for continuous quality improvements in services strongly necessitates an effective learning culture.

2 *Risk management* has become a pervasive aspect of the NHS management ethos. To minimise clinical and organisational risks the NHS has been exhorted to become an 'organisation with a memory', minimising present and future errors by learning from those evident in the past. Advocates of learning organisations would argue that staff and organisations that learn poorly put themselves at greater risk, maximising neither their clinical nor their cost effectiveness.

3 *Workforce development* has always been important but recently has become more so. The NHS has large labour shortages in many areas and the '3Rs' (recruitment, retention and returners) tax the minds of its managers (16). Some localities cannot attract health workers and there are not enough of them overall. To make the NHS an attractive and reliable employer, the personal development of staff is now encouraged by appraisal systems and frames of external reference such as *Improving Working Lives* (14). This positive human resources policy is also enshrined now in the *Knowledge and Skills Framework* (15). Favourable personal development offers several advantages to an organisation in relation to both job satisfaction and a competency based workforce. Thus a learning organisation could optimise both capacity and capability in the NHS.

4 *Research and development* are one aspect of a learning culture. The NHS is particularly interested in the D of R&D to overcome the problem of getting research into practice ('GRiP'). Unless this is overcome, best practice is not ensured and neither clinical nor organisational risks are minimised. Getting knowledge into practice is a challenge for all of the non-clinical aspects of the NHS (including its management processes).

This is not an exhaustive list but it highlights the role that a learning organisation approach could play in maximising clinical quality and NHS efficiency. To that extent, the present policy climate might be expected to make the 'learning organisation' model more attractive to the NHS, and so increase the likelihood that NHS bodies will adopt it. However, there is the rub in current times: these drivers also confront several powerful contemporary systemic constraints or 'challenges' in the daily lives of NHS clinicians and managers.

1 *Inadequate finance for learning* The first 'Wanless Review' (16) assumed that the NHS should spend 10% of its resources on quality improvement through learning by 2010; a substantial rise from between 2-5% in the 2002 baseline estimate. Learning takes time (which has opportunity costs) and clinical and managerial duties must be covered when learning events occur ('backfill' is needed). In a cash-strapped system it is easy for learning to be demoted in importance or become a casualty of the most recent round of cost-savings demanded to balance annual budgets.

2 *Structural instability* It is a cliché but for this reason a truism that the NHS has been reformed repeatedly. Not only is the frequency of successive major reforms accelerating but in more recent times particular initiatives have been announced with gusto one moment to be very quietly dropped the next. To give just two examples, reforms in 2006 will reduce Primary Care Trust numbers dramatically and effectively shift the reduced Strategic Health Authority system back to the older pattern of large regional authorities. Second, the NHS University was a government election promise but it was soon ditched. As a consequence, initiatives to diversify the NHS workforce like the 'First Contact Programme' have now collapsed. Learning organisations are expected to be open to change but too much change brings with it a lack of trust. What happens then is not cultural change but culture shock, which is disabling because it produces personal defensiveness and systemic resistance. The more stable and ever-needed parts of the clinical workforce may develop a cynical view of constant reform. In this context, a learning organisation approach may be undermined because confidence in *all* forms of managerialism may be undermined. It could be readily dismissed by reform-weary clinicians simply as another transient and politically expedient organisational experiment.

3 Systemic turbulence through 'contestability'. One aspect of the recent structural changes in the NHS has been that ministers have promoted the provision of services by non-NHS, especially commercial, providers. Indeed, government ministers have taken pride in boasting this intention about deliberate destabilisation. The commissioning and provision of services are to be increasingly separated and so another systemic tension has been deliberately introduced. Competition is encouraged among providers and international competitors are solicited. Intentionally or not, this policy suggests to many local health care professionals not that they are trusted and valued, but that they are dispensable.

4 Increased bureaucratic complexity The research governance framework was installed in reaction to scandals involving poor informed consent for clinical research at hospitals in Bristol, North Stafford and Liverpool (Alder Hey). During the same period the Shipman Inquiry into a general practitioner who murdered many of his patients put forward recommendations to control poorly performing doctors and reduce risk in primary care. These events have now rendered clinical professionals as perennially suspect social actors. Trust in a professional ethos has been displaced by a distrusting political attitude. Horizontal bonds of goodwill and trust are being replaced by more and more systems of upward vertical accountability. Greater vertical accountability increases rather than decreases the probability of a blame culture. Taken with systemic turbulence, this vertical emphasis means that management cultures are short lived and their leaders may be disposed of if short term goals are not achieved. They are only as good as their most recent local delivery plan or star rating attainment. In a learning organisation, the ethos of 'horizontal' team learning emphasises knowing thyself (and thy colleagues). In a culture where vertical one way accountability pre-dominates, the emphasis instead is on knowing thy place.

4 Competing priorities With structural change and systemic turbulence washing over the clinical workforce and short term goals being frenetically pursued by NHS managers, the nurturing of a learning organisation approach is easily pushed down the order of organisational priorities. Financial performance indicators become more stringent, rendering protected learning time more vulnerable. Financial retrenchment and uni-professional defensiveness in the face of politically elicited culture shock undermine the support for the organisational shifts and risks attending the

development of a learning organisation. Despite the continuing emphasis on the 3Rs noted earlier, year on year cash deficits are now leading some parts of the NHS to shed rather than recruit staff.

Discussion

The logic of a learning organisation model seems hard to reconcile with recent attempts to introduce more market-like models into the NHS. The reason for this discrepancy relates to the organisational and system levels at which health policy makers have tried to introduce the learning organisation notion.

In the private sector a learning organisation works at its best as an *intra*-organisational cultural shift. The competitive world the company exists, and has to survive, in is external not internal. Indeed, a strategic investment in a learning organisation (a cost of time and money) is designed to make the company more robust and efficient in the face of less educated and reflective competitors (thus generating an outweighing benefit). Here there is a clear contrast between single firms, where a 'learning organisation' model can apply, and a whole-market level, where it cannot.

Similarly, it is theoretically possible that in the NHS some sub-systems (for example a local general practice, treatment centre or hospital) could develop a learning organisation approach to maintain or increase its competitiveness. However, it seems simplistic to assume any longer that the NHS can be treated as one whole organisation. Even at the time of the article we used as a springboard (2) the latter assumption could not be maintained whole heartedly. But since 2000, the British Labour government has amplified further the 'internal market' initiated by its Conservative predecessor. As a consequence, a unifying intra-organisational culture has not been fostered. Instead, the NHS has been fragmented and sub-systems and interest groups have been set against each other. This is not a propitious starting point to develop a cohesive, mutually trusting, honest and reflective culture with a common unifying vision.

A learning organisation approach could thrive potentially in a well funded, unified and politically stable State bureaucracy. The same is true of a fully autonomous

business in a free market. It could even be true of single autonomous organisations within a competitive but publicly-funded health bureaucracy (a 'quasi-market'). What seems untenable is that the latter quasi-market status, which increasingly characterises the NHS, could successfully encourage a learning organisation approach across all of its constituent and episodically competing sub-systems. The latter, for now at least, tend to be immature, short lived and cash strapped. Moreover, their inherently competitive relationship fosters distrust not trust, empirically challenging us to identify when and at what level, in complex systems, competition is and is not 'healthy' (the new hope of 'contestability').

The quotation we began with from 1998 was based upon the principle that the NHS might be a single, coherent and collaborative organisation or whole system. If that assumed principle was open to challenge then, now it seems to be glaringly counter-factual. The blue NHS logo is still a static unifying symbol but behind it is a turbulent and divided complex system in rapid flux.

The learning organisation aspiration hinted at by the Secretary of State in 1998 did not exist in isolation from the broader and multifaceted notion of 'modernisation'. It has been part of a complex policy weave, containing strands which have been separate from, and often in opposition to, a learning organisation imperative. The weave has reflected unresolved political dilemmas faced by government, staff and patients alike. These dilemmas have arisen from a core organisational contradiction about the NHS. It is now both *both* bureaucratised *and* marketised and so it is neither fish nor fowl. This point can be exemplified by pointing up four policy contradictions.

First, the research governance framework (RGF) was noted earlier. It was introduced at a time when a variety of capacity building exercises in the NHS had been designed to encourage more research and development in the clinical workforce. However, the RGF has become an anxiously pursued, defensive and bureaucratic process. It may perhaps – although there is precious little evidence either way - be lowering the risk to patients of sub-standard research. However, it has certainly had the effect of producing disincentives and obstacles for all researchers but especially neophytes.

Less, not more grass roots learning are likely as research increasingly becomes the possession of elite university-based departments. The latter are overwhelmingly preoccupied by Research not Development, driven by non-NHS incentives in higher education such as the Research Assessment Exercise and grant chasing. As a consequence, Development, the natural terrain of learning organisation enthusiasts in the NHS, will diminish in organisational importance because it is a burden or dutiful afterthought for academic researchers. This tendency will now increase as local control for the RGF is to be sited in new regional offices and elite academic research is being privileged over service development (17).

Second, the original aspiration of clinical governance being a bottom-up, collectively-owned responsibility for clinical quality was completely consistent with developing a learning organisation ethos. However, with the pressure for vertical accountability rather than horizontal trust and team commitment to service quality, clinical governance has been transformed in the past few years into a narrow devolved responsibility for one sub-system of clinical care, not for the whole system as originally intended.

The success of clinical governance has been defined negatively by the absence of adverse incidents and positively, but very narrowly, by persuasive annual reports to NHS Trust Boards from a small named sub-system (typically called 'the clinical governance department') and its responsible and so potentially blameworthy Executive Director. What started as a rallying call about collective team responsibility for quality at the clinical 'coal face' has turned into standard setting focussed on performance indicators, the application of policies and procedures; forms of bureaucratised vertical accountability. The learning organisation discourse of dynamic bottom-up 'clinical governance' has been replaced by a static and codified top-down one of 'health standards'.

Third, a learning culture in the NHS would only be possible if adequate money for learning and development was consistently guaranteed. The opposite is occurring at present. The most recent structural reform is explicitly about producing leaner and meaner NHS sub-systems. Whilst clinical activity is protected within this policy shift,

savings are being demanded in management. And it is only from the latter that a learning organisation approach could emerge.

Clinical activity develops its own self-sustaining logic, which tends to displace protected learning time because of the opportunity costs involved and the risks accruing to activity targets. In the case of independent practitioners, these are direct financial costs and thus very powerful disincentives. The only learning that might be guaranteed comes from uni-disciplinary, individualised and defensive requirements for appraisal, clinical supervision and the enlarged stick (in the UK post-Shipman) of professional re-validation. These current tendencies are antithetical to a learning organisation, which, as we explained above, is intended to be non-defensive, multi-disciplinary and characterised by team not individualised learning.

Fourth and finally there is the tension between leadership and management. Management is about keeping the show on the road and demonstrating 'deliverables'. It is inherently past-present focused (testing performance against business or 'delivery' plans and the personalised objectives flowing from them). The norms of management are characterised by the sorts of vertical accountability and short-termism noted earlier in the NHS. In its most extreme form of hierarchical functioning, pragmatism and short-term interests it is antithetical to a learning organisation. In contrast, management texts regard leadership as being about inspiring long term cultural change, which is inherently present-future orientated.

In the past five years 'leadership' in the NHS has been encouraged by politicians and civil servants. Potentially this is another driver that could encourage a learning organisation approach. However, different management textbooks advocate quite contrasting 'ideal types' of leadership. For example, one is the 'boot camp' type developed by Tichy at the University of Michigan Business School (18). In this approach to leadership, aspiring leaders go on energetic and demanding courses, where they have to become role models for their workforce. They must be stretched in their ambitions and their commitment to work in their focused imagination and their devoted time and energy. Participants have to work intensively for long hours on projects and then they receive elaborate critical feedback about their performance.

A very different model has been championed by the Banff Centre for Creative Leadership, which emphasises action learning. It utilises Kolb's experiential learning cycle (concrete experience followed by reflection followed by abstract conceptualisation followed by active experimentation leading to a new concrete experience) (19). This learning cycle captures the dynamic logic of the cultural features noted earlier of a learning organisation (11). The leader of a learning organisation would necessarily manifest a mixture of consistent vision and personal humility. This is not the case with the first model of leadership noted above, which encourages individual charisma or even bullish authoritarianism. It is not clear at present which model is being politically preferred in the NHS.

In the face of these four policy contradictions offered as indicative examples of the current NHS, the idea of learning organisations in the latter starts to look like a candle in the wind. However, a caution against this nihilistic conclusion emerges from these contradictions. In a prescient text about the prospect of marketisation of the public sector, the political scientist Claus Offe came to the conclusion that Western democratic capitalism cannot live with the welfare state but also cannot live without it (20). Margaret Thatcher soon discovered this in the 1980s and Tony Blair has struggled with his own version of contradiction management since 1997.

As with Offe's more general point about systemic contradiction, the NHS cannot live with a fully fledged learning culture but also it cannot live without one. The constraints discussed above on developing a learning organisation approach are powerful. At the same time, the drivers outlined prior to this pessimistic discussion are still present. Politicians, NHS managers and clinicians still have to maximise the quality of the patient experience, minimise clinical and organisational risk, develop a competent workforce and encourage research and development. How can any of these be realised in each and every locality unless learning is consistently taken seriously by all those involved?

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