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(Accepted 7 December 1999)

Developing learning organisations in the new NHS

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BMJ 2000;320:998-1001

The government's quality strategy represents a bold blueprint for the new NHS. It embodies the view that managing the organisational culture in tandem with improved learning (albeit overseen by close external monitoring) will deliver substantial gains in performance. The avowed aim is "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

Although learning is something undertaken and developed by individuals, organisational arrangements can foster or inhibit the process. The organisational culture within which individuals work shapes their engagement with the learning process. More than this, there are serious questions about whether and how the organisation can harness the learning achieved by its individual members. Thus, although continuing professional development has long been a part of the NHS, evidence from other sectors suggests that learning needs to take a more central role. Organisations that position learning as a core characteristic have been termed "learning organisations,"²⁻⁴ and this concept is an important one in the context of organisational development.⁵

This paper explores organisational learning and the characteristics of the organisational cultures needed to underpin this learning. We have drawn on existing publications in this area and have used informal synthesis to summarise the key elements of learning organisations and relate these to recent developments in the NHS. Our aim is to encourage the transference of some of these ideas to the NHS.

Learning organisations

Individuals learn and enhance their personal capabilities within organisations, but what does it mean to talk of an organisation learning? Can a hospital, a general practice, or a health authority be said to learn? An organisation is not simply a collection of individuals; the whole amounts to something greater than the sum of the parts. Similarly, the learning achieved by an organisation is not simply the sum of the learning achieved by individuals within that organisation.

Summary points

The national quality strategy for the new NHS highlights lifelong learning as a way of improving health care

Learning is something achieved by individuals, but "learning organisations" can configure themselves to maximise, mobilise, and retain this learning potential

Learning occurs at different levels—single loop learning is about incremental improvements to existing practice; double loop learning occurs when organisations rethink basic goals, norms, and paradigms; and meta-learning reflects an organisation's attempts to learn about (and improve) its ability to learn

Learning organisations attempt to maximise learning capacity by developing skills in double loop learning and meta-learning

Learning organisations exhibit several common characteristics and are underpinned by distinctive organisational cultures which the NHS may need to adopt if it is to achieve substantial quality improvements

Individuals may come and go, but the organisation (even in the turbulent world of health care) usually endures. Robust organisations can still accumulate competence and capacity despite the turnover of staff; individual learning can be retained and deployed in the organisation. How well any organisation can do this depends on factors such as internal communication and the assimilation of individual knowledge into new work structures, routines, and norms. Learning organisations see a central role for enhancing personal capabilities and then mobilising these within the organisation.

Response to uncertainty

Organisations seek enhanced learning for two distinct reasons.³ Firstly, they may wish to maintain flexibility and competence in the face of rapid change and profound uncertainty in their environment. Change and uncertainty may arise from various sources such as technological revolutions, economic turbulence, changing consumer expectations, or increased competition. Rather than implementing fixed responses to change, learning organisations seek to develop structures and human resources that are flexible, adaptable, and responsive. Secondly, organisations need to learn in order to improve their capacity to innovate and hence to compete.

Change and uncertainty abound in the health arena, and flexibility and innovation are key requirements of modern healthcare delivery. Acute NHS trusts are reshaping to face the transfer of some services to primary care. In England, primary care groups have been formed, and are moving through the developmental stages on the way to becoming free standing trusts (in Scotland, primary care trusts are envisaged as the standard configuration from the outset). Health authorities (and, in Scotland, health boards) also see their role changing and face challenging demands to foster innovative service arrangements and partnership working. Thus, healthcare providers face many imperatives to develop effective learning.

The key features of learning organisations (outlined in the box) relate less to the ways in which organisations are structured and more to the ways in which people within the organisation think about the nature of, and the relationships between, the outside world, their organisation, their colleagues, and themselves.

Levels of learning

Crucially, learning organisations do not focus exclusively on correcting problems or even on acquiring new knowledge, understanding, or skills. They aim instead for more fundamental shifts in organisational paradigms and try to encourage the development of learning capacity.

In their seminal work on organisational learning, Argyris and Schön describe three different levels of learning.^{2,6} The most basic level is the detection and correction of error (this they labelled “single-loop learning,” as it is analogous to maintaining a steady course through use of a feedback loop). Single loop learning tends to leave organisational objectives and processes largely unchanged. Clinical audit, for example, in which existing practice is compared with explicit standards, is typical of this type of learning.

Beyond basic error correction, more sophisticated learning which changes fundamental assumptions about the organisation is possible. This level of learning leads, for example, to a redefining of the organisation’s goals, norms, policies, procedures, or even structures. Argyris and Schön termed this “double-loop learning,” as it calls into question the very nature of the course plotted and the feedback loops used to maintain that course. Development of new and innovative models of service and redesign of service from the ground up represent attempts at this more radical form of learning. Unfortunately, many of the

Key features of a learning organisation (adapted from Senge⁴)

- *Open systems thinking.* Individuals within organisations can tend to see activities in an isolated way, disconnected from the whole. The disease model, which is prevalent in modern health care, structures services by diseases or procedures and contributes to this isolationism. Open systems thinking encapsulates the notion of teaching people to reintegrate activities, to see how what they do and what others do are interconnected. This reintegration needs to stretch beyond internal departmental boundaries, and even beyond the boundaries of the organisation itself, to encompass other services and patients
- *Improving individual capabilities.* For an organisation to be striving for excellence, the individuals within that organisation must constantly be improving their own personal proficiencies. However, separate learning by the different professions in health care may be detrimental because individual virtuosity is insufficient—it is teams that deliver health care
- *Team learning.* Team learning is vital because it is largely through teams that organisations achieve their objectives. Development of the whole team rather than learning within single professions is essential
- *Updating mental models.* “Mental models” are the deeply held assumptions and generalisations formed by individuals (internally and often implicitly). These models influence how people make sense of the world. They control, for example, how causes and effects are linked conceptually and constrain what individuals see as possible within the organisation. Changing and updating these mental models is essential to finding new ways of doing things
- *A cohesive vision.* Empowering and enabling individuals within an organisation has to be counterbalanced by providing clear strategic direction and articulating a coherent set of values that can guide individual actions. Encouraging a shared understanding of this vision and commitment to it is crucial in building a learning organisation

pressures on the healthcare system impede such a rethink, and radical change often fails to materialise unless it is precipitated by crisis.^{6,7}

One further, usually underdeveloped, aspect of learning capacity is the ability of organisations to learn about the contexts of their learning—when they are able to identify when and how they learn and when and how they do not, and then adapt accordingly. Thus, successful learning organisations build on their experience of learning to develop and test new learning strategies. This can be thought of as “learning about learning” (or meta-learning). Experience in health care suggests that meta-learning will be difficult to achieve as standard approaches to continuing medical education seem to offer few real gains.⁸ These different forms of learning are illustrated in the box on the next page.

The growth of problem based learning in medical schools and the rise of evidence based medicine are trends that seek to equip individuals with skills rather than a reservoir of facts.^{9,10} As such they may contribute to a culture of single and double loop learning in health care. They illustrate how teaching learning strategies and information skills can enhance learning capacity and flexibility.

Levels of learning: an example in health care

- *Single loop learning.* A hospital examines its care of obstetric patients. Through a clinical audit, it finds various gaps between actual practice and established standards (derived from evidence based guidelines). Meetings are held to discuss the guidelines, changes are made to working procedures, and reporting and feedback on practice are enhanced. These changes increase the proportion of patients receiving appropriate and timely care (that is, in compliance with the guidelines). This is an example of single loop learning
- *Double loop learning.* In examining its obstetric care, some patients are interviewed at length. From this it emerges that the issues which are bothering women have more to do with continuity of care, convenience of access, quality of information, and the interpersonal aspects of the patient-professional interaction. To prioritise these issues, obstetric care is completely reconfigured to a team system led by midwives. The standards laid down in the evidence based guidelines are not abandoned but are woven into a new pattern of interactions and values. This is an example of double loop learning
- *Learning about learning.* The experience of refocusing obstetric services better to meet patient needs and expectations is not lost on the hospital. Through its structure and culture, the organisation encourages the transfer of these valuable lessons. The factors that assisted the reconfiguring (and those that impeded it) are analysed, described, and communicated within the organisation. This is not done through formal written reports but through informal communications, temporary work placements, and the development of teams working across services. Thus, the obstetric service is able to share with other hospital services the lessons learned about learning to reconfigure. This is an example of learning about learning or meta-learning

Skills of learning ... and “unlearning”

However, learning is not always about acquisition. As so much of health care is based on custom and practice rather than evidence,¹¹ there is also a need for learning strategies that focus on “unlearning” previously established ways of doing things.¹² This kind of unlearning is not just about individual practitioners changing their practice. More importantly, the organisation should develop the ability to identify, evaluate, and change whole routines embedded in organisational custom. For example, moving services from secondary to primary care challenges many deeply held assumptions about the role of specialists. This unlearning may prove especially difficult because of the personal investments people have in current competencies. Experience after the healthcare reforms of the early 1990s showed that, despite the apparently radical nature of the changes, continuity rather than change was the dominant theme.¹³

Learning and the national quality framework

In the national context, the national framework for assessing service performance facilitates single loop learning by providing clear measures of performance and benchmarks against which these measures can be judged.¹⁴ However, the framework provides less opportunity to question underlying assumptions and goals, and therefore contributes little to double loop learning. In contrast, the lifelong learning emphasised in *A First Class Service* describes a notion of professional development that captures single loop learning and some elements of double loop learning: “Continuing Professional Development (CPD) programmes need to meet both the learning needs of individual health professionals ... but importantly they

also need to meet the wider service development needs of the NHS.”¹

How these “wider service development needs” are to be met and whether learning in the NHS is to embrace meta-learning remain unclear. How are successes in transforming the NHS culture to be identified, analysed, and communicated? What can NHS trusts and health authorities do to transform themselves, and what role should the central NHS infrastructure take in communicating models of good practice across the country?

Cultural values

Building learning organisations is, in effect, an attempt to manage the culture of that organisation.^{15 16} It requires attention to some key cultural values if it is to be a successful undertaking. These values are outlined in the box on the next page.

Some of these values—for example, the celebration of success—are already central to the healthcare professions and the NHS, while others such as openness and trust may need more work. Inculcating the cultural values outlined in the box into a knowing and, at times, sceptical workforce will be no easy matter. Integrating these values with other organisation wide initiatives such as strategic planning, financial restructuring, and clinical governance will be harder still. In addition, long ingrained cultural values emanating from outside bodies such as the royal colleges will certainly impinge on and may even impede this process.

Interactions between attempts at internal cultural change and external accountability mechanisms may add further complications and conflicts. For example, the high levels of trust needed to underpin learning organisations may be damaged by some of the more judgmental aspects of the national performance framework.¹⁷ Finally, the values underpinning learning organisations have inbuilt tensions that require careful balance between their sometimes conflicting demands (for example, celebrating success while tolerating and learning from mistakes). There is precious little empirical work specific to the NHS to inform strategic and managerial actions in these areas, and this lack should be attended to urgently if the government’s ambitions for the NHS are to become reality rather than rhetoric.

Conclusions

It is clear from official policy documents that the government would like to see the NHS undergo a cultural transformation incorporating considerable attention to learning. If the NHS is to make progress towards such a goal, a number of considerations are germane.

- Several publications describe learning organisations and the cultural values that underpin them.^{16 18-21} This framework will undoubtedly be helpful in shaping policy and managerial strategies. However, much more empirical work is needed, particularly in the context of the reformed NHS
- Experience from other sectors shows that learning strategies tend to focus on single loop learning, with relatively little double loop learning and virtually no meta-learning.⁵ If the NHS is to learn how to adopt the

key features of a learning organisation and the concomitant underlying values, the issue of meta-learning will need considerable attention

- The emphasis on team delivery of health care reinforces the need for team learning. Learning that is limited to individual professions and traditional approaches to continuing medical education may be insufficient to bring about substantial changes in learning capacity

- Different strands of the government's quality strategy such as internal learning and external oversight may interact in deleterious ways—for example, by damaging trust and increasing defensiveness.^{22 23} Ways of minimising these collisions need to be found

- Developing learning capacity may lead to more flexible healthcare services and may enable providers and health authorities to meet parts of the government's quality agenda. However, there is no guarantee that learning will lead healthcare organisations in predictable directions. Indeed, the growth of capable and reflective organisations may highlight dissonance between what organisations perceive as appropriate goals (and the means of achieving them) and the directions stipulated by national policy or overseeing bodies. Managing these conflicts will require care

- Within any busy organisation there is a tension between “doing” and “learning about doing.” Providing incentives as well as resources to develop learning about doing may help ease this tension.

The government talks about the new reforms as “a 10-year modernisation programme.”²¹ This is probably a realistic estimation of the extent of the task. Cultural remaking of the sort envisaged is rarely quick and never simple.²⁴ Even the introduction of widespread single loop learning into health care (clinical audit) proved troublesome and not especially effective.²⁵ However, there is some clear guidance on the sorts of cultural changes required to underpin the transformation of the NHS into a learning organisation. Rapid evaluation and diffusion of the best ways of putting these into operation will be required if success is to be anything but sporadic and localised.

Huw Davies was on sabbatical in the United States as a Harkness fellow in health care policy during the preparation of this paper. Funding for the fellowship was provided by the Commonwealth Fund, a private independent foundation based in New York city. However, the views presented here are those of the authors and not necessarily those of the funding bodies, their directors, officers, or staff.

Competing interests: None declared.

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Underpinning cultural values (adapted from Mintzberg et al²⁶)

- *Celebration of success*. If excellence is to be pursued with vigour and commitment, its attainment must be valued within the organisational culture
- *Absence of complacency*. Learning organisations reject the adage “if it ain't broke don't fix it”; they are searching constantly for new ways of delivering products and services. Thus innovation and change are valued within the organisation
- *Tolerance of mistakes*. Learning from failure is a prerequisite for progressive organisations. This in turn requires a culture that accepts the positive spin offs from errors, rather than seeks to blame and scapegoat. (This does not, however, imply a tolerance of routinely poor or mediocre performance from which no lessons are learned)
- *Belief in human potential*. It is people who drive success in organisations—using their creativity, energy, and innovation. Therefore the culture within a learning organisation values people, and fosters their professional and personal development
- *Recognition of tacit knowledge*. Learning organisations recognise that those individuals closest to processes have the best and most intimate knowledge of their potential and flaws. Therefore, the learning culture values tacit knowledge and shows a belief in empowerment (the systematic enlargement of discretion, responsibility, and competence)
- *Openness*. Because learning organisations try to foster a systems view, sharing knowledge throughout the organisation is one key to developing learning capacity. “Knowledge mobility” emphasises informal channels and personal contacts over written reporting procedures. Cross disciplinary and multifunction teams, staff rotations, on site inspections, and experiential learning are essential components of this informal exchange
- *Trust*. For individuals to give of their best, take risks, and develop their competencies, they must trust that such activities will be appreciated and valued by colleagues and managers. In particular, they must be confident that should they err they will be supported not castigated. In turn, managers must be able to trust that subordinates will use wisely the time, space, and resources given to them through empowerment programmes—and not indulge in opportunistic behaviour. Without trust, learning is a faltering process
- *Outward looking*. Learning organisations are engaged with the world outside as a rich source of learning opportunities. They look to their competitors for insights into their own operations and are attuned to the experiences of other stakeholders such as their suppliers. In particular, they are focused on obtaining a deep understanding of clients' needs

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(Accepted 11 November 1999)