Organisation Development in Health Care

Strategic issues in health care management

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Huw Davies
Manouche Tavakoli
Mo Malek
Rosemary Rushmer

Editors' Preface: Organisation Development in Health Care

Introduction

The *Fourth International Conference* on *Strategic Issues in Health Care Management* took place in St Andrews in spring 2000. Delegates from over 20 countries heard around 100 presentations on a diverse range of topics – from the big issues of national health systems reform, to the human problems of developing a patient-focused culture. The result of those three days intense activity was not only new friends and expanding professional networks, but also three eclectic collections of papers on key issues facing health services development: managing quality; developing organisations; and controlling costs. The papers in this volume, selected from nearly 100 original high quality submissions, reflect the upsurge of innovative work currently taking place on *organisation development issues within health care*. Papers in companion volumes examine health policy issues from an economic perspective (*Health Policy and Economics: Strategic Issues in Health Care Management*, Ashgate, 2001), and the challenges of quality in health care (*Quality in Health Care: Strategic Issues in Health Care Management*, Ashgate, 2001).

What is Organisation Development?

At the beginning of this volume it is perhaps worth summarising the main aims behind an organisation development (OD) perspective to organisational change. The main belief of an OD approach is that the methods and findings of the social sciences can be applied to an organisational setting to create an organisational environment that will foster and facilitate an excellent performance by its members. Logically, this rests on the assumption that the members of the organisation are *able* to improve practice (given the right conditions), thus training and individual development are cornerstones of the approach. Great attention is paid to the way people and services are organised in order to achieve the set tasks, in what functional groups and with what

supporting infrastructures. The argument is that a structure and climate that allows professionals to actively participate in the provision and organisation of their service will give rise to commitment, loyalty, dedication and job satisfaction on the part on the staff. A happy worker is a 'productive worker'. Thus, a unitarist culture is assumed – i.e. that staff will *want* to enhance performance and service delivery (given the opportunity) and that there is a high degree of agreement in what the organisation's purpose is (and how to achieve it).

Readers familiar with the NHS in the UK, may well hear echoes in these assumptions of the term the *NHS family* and, more widely, the strongly held belief that working in health is a vocational undertaking engaged in by like-minded individuals dedicated to providing the best possible care to the patients they serve. Some of these assumptions are addressed and challenged either directly or indirectly by the following papers.

Involvement and Partnership Arrangements

To begin this collection of papers, the first section addresses issues of cooperative working arrangements – what are the best ways to organise staff to encourage cooperation, and avoid duplication and inter-professional rivalry. Changes, driven by legislation, have been introduced as recently as April 1999, aimed at changing the macro-organisational structure of the NHS in the UK. Opening with the paper by Lawrence Benson and Gillian Wright of Bradford, an initial exploration of the introduction of Primary Care Groups (PCG) into England is undertaken. As a form of collaborative working arrangements imposed upon the organisation of health care, the impact, effectiveness and perception of *institutionalised collaboration* by those involved in the groups themselves is mapped out.

The paper by Stephanie Williams pursues this theme by examining the establishment of Local Health Groups in Wales. She concludes that the rationale and theory behind the introduction of collaborative working in Primary Care is sound and commendable but that in practice, implementing hybrid organisational arrangements and structures in practice brings challenges as well as opportunities.

Alternatively, the approach taken by the paper authored by Sue Phillips, Oliver Nyumbu and Brian Toner is to argue that collaborative arrangements and involvement *must* become a working reality. Taking an unashamedly unitarist perspective towards their work in Birmingham, they argue that

involvement in change is pivotal in order that health professionals may embrace the changes necessary to allow the organisation to move forwards successfully and adapt to the realities and constraints of service delivery in the new millennium.

Teams and Interdisciplinary Working

Teamworking as an OD technique within health care offers the promise of integrating the differing contribution of the various health professionals in a complementary way to enhance service delivery to patients. A cohesive, loyal unit dedicated to one aspect of service delivery logically can enhance task identity, encourage cooperation and participation and effective working relationships. Given a degree of self-management and autonomy the team can become a concentrated unit of organisational change and best practice.

Rosemary Rushmer, Julia Parker and Sheila Phillips, in their paper, outline details of a change programme in the East of Scotland to introduce self-directed Primary Care Teams. Aiming to foster empowerment, encourage integrated working and reduce duplication, multidisciplinary practice-based teams can localise their service provision to suit the needs of their practice population. However, limits to the degree of local diversity in service provision are outlined as the coherence and consistency of the NHS is potentially threatened, and health care dictated by postcode looms.

Brain O'Neill and colleagues, working in a Canadian context, argue convincingly for the benefits of interdisciplinary training as a basis for building future cooperative relationships. They argue that interprofessional education brings unique benefits, widening the learning experience by bringing to the fore the multidisciplinary concerns involved in the treatment of chronic, complex and infectious diseases such as HIV/AIDS.

Similarly, Terry Downes and Jayne Sayers examine the efficacy of teamworking as a means to integrate and coordinate the delivery of care to the elderly with mental health problems in the Birmingham area. They map the success of a newly-formed team of five liaison nurses facilitating the multidisciplinary care needed to manage the complex social and health needs of these elderly individuals and their families.

Leadership

Pursuing the organisational problem of coordination and integration, commonality of purpose and focus in the organisation of health care services can be provided not just by integrating structures or by teamworking, but also by and through effective organisational leadership. The visionary leader can be a powerful focus in creating and disseminating the dominant organisation ethic and stabilising a unitarist culture.

Helen Bussell and colleagues in Middlesborough investigate the skills necessary in order to fulfil, successfully, such a demanding role. Interviewing active Primary Care Group members they identify a set of core skills common to leadership situations at PCG level in the NHS. They suggest details of a management development programme to build these skills in the participants.

Graeme Currie and Stephen Procter argue from a slightly different perspective, drawing upon the critical human resource management literature, they analyse the role of the middle manager within health care organisational structures in England. They examine the opportunities (and situational constraints) presented to leaders and managers in the NHS to both set and operationalise health policy decisions.

Effective and ineffective leadership action is also examined by Paula Palmer, within the NHS in Wales. She considers the full range of leadership behaviours observable and analyses the effect of the different styles on the followers. Transformational leadership in fostering vision and encouraging trust and commitment is identified as the single most effective leadership style within the contexts examined. Gender as a leadership issue is also identified, followers preferring to be led by male leaders. The implications of this are explored.

Exploring and also proffering transformational style leadership, Mansour Jumaa and Jo Alleyne in their paper construct a leadership model for training potential clinical leaders within health care settings in transformational behaviours. The basis of their argument is that their model provides a framework for an evidence-based model of health care leadership training.

Leadership training and its effectiveness is a theme considered again in the paper by Zillyham Rojas, Dave Haran and Neil Marr. Training in health care management is evaluated in five developing countries in South America to assess the impact of the training programme on the enhancement of service delivery. Conclusions drawn are pessimistic regarding the effectiveness (in terms of hard measurable outcomes) of aid money spent in this way. However, the paper critiques its own approach (and those of others like it), in attempting

to measure in a quick, simple and direct way what are complex and long-term development challenges intermixed with cultural issues.

Future Trends in Development

The last section in this collection considers possible future developments in the areas of OD as applied to health settings. More than this, it opens and widens a space to view alternative organising frameworks for the management, delivery and execution of health care services. It encourages us to 'think out of the box' to other possibilities.

The paper by Leonard Lerer and John Kimberley examines the health care sector from a European perspective. Based in France, they speculate as to the future of health care provision in a more closer linked, deregulated, European market for health provision, characterised by increasing consumer choice against the background of changing economic, social and demographic trends in the member states of the EU.

The paper by Steven Simeons and Robert McMaster returns the train of thought to the UK and to the NHS in particular. They initially take a historical perspective on the changing value system in the NHS as brought about by the introduction of the 'internal market' system. They argue that the competition engendered by this reform damaged the NHS family and its unitarist culture (perhaps irrevocably), moving working relationships between NHS stakeholders from one of 'trust' to an attitude now more likely to be characterised by calculative self-interest.

Donald Coid and Iain Crombie widen the debate beyond the NHS again, looking at the voluntary sector's contribution to health care provision within Scotland. They examine the evidence indicating levels of funding made to health voluntary organisations from the NHS in Scotland. They reveal dramatic regional differences in funding made available to voluntary organisations. They argue strongly that this limits the potential contribution able to be made by the voluntary sector in Scotland to carry out health care work easing the burden on the provision which has to be made by the statutory health agencies.

The final paper in this collection, looks at the growth in what it terms 'telehealth' that is to say, health care services delivered via the means of new technology. Sharon Levy and his colleagues in Dundee argue that the potential to access health care information via ones own efforts in the use of new technology could mark a considerable shift in the 'power' inherent in most health care relationships. Instead of expertise residing with the health

professional telling and guiding patients in their treatment, telehealth could mean patients are able to become active, autonomous and empowered in searching out and responding to information that they now have access to. Whether this will mean that the relationship between patient and professional will become far less asymmetrical and much more democratic than at any other time in the past, is debated.

Concluding remarks

Health care provision is a service, a service does not exist without the people who deliver it and those who receive it. Exactly how best to organise, structure and facilitate that process such that the meeting of care providers with care receivers happens in the *most effective way possible* will remain an issue of considerable debate for as long as the service remains to be delivered. It is an issue that is constantly open and privy to the strong and legislative intervention of successive governments sometimes with and sometimes without the 'blessing' of the health care professionals themselves. We have learnt much over the past two decades about the effect of altering the nature of health care organisations and the way they function to deliver health care services. We must continue to examine, analyse and report findings on the on-going change in the organisation of health care to provide evidence upon which to base sound future decisions about the changes necessary to health care and its management.

We hope that you enjoy these contributions to the debate, and we look forward to welcoming you to SIHCM 2002 – to be held in St Andrews in spring of 2002.

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* For further information on SIHCM 2002 please email SIHCM@st-and.ac.uk

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INVOLVEMENT AND PARTNERSHIP ARRANGEMENTS

Chapter One

Primary Care Groups – What are They and Why are They Here?

Lawrence Benson and Gillian Wright

Understanding PCGs

This chapter reports a study which explores factors affecting (inhibiting or promoting) the development of corporate board teams within complex and hybrid public sector organisations through a period of continuous transformation. The study takes executive board members for English PCGs as its unit of analysis for the period 1999 to 2002. This chapter explores the ways PCGs see their structure and objectives. It reviews the process of the formation of PCGs and presents an agenda arising from their nature which makes them a particularly interesting focus of research. The chapter summarises relevant literature, describes the research methods to be employed in the programme and presents results from the first phase of the study.

Establishing PCGs

The UK's National Health Service (NHS) is in a period of major reorganisation and probably this is no more radically felt than within the primary care sector. The current strategic direction for this attempt at health care reform can be found in the government White Paper *The New NHS, Modern and Dependable* (Department of Health (DoH), 1997) which addresses the NHS in England and this has heavily influenced health policy reform in other parts of the UK for example Scotland (Scottish Office DoH, 1997).

The purpose and role of PCGs in England and the NHS was announced in the government White Paper for England as bringing together:

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