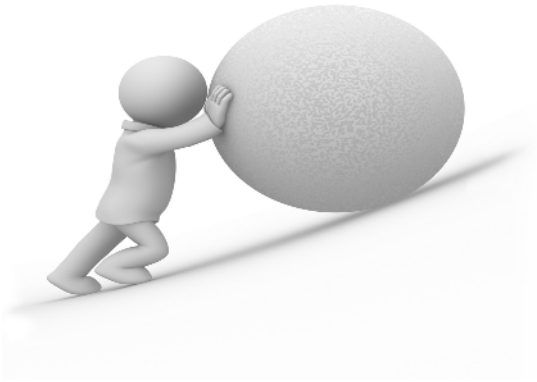
PUSHING THE BOULDER UP THE HEALTH COLLABORATION HILL

Jackie Hewlett-Davies CTArc, *is MD of Hewlett-Davies Associates Ltd*

In my module 2 assignment for the *Postgraduate Certificate in Collaborative Transformation*, I chose to explore *'Organisational Culture and its impact on achieving Health and Social Care Integration and Collaboration Policy Objectives'*.

The research evidences that whilst collaborative working is a key solution to health and social care activity, the NHS funding and culture may prevent it from happening.



Partnership is no longer an option

Closer integration of, and collaboration between, health and social care has been the stated policy direction of successive UK governments for many years.

Dowling and others have highlighted that it is *"difficult to find a contemporary policy document on the delivery of health and social care that does not have collaboration as the central strategy for the delivery of welfare. Partnership is no longer simply an option; it is a requirement.[1]"*.

"[It is]…difficult to find a contemporary policy document on the delivery of health and social care that does not have collaboration as the central strategy for the delivery of welfare. Partnership is no longer simply an option; it is a requirement."

However, progress towards those stated goals has not been fully delivered and remains patchy and limited.

Differences in culture and ways of working have been identified as one of a variety of reasons for this, as well as several rounds of organisational change to the systems governing the NHS which have created further fragmentation and division.

This is not helped by the different commissioning, funding and performance management regimes that apply to different parts of the system[2].

[1] *Dowling et al., (2014)*

[2] *Humphries, (2015)*

Setting the policy context

The current legislative framework for health and social care in England is the Health and Social Care Act (2012) and the Care Act (2014) which both place duties on organisations to promote integrated care.

The resulting publication of the *Five Year Forward View*[3] (FYFV) is the latest stage in many years of health policy encouraging the NHS to build new partnerships with carers, patients, voluntary sector organisations and communities.

It describes how the system will work in new ways to break down the barriers of care provision between:

- family doctors and hospitals,
- between physical and mental health,
- between health and social care.

The FYFV sets out a vision of personalised and co-ordinated care designed around people and their care needs with the opportunity for shared budgets across health and social care.

[3] *(NHSE, 2014)*

*The **medical model** is based on diagnosis of disease and application of cure, whereas the **social model of care** promotes a more holistic approach focusing on the maintenance of well-being and interaction with the whole person.*

The organisational culture context

Schein describes organisational culture as *"a pattern of basic assumptions – invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration; that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems[4]"*.

Scott explores organisation culture further as including an organisation's customary dress, language, behaviour, beliefs, values, assumptions, symbols of status and authority, myths, ceremonies and rituals, and modes of deference and subversion; all of which help to define an organisation's character and norms[5].

The causal link between culture and performance started to be questioned by the end of the 1980s which then led to a large number of studies from the 1990s[6]. They identified the relationship between the performance of the organisation and the strength of commonly shared values that would also help management predict employees' reactions to particular change options.

Organisational culture can provide a framework of consistent values and views of the world to support decision-making, co-ordination and control. However, a strong culture may result in those attitudes and beliefs becoming embedded, difficult to challenge and therefore resistant to change.

Bringing the discussion up to date, Muls and others, perceive that culture in a large organisation is seldom uniform and that subcultures can exist. Different values can compete at different levels and in different professional groups[7]. Therefore change specialists need to understand these subcultures in order to understand why some strategies can be affected and others are resisted.

Organisational culture in health and social care

There has been a focus on the culture in healthcare, in particular following the *Francis Report* into Mid Staffordshire hospital[8] that mentioned the word 'culture' 486 times and stated: *"What is required now is a real change in culture, a refocusing and recommitment of all who work in the NHS – from top to bottom of the system – on putting the patient first. We need a common patient centred culture which produces at the very least the fundamental standards of care to which we are all entitled, at the same time as celebrating and supporting the provision of excellence in healthcare[9]"*.

Following the publication of the *Francis* recommendations, the requirement for healthcare organisations to embed a culture of learning, safety and transparency were recurring themes in three subsequent publications:

- the *Berwick Report* (2013)
- the *Keogh Review* (2013)
- *Hard Truths: The Journey to Putting Patients First (*DH, 2013)

The cultural gap between healthcare and social services with regard to philosophies, priorities and perspectives has been highlighted by McMurray[10]. He argues that there are three factors that continue to act as barriers to greater collaboration and integration in health and social care:

- the dominance of the medical model in health;

[4] *Schein (1985, cited in Scott et al., 2003)*
[5] *Scott et al. (2003)*
[6] *Denison (1995) and Ogbonna (2000, 1993, cited by Nazir and Mushtaq, 2008)*
[7] *Muls et al., (2015)*
[8] *(DoH, 2013)*
[9] *(Francis, 2013, P 64)*
[10] *McMurray (2006)*

We are still in an environment where greater integration is described as the only way we are going to deliver sustainable services, but the funding, regulation and governance arrangements remain separate at a policy level nationally.

- the reinforcement of that model through government policy and
- the continued existence of quasi-markets for healthcare.

The **medical model** is based on diagnosis of disease and application of cure, whereas the **social model of care** promotes a more holistic approach focusing on the maintenance of well-being and interaction with the whole person.

In other words, health professionals were looking inwards at the anatomical parts and thinking within the bounds of their organisation's function, whereas social care workers considered the person as a whole and the spaces between provider agencies.

My recommendations

From reviewing the literature and reflecting on my particular project to establish a collaborative approach to medical recruitment, it emphasised the need to take account of the strength of the sub culture that exists within the medical and healthcare professional groups. For example the impact of those professional bonds on their willingness or capacity, to change their own behaviour to achieve an organisational goal.

Medical consultants, and particularly those in managerial roles such as clinical directors, stated their support of the model in the light of the need to save money. However, I recognise that financial arguments are probably not sufficiently compelling to that group and their colleagues. This reflects the need to achieve alignment between the clinical, financial and operational aspects of any change programme.

I also recognised that frequently, other HR directors, although a powerful group and very senior in their organisations, may not have the strategies available to challenge, or change, the behaviours of the medical professional group.

Therefore, I would recommend that collaborative working project leaders in health and social care, should take more time to ensure that they engage directly with senior medical leaders in the organisations to identify champions who would support the concept and the implementation at a practical level.

Greater investment in work on stakeholder mapping will also be beneficial in identifying the variety of organisational cultures and sub cultures within partnering organisations, in order to develop a more targeted business case that would appeal to each group required to be influenced and persuaded.

In addition, I found a great deal written about organisational culture within the different health sectors and how to achieve more integrated working between secondary care and primary care, commissioners and providers, consultants and general practitioners, acute and community services for example, but there is a lack of literature available on delivering integration between health and social care.

However, I was disappointed that, despite the clearly stated policy direction of greater integrated working between health and social care, the Department of Health policy documents still refer to the NHS as the leader of the system needing to bring in other partners.

We are still in an environment where greater integration is described as the only way we are going to deliver sustainable services, but the funding, regulation and governance arrangements remain separate at a policy level nationally.

In that context, for many health and social care project leads it will feel like they are pushing the collaboration boulder up a hill.