Defensive Behaviours toward Knowledge Sharing

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DECLARATION

The author has used no material in this thesis before and none of the material in this thesis has been published anywhere.

This thesis is the work solely of the author and has not been submitted for any other degree at any other university.

SUMMARY

Direct patient care requires knowledge sharing between clinical professionals. However, clinicians have often been suspicious of managers' motives, this lack of trust often resulting in reluctance to share knowledge for managerial purposes.

Trust is one component of the *psychological contract* - an unwritten set of expectations between employees and employer. There are strong links between components of the psychological contract and defensive behaviours. There is much theory to support these links but little research evidence to support and explain these links.

To overcome defensive behaviours requires an understanding of how they have developed, and particularly the role played by the psychological contract. This research builds on research first undertaken by Argyris in the 1960s, enhanced and made relevant to the current business environment and organisational arrangements currently prevailing in the NHS. A model and an analytical framework were developed for this research to assess organisational, professional and employee *health* in two health authorities.

This research concludes that organisational *ill-health,* and failure to ensure the psychological contract is intact, result in employees displaying defensive behaviours and keeping knowledge to themselves. Components of the psychological contract were found to have strong links with organisational arrangements. Subtle variances were found between clinical and non-clinical employees, and between Chief Executives/Directors and those below this level.

This research adds to our knowledge by identifying the different ways in which these groups develop paradigms that are often in conflict, sometimes intangible, and usually difficult to change. This added knowledge will allow organisational, team and personal development to have a sharper focus, particularly with reference to development of the psychological contract in the NHS, overcoming defensive behaviours, and breaking down barriers to knowledge sharing. This will support the development of infrastructures, teams and individuals to take NHS organisations into the 21st century with added confidence.

DEFINITIONS

Adhocracy *(organisational form)*	A form of sophisticated organizational structure that typically uses teams and is designed to survive in complex, dynamic environment..... It is temporary, adaptive and creative. Adhocracy is similar to the concepts of **organic** and **integrative** organizational styles. *Buchanan & Huczynski (1997)*
Authority	Managing to get things done because one's orders are seen by others as justified or legitimate. The right to guide the actions of others and extract from them responses which are appropriate to the attainment of an organization's goals *Buchanan & Huczynski (1997)*
Behaviour	The things that people do that can be directly observed by others. *Buchanan & Huczynski (1997)*
Bureaucracy *(organisational form)*	The legal-rational type of authority characterised by a specialization of labour, a specific authority hierarchy, a formal set of rules and rigid promotion and selection criteria..... Bureaucracy equates to ***mechanistic*** and ***segmentalis***t approaches. *Buchanan & Huczynski (1997)*
Corporate culture	The pattern of basic assumptions that a given group has invented, discovered or developed in learning to cope with its problems of external adaption and internal integration, and that have worked well enough top 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. *Schein (1984)*
Data	Raw numbers or anecdotes which in themselves are not revealing. *Rajan, Lank and Chapple (1998)*
Divisional *(organisational form)*	Very large organisations broken down into smaller, quite formal, product or service based sections that have moderate levels of autonomy. *Adapted from Mintzberg*

Dominant coalition	The objectives and strategies (for the organisation), the personal characteristics, and the internal relationships of that minimum group of co-operating employees who oversee the organisation as a whole and control its basic policy making. *Kotter (1978)*
Effectiveness	Effectiveness of an organisation can broadly be defined as one that makes best use of its resources to attain high levels of performance, thus successfully achieving its purpose and objectives while also meeting its responsibilities to its stakeholders. *Armstrong (1994)*
Elicitation	Refers to behaviour that is not spontaneously produced by an organism but is 'drawn out' by the presentation of the appropriate stimulus. *Reber (1985)*
Employees and other tangible assets	The size (or number) and internal characteristics of an organisation's employees, plant and offices, equipment and tools, land inventories and money. *Kotter (1978)*
Entrepreneurial/ Simple *(organisational form)*	One person as leader with a legitimate power base. Often with a single product or process, the organisational arrangements are simple, dynamic and there is little formalisation. *Adapted from Mintzberg*
Environment	Those internal and external forces that act upon an organisation, those forces that an organisation places upon its internal and external environments. *Adapted from Zairi and Leonard*
External environment	An organisation's task environment can be defined as all possible suppliers (of labour, information, money, and materials, and so on), markets, competitors, regulators and associations that are relevant in light of the organisation's current products and services... The wider environment... can be defined by such indicators as public attitudes, the state of technological development, the economy, the occupational system, the political system, the demographic characteristics of people and organisations, the society's social structure, current price levels, laws and so on. *Kotter (1978)*

Explicit Knowledge	Transmittable, informal, systematic language. Making sense of information in order to propose action. *Rajan, Lank and Chapple (1998)*
Formal organisation	The collection of work groups that have been consciously designed by senior management to maximize efficiency and achieve organizational goals. *Buchanan & Huczynski (1997)*
Future shock	The stress and disorientation suffered by people when they are subjected to excessive change. *Buchanan & Huczynski (1997)*
Group effectiveness	The adequacy of a group in performing its functions as an organized system and achieving its task-related goals. *Buchanan & Huczynski (1997)*
Group relationships	The interaction within and between groups and the stable arrangements that result from such interactions. *Buchanan & Huczynski (1997)*
Informal organisation	The network of relationships that spontaneously establish themselves between members of the organization in the basis of their common interest and friendships. *Buchanan & Huczynski (1997)*
Information	The key messages from the data once they are analysed for their meaning. *Rajan, Lank and Chapple (1998)*
Intellectual capital	Skills, competencies and knowledge that are in demand and unique to an individual or, at most, available from just a limited number of people. *Dale (unpublished 1998)*
Internal environment	The total physical, organizational and social surroundings of an individual in their organization. *After Reber (1985)*
Interpersonal relationships	The simplest social bonds which occur when two people stand in some relation to each other. *Buchanan & Huczynski (1997)*

Knowledge management	That explicit and tacit knowledge held by an individual or an organisation. Making sense of information from transmittable, informal, systematic language in order to propose action. Some knowledge will be personal, context-specific but hard to formalise and communicate (in oral or written form) because it comprises insights, hunches and intuitions. *Rajan, Lank and Chapple (1998)*
Leadership	The creation of a vision about a shared future state which seeks to enmesh all members of an organization in its net. A social process in which one individual influences behaviour of others without the use of threat or violence. *Buchanan & Huczynski (1997)*
Learning	The process of acquiring knowledge through experience which leads to an enduring change in behaviour. *Buchanan & Huczynski (1997)*
Machine bureaucracy *(organisational form)*	Possessing all the characteristics of a bureaucracy and additionally the important decisions are made at the strategic apex of the organizational pyramid; whilst at the bottom, standardised procedures are used which have been developed by specialists at headquarters. There are many support staff, and many layers of hierarchy between the apex and the bottom operating levels. *Buchanan & Huczynski (1997)*
Matrix structure *(organisational form)*	A type of organizational design that combines two different, traditional types of structure and a project structure, which results in an employee being part of both a functional department and a project team, and in consequence, having two reporting relationships. *Buchanan & Huczynski (1997)*
Motivation	The cognitive decision-making process through which the individual chooses desired outcomes, and sets in motion the actions appropriate to their achievement. *Birchall & Lyons (1995)*
Organisational attitude	A tendency to respond in a certain way (favourably or unfavourably) to objects, persons or situations. *Buchanan & Huczynski (1997)*

Organisational belief	The acceptance of a proposition. It does not necessarily imply a preference 'for' or 'against' anything. Beliefs are assumptions about the organization and the situation within it. *Buchanan & Huczynski (1997)*
Organisational competence	That blend of technologies, understanding of clients/customers and product/service knowledge that uniquely apply to that organisation and which give it a commercial edge. *Birchall and Lyons (1995)*
Organisational values	Anything that has personal worth or meaning. Values are typically based on moral, societal or religious precepts that are learned in childhood and modified through life. Shared values produce beliefs. *Buchanan & Huczynski (1997)*
Organisation structure/form/ arrangements	All formal systems that have been explicitly designed to regulate the actions of an organization's employees (and machines). *Kotter (1978)*
Organisation	An organisation is the planned co-ordination of the activities of a number of people for the achievement of some common, explicit purpose or goal, through the division of labour and function, and through a hierarchy of authority and responsibility *Buchanan & Huczynski (1997)*
Organisational norms	Derived, expected modes of behaviour. They are based on organization's values and beliefs, and they provide guidelines for individual and group behaviour. These in turn produce outcomes that reinforce shared values and beliefs. *Buchanan & Huczynski (1997)*
Organisational processes	The major information gathering, communication, decision-making, matter/energy transport, and matter/energy-converting actions of the organization's employees and machines. *Kotter (1978)*
Organisational standards	The values, beliefs, attitudes and norms of an organisation. *Dale*
Personal competence	The qualities that an individual brings to a job in order to perform its various aspects at the required standard of performance. *Birchall & Lyons (1995)*

Power	The ability to get things done by threats of force or sanction. *Buchanan & Huczynski (1997)*
Professional bureaucracy *(organisational form)*	Possesses all the characteristics of a bureaucracy. Decision-making is decentralized, and there are few levels between the strategic apex and the operating staff (professors, doctors, nurses). Control of staff is achieved by the professional indoctrination of its members. *Buchanan & Huczynski (1997)*
Psychological contract	1. The degree to which their *(the employee's)* expectations of what the organisation will provide them and what they owe the organisation in return matches the organisation's expectations of what it will get in return. 2. The nature of what is actually to be exchanged (assuming there is some agreement) – money in exchange for time at work; social need satisfaction and security in exchange for hard work and loyalty; opportunities for self-actualisation and challenging work in exchange for high productivity; high quality work and creative effort in the service of organisational goals; or various combinations of these and other things. *Schein (1988)*
Relationship management	Developing specific skills in managing relationships and identifying/managing conflict in order to maximise the potential benefits of working in matrix and organic/network structures, and maximising opportunities for information seeking, sharing and use.
Responsibility	An obligation placed on a person who occupies a certain position in an organisation structure to perform a task, function or assignment. *Buchanan & Huczynski (1997)*
Self-fulfilling prophecy	An expectation that leads to a certain pattern of behaviour whose consequences confirm the expectation. *Buchanan & Huczynski (1997)*
Self-Reference	Being aware of personal values, beliefs and culture and of those you work with, being aware of (and become confident in) your personal and professional skills, knowledge, experience, values and culture and ensuring these are fully aligned with those of your profession, function and team(s) in which you work.

Social system	Culture and social structure. Culture can be defined as those organisationally relevant norms and values shared by most employees (or sub-groups of employees). Social structure is defined as the relationship that exists among employees in terms of such variables as power, affiliation, and trust. *Kotter (1978)*
Stakeholder	Anyone who is likely to be affected, directly or indirectly, by an organizational change or programme of changes. *Buchanan & Huczynski (1997)*
Systems	Something that functions by virtue of the interdependence of its component parts. *Buchanan & Huczynski (1997)*
Tacit knowledge	Insights, hunches and intuitions that are personal, context-specific and consequently hard to formalise and communicate in oral or written form. *Rajan, Lank and Chapple (1998)*
Technology	the major techniques (and their underlying assumptions about cause and effect) that are used by an organisation's employees while engaging in organisational processes, and that are programmed into machines. *Kotter (1978)*
Universalism	The concept that principles of human behaviour can be studied as a technical question irrespective of the purpose of the enterprise. As a result, the proposal that organizational design (and organisational effectiveness) can be arrived at by the application of these principles to the allocation of tasks, control of work being done and the motivation and reward of those doing it. *After Buchanan & Huczynski (1997)*
Values	Incorporating values and norms, they define what is 'good' and 'bad' and together constitute what is acceptable behaviour and why. *Buchanan & Huczynski (1997)*
Wisdom	The combination of all categories of knowledge to the extent that its deployment requires mental and emotional intelligence, learning and experience, thinking and doing. *Rajan, Lank and Chapple (1998)*

TABLES

FIGURES

CHAPTER ONE

INTRODUCTION

" No task is so difficult
To set about
No leadership so delicate
No venture so hazardous
As the attempt to introduce
A new order of things

Those who change
Find as their adversaries
All those who succeeded well
Under the old order
And no more than lukewarm
Supporters among those who
Might function under the new "

Machiavelli
16th century

Introduction

In 1988 Drucker described the typical business in 2008 as:

> " .... knowledge-based, an organisation composed largely of specialists who direct and discipline their own performance through organised feedback from colleagues and headquarters. For this reason, it will be what I call an information based organisation.....We can perceive, though perhaps only dimly, what this organisation will look like, but the job of building information-based organisations is the managerial challenge for the future. "

In 1998, just ten years after Drucker described his vision of the future, executives in the private sector were asked how they could ensure that their organisation was capitalising in its most critical asset – the knowledge that its people had (Ernst and Young, 1998). Whilst 87% of the executives responded that their organisations were *knowledge intensive*, 60% ranked their ability to get employees to share knowledge as average or below average. The reluctance of

people to readily and freely share their knowledge is clear, and yet the reasons for it are still not fully understood.

Like most modern organisations the NHS is increasingly dependent on information and knowledge for direct patient care, for planning of health interventions, and for assessing efficiency and effectiveness. Supported by their professional ethics, clinicians have developed comprehensive, world-wide mechanisms for sharing information and knowledge that benefits direct patient care. However, clinicians have continued to be wary of sharing patient related information with non-clinicians, or sharing information and knowledge that may, in their view, compromise their ability to provide comprehensive services to patients. Patient confidentiality has often been cited as the reason for not sharing knowledge and information and is supported by recommendations of the Caldicott Report. Clinicians have been sceptical about the motives of non-clinicians who they see as having kept planning and commissioning of health services within the bureaucratic sphere of the NHS, often to the detriment of patients. This has created elements of distrust in the past between clinicians and non-clinicians in the NHS, as well as between health authorities, local Trusts and General Practitioners (GPs).

The NHS introduced an *internal market* in 1990. Hospitals and community units were encouraged to become self-governing Trusts, and GPs were encouraged to become *fund holders* with responsibility for planning and commissioning a defined range of services for their patients.

In 1994, the NHS Executive (NHSE) replaced the 14 regional health authorities with 8 regional outposts of the NHSE. The new outposts were now part of the civil service rather than part of the operational NHS. At this time, *district health authorities* (DHAs) were urged to work collaboratively with their local *family*

health service authority (FHSA) with whom they merged in April 1996. These merged health authorities thus became the sole NHS organisation responsible for strategic planning and commissioning of local health services other than those commissioned by GP Fund holders.

Managing the New NHS - Functions & Responsibilities in the NHS (1993) summarised the new overall responsibilities of health authorities as *strategy, support and monitoring* and stated that the new focus of health authorities needed to be on:

- evaluating the health and health care needs of the local population
- establishing a local strategy to implement national priorities and meet local health needs, in collaboration with GPs (fund holders and non-fund holders), local people, providers, other statutory and non-statutory organisations
- implementing the local health strategy by:

    - ensuring hospital and community health services are secured through contracts with NHS and other providers
    - developing primary care, including the regulation, management and development of the services provided through the Family Health Service contractors
    - working with GPs (fund holders and non-fund holders) to achieve locally agreed targets
    - developing local alliances with and influencing organisations whose activities impact on health

  - communicating with local people, seeking and responding to their views, improving their understanding of health and health services, and acting as advocates for their health interests
  - working with existing and potential NHS and non-NHS providers to shape delivery of service within the health services market to seek improved value for money
  - improving the quality and clinical effectiveness of care
- monitoring and evaluating changes in health and the delivery of health services to ensure strategic objectives are achieved, refining the strategy as appropriate in the light of performance achieved
- developing the capability locally to achieve the strategy both within the organisation and outside
- discharging other corporate and statutory responsibilities

These were refined into six key tasks:

1. setting a strategic framework
2. securing and allocating resources
3. human resource management
4. working with clinical staff
5. performance management and accountability
6. developing and regulating the market

These processes were required if health authorities were to function effectively, the processes being a series of linked activities involving a number of departments and/or individuals.

Public health professionals were given the responsibility for preparing the necessary targets, strategies and monitoring arrangements. Public Health roles and responsibilities were to be a key focus at health authority level. They included statutory roles such as: communicable disease control, implementation of the *Health of the Nation* national programme, contributing to the assurance of clinical effectiveness in health care contracts, health promotion, assessment of health need and development of relationships with GPs and clinicians in Trusts. The responsibilities of Public Health were also summarised in *Managing the New NHS - Functions & Responsibilities in the NHS* (1993) as:

- monitoring the health of the population
- ensuring the public health considerations drove the health authority's purchasing and health commissioning activities
- monitoring health outcomes of interventions
- improving the effectiveness and value for money of clinical and non-clinical interventions
- developing local health strategies and the alliances necessary to implement these; developing and sustaining effective relationships with local clinicians including those working in primary care and community-based health programmes
- collaborating with local authorities and other agencies as appropriate to monitor and control communicable disease and non-communicable environmental exposures, and in their prevention
- informing the public about health and what can be done to improve it; involving the community in discussion about health needs and service provision

- ensuring that local GP fund holders and all providers of primary, hospital and community care, including those in the voluntary and private sectors, have access to adequate and appropriate public health advice

Health authorities, GP fund holders, and Trusts required new information to plan and commission health services. Public health in particular needed, for example, details of patient episodes in hospital and more importantly needed information from GPs about morbidity in order to assess need and link *health events*.

The sharing of this information, even at professional level, was slow to happen for a number of reasons including incompatibility of computer systems, distrust between GPs and health authorities, the business ethic between fund holders and Trusts, and competition between fund holders.

Since 1994 there has been intense pressure from the NHS Executive on health authorities to prove they are effective (delivering promised change and associated health improvements) and pressures to reduce the costs of managing health authorities. Every year new, lower targets were set for these *management costs* and this meant that many of the staff working in health authorities felt the continual threat of redundancy.

To function well under these conditions the affected staff to feel very confident about themselves and the contribution they can offer. This confidence comes from the self-belief that the knowledge they have acquired is unique to them or at least in short supply. Theories of motivation suggest that where basic human needs of security are threatened, people become defensive (Jewell and Siegall, Vroom, Locke, Adams, McClelland, Porter and Lawler). Where knowledge is seen

as bestowing power upon the holder, any personal threat to the physical or mental wellbeing of the individual is likely to result in people becoming defensive. A sign of this defensive behaviour would be knowledge being held as a personal asset by the individual and used as a bargaining tool. Perceived threats to personal or professional status, or threats to personal standing in a community or profession, are likely to evoke the same response.

However, those responsible for planning and commissioning local health services have been at a different hierarchical level to those who provide direct patient care services. These hierarchical levels (district, area and regional health authorities) have been perceived by many clinicians as being run by administrators who have obstructed progress. A good example would be the imposition of financial limits upon expenditure, the rationale for which did not convince some clinicians.

Some GPs saw the introduction of fund holding as a golden opportunity to rid themselves of the historic burden of bureaucracies to which they had been subjected. Some developed an arm's length relationship with their local health authority whilst others enthusiastically embraced the new developments and began to work more closely with their local health authority.

The recent establishment of Primary Care Groups (PCGs) was to be the latest vehicle for change and yet early signs were that there were tensions over roles and responsibilities, who should 'lead' and reluctance from practices to co-operate with each other. Even before the framework for the establishment of PCGs was announced, Crail (1998) saw health authorities as likely to feel defensive towards their establishment. Crail quotes Cathy Hamlyn, associate director of health policy at the NHS Confederation who said "A lot of things seem to have been given away to GPs already. But we are still concerned that health authorities as well

as GPs are seen as part of this". Wall (1996) saw the introduction of locality commissioning as a way of overcoming differences of culture, values and beliefs but both Wall, and Hudson (1995), recognised that this could cause more problems than it would solve. Wall believed commissioning organisations (*health authorities*) had difficulty in knowing how much to delegate their authority – too much and they removed their own purpose, too little and locality managers just became post boxes.

The NHS confederation hosted a conference in May 1998 at which 81 people attended a focus group to discuss these issues. The group included 15 GPs, 29 managers from health authorities, 13 practice managers and 4 managers from provider organisations. The level of interest from health authorities indicated the unanswered questions they had about making the new arrangements work. Whilst cautiously optimistic about the benefit to patients, the group concluded there were major barriers to be overcome.

The biggest of these barriers was the need for practices to co-operate, with 'managing conflict' a recurring theme along with issues of distrust and suspicion (Place and Street 1998). The group also saw difficulties with developing a common vision so members of PCGs could have a commitment to shared objectives and achievements. Nurses in this group felt they had lived for too long with decisions being made by others with too much attention being paid to GPs. A general feeling was that insufficient information was available and yet the suspicion with which the key players were viewing each other suggests that information and knowledge sharing would become an issue when it did become available. The Chartered Society of Physiotherapists were quoted as being "alarmed" at the lack of opportunity for professionals not listed in the national guidance to be represented on

PCG boards and the Royal College of Midwives said they were 'concerned' about many issues.

The whole process of change was seen as having yet another destabilising effect but by Hunter (1998a) also believed that there was a very real danger that as managers and professionals were swept up in yet more organisational turbulence, the less glamorous structural issues of public health, health gain, health improvement and inequalities would be forgotten. The early indications were that this research would be as valid for PCGs as it was for health authorities.

Organisations have increasingly become more dissociated and employment become a portfolio of projects and tasks rather than one single 'job'. Organisations and individuals need to be constantly aware of how these new dynamics will affect them and where the focus for organisational and personal development should be. Currently emerging are organisational dynamics relating to:

- the rapid developments in the information/knowledge cultures of organisations
- the impact of more dissociated organisational structures on the need for people to acquire skills in the management of relationships
- the need in the current climate of 'portfolio' careers for individuals to develop a reference framework for themselves from which they develop skills associated with moving from team to team, working co-operatively with many other disciplines and professions, and being confident in their own skills and knowledge.

These would fuel revitalised local partnerships and the resultant improvements in knowledge sharing would facilitate health authorities (particularly

those in public health), and Primary Care Groups, secure planned improvements in health gain and the health status of individuals and local populations.

There has been research into why people become defensive but little is known about how this relates to barriers to knowledge sharing. Even the work that has been done on examining defensive mechanisms has yet to fully assess the impact of the organisational dynamics that are now emerging.

An influential researcher and author in the field of defensive behaviour is Argyris. Argyris (1985) found that whilst efforts can be made to overcome these defensive behaviours (Argyris called these defensive routines), personal opportunity or threat was the over-riding motivation for people to be overtly and/or covertly supportive, or to be defensive towards proposals which they found threatening to deeply held personal or professional values, culture or beliefs. To overcome these defensive routines Argyris suggested that people needed to be educated in a new ways of working in which individuals had to develop their own information and own it, receive feedback positively and receive feedback in ways that encouraged the individual to act 'appropriately'.

If the criteria suggested by Argyris are satisfied then there is one further confounding factor that Schein, an eminent psychologist, proposed: employees traditionally have contracts of employment that define pay, hours, leave entitlement etc. that are very tangible and can easily be shown to be either adhered to or broken. However, there are also unwritten expectations that employees have of employers, and vice versa. For example, employees will expect that they will be treated with respect, that their career aspirations will be met, that others will have respect for their professionalism and that they will feel their jobs are secure. Employers will expect loyalty, high levels of commitment and considerable flexibility

in working arrangements. These latter expectations form part of less tangible *psychological* contracts. When contractual or psychological contracts are broken then working relationships deteriorate, trust is lost and individuals become nervous about their personal futures.

Organisations are now intensively information and knowledge based, but information and knowledge will only flow and be shared more freely if relationships are managed well. Relationships will only improve if those seeking to elicit knowledge prove themselves to be trustworthy, understanding, responsive and effective. Health care organisations need to prove themselves by entering into real partnerships with each other. For health authorities this means partnerships with local GPs and local Trusts. However, many of these potential partners of health authorities can be sceptical and mistrusting of the motives of those in health authorities. As a result there can be a reluctance to share information and knowledge, and so the specious argument could go on. In order to be effective this circle needs to be broken.

It was believed that through the research carried out for this thesis there would be a significant contribution to knowledge by exploring the extent to which maintaining the psychological contract could overcome defensive behaviours towards knowledge sharing and facilitate the development of the NHS at local, and perhaps national levels.

Background - A brief history of NHS development

Reviewing NHS development gives insight into reasons for defensive behaviours towards knowledge sharing and how the development of psychological contracts could overcome many of these defensive behaviours.

The Beveridge Report published in 1942 contained far-reaching recommendations for the formation of a National Health Service. One of its central assumptions was that a comprehensive system of healthcare was essential to any scheme for improving health standards. Comprehensive was described as medical treatment available for every citizen, at home and in hospital, available as and when they should need them.

However, the initial proposal to have GPs as full-time employees was received by them with scepticism about the Government's real intentions. The British Medical Association (BMA), the professional organisation representing medical practitioners, withdrew from discussions that were then halted.

The White Paper, *A National Health Service*, was finally published in 1944 and by the time negotiations were completed GPs had the opportunity to remain independent practitioners.

GPs were thus an integral part, but not an integrated part, of the NHS. An early opportunity to integrate the three arms of the NHS – hospital services, community services and Family Practitioner Services – had been lost. GPs remained strenuously opposed to being made employees of the NHS, seeing their separation from hospital services as necessary to retain their professional autonomy.

When the NHS came into being on 5 July 1948 there were many compromises other than those relating to GPs - the original proposal to have a joint service with local authorities was dropped, only to be raised again in 1968. The concept of regional and local levels of management was also dropped and the 'health centre' principle was only included as an experiment.

The compromises made in order to establish the NHS were contributory to the problems the NHS encountered in the period up to 1974. Failure to meet original hopes of a fully unified, comprehensive service were exemplified by the introduction of compulsory payment by patients for certain services, e.g. prescriptions. When NHS contributions were introduced the principle of a free service was lost for ever.

The major problem, however, was that demand quickly outstripped the available supply of funding. Reviews published in 1956 (Guillebaud Report) again identified the weakness of the NHS having its three parts operated by three governing bodies with no effective link between them. Between 1956 and 1962 various reports (Porritt, Gillie and Cranbrook) addressed the issues of unification.

From 1948 to 1967 little further attention was paid to the organisational arrangements of the Family Health Services, and the effectiveness or relationships with other related service providers. The complexity of the NHS meant that by 1967 there were 15 Regional Hospital Boards, 36 Boards of Governors, 336 Hospital Management Committees and 134 Executive Councils separately administering the services of 20,000 general practitioners who functioned as independent contractors. 175 local authorities independently ran the community services.

In 1968 Kenneth Robinson (Minister of Health) published *The Administrative Structure of Medical and Related Services in England and Wales* which had a central theme of unifying health services under 40-50 Area Boards serving populations between 750,000 and 2-3 million. In February 1970 *The Future Structure of the National Health Service* was published. The main themes were that:

- the new Area Health Authorities would be independent of local government and directly responsible to the central department
- the public health and personal social services would continue to be the responsibility of local government
- the boundaries of the new health authorities would match those of local government.

The new arrangements for the NHS were planned in the context of new arrangements for local authority personal social services. The First Green Paper again recommended to jointly administered health and local authorities. The Second Green Paper favoured the separate administration of health services but within the same geographical areas as those defined for local authorities.

Regional inequalities in health care were by now being identified. These inequalities have been attributed to a number of factors including unemployment, overcrowding and low wages but the failure of the tripartite structure to iron out these inequalities was partly due to the disparate nature of hospital, community and family practitioner services. The inception of Area Health Authorities (AHAs) was an attempt to provide the necessary infrastructure to overcome this obstacle. The 99 AHAs set up in England were largely co-terminus with local authority boundaries and covered populations of a quarter of a million to over one million.

The Chairman of each AHA was appointed by the Secretary of State. Membership of the AHA included local authority, university and professional nominees. However, appointed as generalists, there was inevitably conflict with political or professional doctrines. AHAs had a split role being responsibility for both planning and providing health services. Where AHA populations were sufficiently

large, sub-division was made into District Health Authorities (DHAs) whose role was primarily to implement policy.

The major reorganisation in 1974 was implemented over several years. Almost immediately a Royal Commission was set up under the Chairmanship of Sir Alec Merrison to review managerial and financial arrangements. Reporting in 1979 the report was critical of management of the NHS - too many tiers, too many managers and failure to make swift decisions being cited.

The Government's response was *Patients First* (1980) which focused on structural change and proposed the abolition of AHAs and strengthening the role of DHAs. *Patients First* also suggested streamlining professional consultative machinery and planning systems. Unit management of hospitals rather than functional management was also proposed.

Following consultation, the NHS was re-organised in 1982. This was seen as the opportunity to resolve dissatisfaction, which had surfaced almost immediately the 1974 re-organisation had started. The premise that AHAs would be sensitive enough to local needs and that the DHAs would not have their own ideas about the shaping of health services was poorly founded. Differences of viewpoint were inevitable. District Management Teams (DMTs) were not accountable to the Area Teams of Officers (ATOs) but could be monitored by them. The opportunities for resenting such arrangements should have been clear.

The major difference with the 1982 proposals was that each Region was given responsibility for making its own arrangements. Although 'minimum upheaval' was advocated by *Patients First* and also by the Secretary of State, most Regions had to manage displaced officers from the Area tier many of whom became District officers who in turn moved to other DHAs.

These new arrangements still left no clear point of accountability in a District Management Team since they worked by consensus. Critical of this, the Secretary of State appointed Sir Roy Griffiths, seconded from Sainsbury PLC, to lead a team to advise him. The report, *NHS Management Enquiry*, confirmed this lack of clear leadership and accountability. The resultant appointment of General Managers did much to set the NHS on a course for more accountable management, less ambiguity and tighter control. Even so, the Government remained concerned, particularly with financial demands. Abolition of AHAs in 1982 also left Family Practitioner Committees (FPCs) and health authorities non-coterminous and encouragement for joint working was consequently reduced.

By the late 1980s financial pressures resulted in service cuts and closure of wards on a significant scale. The factors leading to these pressures were coming from growing public expectations, advances in medicine and an ageing population. Increasingly there was a belief in the Government that a market economy would encourage greater efficiency if adopted by the NHS. This had many attractions not least of which was an opportunity for patients to influence the way in which services were bought and a perceived ability to abstractly manage financial pressures as a result.

A greater focus on primary care came with *Promoting Better Health* a Green Paper (1987), which had three main objectives:

- Improving general standards of primary care
- Giving consumers greater choice
- Increasing the emphasis on health promotion

However, the GPs' negotiators soon decided, once again, that this was a threat to their autonomy. The government implemented the reforms and the

resultant *National Health Service and Community Care Act* came into being in October 1990. This Act introduced the NHS Management Executive (latterly the NHS Executive). Led by a Chief Executive the group has membership of civil servants and NHS managers together with other professionals with specialist knowledge.

Health Authority arrangements changed so that there were equal numbers of executive and non-executive directors together with a Chair. The Secretary of State now appointed the non-executive officers who appointed the executive officers with the Chief Executive. This model was similar to that used in commercial organisations. Hospitals and Community Units became self-governing Trusts. This gave them new latitudes of self-governance within an overall framework and the ability to develop their 'market'. Trusts had their own boards of management with a Chair and Chief Executive and the new family health service authorities (FHSAs) had a greater role in planning.

One of the distinctive features of the new arrangements was the principle that money should follow patients wherever they were treated. In this way Districts were funded for their resident population. Contracts with Trusts allowed funds to flow with the patients to the Trusts. Where no contract existed then Extra Contractual Referrals (ECRs) were arranged. Costs of emergency treatments were absorbed by each Trust as part of their business plans and pricing structures.

To move the focus more to the primary care setting, GPs were given the opportunity to have control over their own budgets to use on their patients' behalf for certain clinical procedures. This gave GPs an added influence on the quality of hospitals' service provision. GPs could decide whether the service they were being offered was clinically effective and cost effective, and refer patients accordingly.

These arrangements encouraged GPs to be critical of their assessment of need and use of financial resources.

The changes from FPC to FHSA marked some significant changes in approach, characterised as moving from *administration* to *management*. FHSAs were tasked with reducing drugs budgets and introducing 'competition' between GPs. The latter permitted advertising and encouraged GPs to group together for economies of scale.

Administrators of FPCs had hitherto been on salaries considerably below those of corresponding peers, especially at district levels. This had caused considerable resentment and whilst introduction of general managers for FHSAs on salaries comparable with DHA General Managers gave potential for improvement, the resentment of years of lagging behind remained with many for some time.

Further structural changes were announced by the Secretary of State in *Managing the New NHS* on 21 October 1993. This identified functions to be carried out at local level - by Trusts, GPs and other primary care providers, and health authorities - and those which were to be the responsibility of the NHS Executive either at its headquarters or in regional offices. The framework was shaped by the twin objectives of maximising the responsiveness to local people and achieving best value for money for patients and the public.

These changes abolished the 14 Regional Health Authorities (RHAs) and created a single structure for central management, the NHS Executive, comprising a headquarters and eight regional offices. DHAs and FHSAs were to merge and form new health authorities. The regional offices came into existence on 1 April 1994 at the same time as the NHS Executive. Merger of DHAs with FHSAs required legislation and was targeted for 1 April 1996.

The organisational changes that took place in April 1994 were aimed at encouraging co-operation, efficiency and effectiveness by overcoming organisational barriers. These new arrangements required people to work openly with each other in partnerships, sharing their skills and knowledge in pursuit of improved services for patients and improved health status of local populations.

Considerable unease accompanied the early days of these changes. Fears of the NHS losing its public accountability were, at the margins, heightened by fears that this was the start of privatising the NHS. These fears have, to date, been groundless. However, the increased need to ensure effective use of resources had prompted GPs and Health Authorities to seek closer working arrangements. This has been seen by many of the general public as rationing and further undermining a *comprehensive* service.

The introduction of GP fund holding, and the general move towards a primary care-based NHS, were directed at making the provision of healthcare increasingly more responsive to the needs of patients and the more equitable provision of local services. The formal integration of DHAs and FHSAs was the first real opportunity for an integrated approach to the achievement of health gain for local populations.

A strong public health function would be needed in each new health authority, led by a Director of Public Health (DPH) as a senior member of the corporate management team. The DPH was also to have ready access to advice from clinicians, including GPs and from other professionals. It was likely that, as the authority evolved into a public health organisation, public health skills would become disseminated more widely throughout the organisation and the DPH would function increasingly as a matrix manager, working in their professional functional and on multi-disciplinary project-based tasks at the same time.

Rationale for the Research

In general, the current experiences of the NHS follow general trends being experienced in European health care. These were summarised by Brazil (1996) as:

- a move away from universalism
- greater reliance on family and friends
- insufficient resources to fund public service demand
- acceptance of need for explicit rationing of public services

Additionally Brazil foresaw a blurring of professional boundaries with associated multi-skilling, faster changing technology and greater user involvement. Brazil identified five issues that European health care needed to address:

- how is the funding for health care to be organised?
- how is the work of professionals to be organised?
- what, in consequence, is the structure required?
- what outcomes are required?
- how are service providers to be held accountable?

Unlike most large organisations, the NHS has the government as its major stakeholder. This means that political and local imperatives can be in conflict with each other. Political and local imperatives can also be in conflict with clinical and non-clinical visions, values and cultures. As a result, behaviours may not always being predictable.

Individuals, teams and organisations usually set out to be effective - visions are agreed, strategies are developed, targets are set for excellent performance, and people trained for the tasks ahead and yet over time many organisations are often faced with a puzzle: *why do apparently well-intentioned, well-motivated people set out to be effective but end up dealing with each other in ways that result in mediocrity or failure?*

Buchanan & Huczynski (1997) saw this organisational dilemma as one of reconciling the potential inconsistency between individual needs and aspirations on the one hand, and the collective purpose of the organisation on the other. Buchanan & Huczynski acknowledged that organisations could not be treated as just logical or mechanistic since there were political systems in which individuals strive to achieve control over each other, to gain wealth, status and power.

One of the most basic of human instincts is survival and to ensure survival one of the basic human reactions to a threat is *flight or fight*. This reaction is instinctive and hard to keep under our own control. These threats may be to life or to livelihood. Either way, our reaction tends to be one of personal survival or to ensure survival of those to whom we have very close personal bonds.

As a state-run organisation the NHS frequently has the agenda for change imposed on it, and this has been especially so for many years. An example would be the capping of management costs for health authorities by the Department of Health. Decision-making about where savings had to be made were usually determined at health authority management team level and resulted in lower morale within those organisations. Kanter (1991) found that successful organisations were those that have not only been honest about what was needed but had also involved the employees in deciding what action to take.

In our working lives threats may arise from fears about job security, status, professional opinion or a number of other reasons. In a rapidly changing work environment the threats, real or perceived, may arise simply because of change itself and the general uncertainty it brings. There are many people who see change as providing new opportunities. There are also those who, seeing this change as a threat, form safety barriers around themselves and put promote themselves as being indispensable to safeguard their continued employment. To achieve this they are likely to regard knowledge as power - intellectual capital with which they can trade.

People may be able to overcome these barriers fully or partially if they have the motivation to do so. However, if they feel personally threatened in any way they will probably become defensive and develop defensive routines to safeguard themselves. The issues may be sufficiently sensitive that people are reluctant to discuss them and the issues then re-occur and behaviour becomes reinforced. These defensive routines are most likely to manifest themselves in interpersonal relationships and, if knowledge is felt by individuals to give them power, a reluctance to share knowledge for fear of jeopardising their own position.

Where knowledge is regarded as endowing the holder with power, the holder may be reluctant to share this *intellectual capital.* This may well result in an apparent inertia to organisations being effective despite good intentions and an apparent commitment by all to new ways of working, organisational change, re-engineering or other proposals which, on the face of it, ought to produce harmonious working arrangements and conditions. A good example of this reaction has been managers in hospitals not sharing information readily with health authorities (Wall, 1996).

Governments have introduced many important imperatives over the last few years e.g. Health of the Nation, and reduction in waiting times. These have inspired achievement in some parts of the NHS and abject failure to meet even basic standards in others. Good practice has been identified and shared at numerous conferences and seminars as well as being written up in journals. Task forces have been established and yet these spectres come back to haunt us as measures of performance and effectiveness often show that little has changed.

Changes in the NHS have been aimed both at making the NHS more 'competitive' and developing partnerships – alternately creating and then seeking to dismantle barriers. Hunter (1998) noted that the competitive market was to be replaced because of the dysfunctional behaviour and perverse incentives it had spawned. The local driving force for these changes within the NHS (as opposed to civil service channels) is usually through health authorities. Partnership is now a key theme in the government's plans for change and this puts a considerable burden upon a layer of management that has no direct control over the delivery of health care either through GPs, hospitals, community services or social services. This means that unless the organisation itself, and its relationships with partners are good, the chances of success are much reduced.

Health authorities have had the strategic responsibility for effecting change at local level. There are, however, real concerns that the suspicion and mistrust being expressed will create organisational, personal and professional barriers. These cause the development of interpersonal and individual-organisational barriers to organisational effectiveness in general and knowledge sharing in particular as individuals start to behave defensively towards those seeking to elicit knowledge from them.

Summary

The NHS has rarely had any periods of significant stability in which to fully implement and refine changes which themselves have been implemented largely by political will. The NHS has changed considerably since its inception in 1948 but the changes have continually resulted in discord, mistrust and scepticism between those who ostensibly should have been partners in health care. Until recently, hospital, community and Family Health Services have been planned and administered in relative isolation from each other, and in isolation from local authority social services. Development of empires was an inevitable result and as layers of bureaucracy were stripped away, many of those charged with implementing the changes may have felt that the constant and considerable upheavals made them nervous about personal futures, even though they may not have displayed these feelings publicly. Clinicians saw these changes as reducing layers of unnecessary and costly bureaucracy that would release money for direct patient care. Whatever the personal or professional agenda, relationships were poor and proposals for change often met with suspicion as to the motive. As a result, knowledge was often seen as representing power other than in a clinical environment where sharing knowledge was usually seen as acting in the best interests of patients.

This research was planned to:

- use Argyris' theories to identify the critical issues which might act as barriers to knowledge sharing and cause people to develop defensive behaviours toward knowledge sharing
- use theories relating to the psychological contract to assess the extent to which components of the psychological contract might influence defensive behaviours
- adapt an established framework for analysing organisational dynamics to account for *emergent* organisational dynamics
- develop a questionnaire that enables answers to the relevant research questions to be sought
- secure the commitment of one (or two) health authorities to applying the questionnaire to their organisation(s)
- use responses to the questionnaire to assess the extent to which barriers to knowledge sharing exist, and determine how these barriers have developed or been overcome
- use the outcomes of the research to inform organisational development needs and especially how knowledge sharing can be successfully encouraged
- assess the potential of the research outcome to inform the developmental needs of Primary Care Groups

The framework developed could evolve into a simple analytical tool for other organisations, especially PCGs, to assess the extent of defensive behaviour. This would result in improved organisational effectiveness as a result of facilitated knowledge sharing, enhance the planning, commissioning and delivery of health care interventions.

Summary

The NHS gives high levels of political, top-down direction to Regional Offices as civil service outposts of the NHS Executive and to health authorities (and latterly Primary Care Groups) as the lead in long and medium-term strategic health development and improvement. Operational service delivery and decision-making continues to reside with Trusts and General Practice. Models of planning, primary care delivery and influencing secondary care provision continue to focus on the primary care setting. Health authorities (and latterly Primary care Groups) therefore find themselves at the crossroads of primary care and secondary care planning and provision, whilst retaining responsibility for achieving longer term improvements in health gain, health improvement and redressing inequalities in provision.

Health authorities will need to ensure that they are 'healthy' organisations where all efforts can be focused on ensuring the future success of PCGs and other initiatives. Because health authorities are not direct patient care providers they have, arguably, they greatest need to acquire, share and use knowledge and information as their primary asset.

To achieve the necessary high levels of knowledge sharing it will be essential to identify and understand the barriers to knowledge sharing and then be able to develop individuals, teams and organisations accordingly. The psychological contract is a relatively new concept to the NHS, and Its potential to overcome barriers to knowledge sharing, and facilitate knowledge elicitation needs to be explored.

CHAPTER TWO

LITERATURE REVIEW

Introduction

In 1995 when this research was started there was very little published literature on barriers to sharing knowledge as an aspect of knowledge management. What was found focused on the technological aspects of storing and disseminating of knowledge. This technical focus was not that which was required for the research, the focus needing to be on knowledge elicitation and the barriers to sharing knowledge. This shortage of literature was confirmed by Scarborough, Swan and Preston (1999) when they undertook a literature review on knowledge management for the Institute of Personnel and Development (Table 1)

Table 1 BIDS-ISI (SSCI) – numbers of references to knowledge management and learning organisations

Search term	1993	1994	1995	1995	1996	1998 (Jan-Aug)
Learning organisation	9	15	20	13	20	(15)
Knowledge management	1	4	5	11	26	(21)

Scarborough, Swan and Preston p13

Up to 1998, a journal review by Scarborough *et al* found that out of 184 thematic references to knowledge management, just 9 (5%) were written with reference to human resource issues. The vast majority 124 (68%) were written with

reference to information technology or information systems and even in those with a strategic management or human resource management 44 (24%), Scarborough *et al* found that there was "a rather narrow IS (*Information Systems)* perspective".

The result has been that the 'people issues' and associated barriers to knowledge sharing have been poorly researched. This was surprising as Scarborough *et al* were later to describe this as "the bedrock of KM (*knowledge management)* initiatives". However, this researcher was encouraged, as the ability to add to knowledge was evident. In particular there were no specific references found by Scarborough *et al* or this researcher on topics directly addressing this area of research.

Organisation

This section defines 'organisation', introduces the four basic ideas that underlie the concept of 'an organisation' and the interrelation of these four ideas explored. A working definition of 'effectiveness' applicable to the NHS is developed and the concept of organisational effectiveness introduced.

Frameworks are then developed and used to analyse organisational forms and organisational dynamics applicable for the NHS. Barriers to the sharing and use of knowledge and information are explored and potential interventions for overcoming these barriers identified.

The Concept of 'Organisation'

Most people would probably be able to name an organisation familiar to them e.g. NHS, football supporters club or neighbourhood watch, but what makes a corporate body different from a club or just a group of people? Koontz, O'Donnell and Weihrich (1980) described an *organisation* as:

- an enterprise itself
- co-operation of two or more persons
- the internal structure of roles in a formally organised enterprise
- a system or pattern of any set of relationships in any kind of undertaking
- all behaviour of all participants in a group

Reber (1985) used the description:

- a characteristic of any complex system that reflects the degree to which it's several, structurally distinguishable parts are functionally co-ordinated and interrelated
- the process that operates so as to bring about such a co-ordinated system
- the system itself as it displays such properties

Buchanan & Huczynski defined *organisation* as:

> "social arrangements for achieving controlled performance in pursuit of collective goals"

These definitions propose that an organisation is a complex set of interactions between two or more people, in an enterprise that has a structure, and

within which there is co-ordination of effort. Each individual has unique skills, knowledge and experiences that when combined with those of other individuals, creates a situation where the whole is greater than the sum of the parts. Although implied, these definitions do not reflect this division of labour. Similarly there seems to be an assumption that those people working together are doing so in the pursuit of a common goal or purpose to which they are individually committed.

Individuals usually lack the ability to satisfy all of their own needs and wishes. However, when skills, knowledge and experience are pooled, and individual efforts are co-ordinated, outputs and outcomes can be achieved that individuals would have been unable to achieve on their own. This is the first of four basic ideas underlying the concept of organisation that Schein (1988) proposed. The idea of *co-ordination of effort in the service of mutual help*, implies that those working together are doing so willingly and have a shared vision of why they are working together.

The second basic idea Schein proposed was that people work together for the achievement of common goals (purpose or objectives) to be achieved through co-ordination of effort.

To achieve these common goals reliance is placed upon individuals with different skills, expertise and knowledge being grouped into small units within the organisation that satisfy particular needs of the organisation. These smaller units may be functionally and/or geographically separated. This *division of labour* is the third idea that Schein suggested was common to organisations.

It is the fourth and final idea that Schein proposed was that if labour is to be differentiated through division of labour, then to achieve co-ordination requires *integration* to ensure that all the smaller units are working towards the common

goals, purpose or objective (Schein). This fourth idea defines an organisation and implies that the *smaller units submit to some sort of authority for the greater good of the organisation as a whole, most typically through a hierarchy of authority*.

The ideas and concepts proposed by Schein address the issues implied but not reflected in the earlier definitions of *organisation* and were summarised by Schein and formed the definition of *organisation* that has been used during the course of this research.

It should be recognised that the concept of *organisation* does not imply that it is actually achieves what it set out to achieve, nor does it imply that what it sets out to achieve actually benefits those inside or outside the organisation. It also assumes that organisational and individual competencies have been assessed and are adequate to achieve the desired outputs or outcomes. For example, it assumes that human beings have the requisite skills to interrelate perfectly. Personal experiences suggest this is not always the case and yet relationships have not formed a major part of social analysis until comparatively recently (Schlutter & Lee, 1993). Cooper & Williams (1994) found that healthy organisations were not created by accident. However, many of the theories for change, organisational development and programmes for organisational audit appear not to adequately address these issues and explore why people act defensively with each other and with organisations of which they are part.

There are several different types of organisation and these need grouping so that characteristics and robust comparisons can be made. Blau and Scott (1962) described four types of organisation and associated benefits:

Mutual-benefit associations: those that benefit primarily the members of the organisation, the rank and file (for example, unions, clubs, political parties, religious sects, and professional societies)

Business concerns: Those that benefit primarily the owner-managers (such as industries, stores, banks, and insurance companies)

Service organisations: Those that benefit primarily their clients (for example, hospitals, schools, social work agencies)

Commonwealth organisations: Those that benefit the public at large (government organisations, such as the Internal Revenue service, Defence Department, police, fire department, and research organisations)

Using the above definitions, the NHS could be defined as a *service organisation*.

Summary

'Organisation' implies that there is some type of formal organisational structure, accepted as legitimate by those it employs in order to integrate the different parts. 'Organisation' also implies that differences in profession and function are accepted i.e. differences in culture, values and beliefs are known and understood such that they do not form barriers to mutual help or common goals and that this allows full co-ordination of effort.

Personal experiences suggest that full conformance to these ideas is seldom achieved unless the organisation has especially strong or influential purpose or goal(s). This may occur where members of the organisation have bonds between

them that override any personal differences either because of affiliation e.g. religious organisations, professional organisations, fear e.g. criminal gangs or exceptional legitimacy of the hierarchy of authority e.g. armed forces.

It is therefore essential to understand the structure of organisations and the dynamics between the ideas and concepts that define 'organisation'. From individual perspectives it is essential that motivational concepts are understood and especially what barriers there might be to people working well together, and in particular what barriers there are to the sharing and use of knowledge for health authorities.

Effectiveness

It has been identified that being organised does not imply that an organisation achieves what it sets out to achieve, and whether this simplistic definition of *effectiveness* is valid for the purposes of this research.

At the top level Tomkins (1987) found that there were few generic definitions of effectiveness found in the literature. Tompkins used the definition:

> " Effectiveness may be defined as how well a programme or activity is achieving its stated objectives, its defined goals (e.g. targets, market share or other intended effects). "

Tomkins' definition does not explicitly reflect the need for an organisation to meet responsibilities to other interested parties outside its organisational boundaries.

In the NHS there are many checks and balances to ensure that purpose and objectives are legal, ethical and legitimate. The annual strategic and operational planning arrangements together with, for example, national Planning and Priorities

guidance, regional office reviews of health authorities and Trusts, the open nature of health authority meetings, the public interest in health issues and much NHS information being in the public domain ensure that purpose and objectives are appropriate. It is reasonable, therefore, to define effectiveness in the NHS as achieving what it set out to achieve. For the reasons stated above the following definition by Armstrong (1994) will be used to describe *effectiveness* of an organisation:

> "An effective organisation can broadly be defined as one that makes best use of its resources to attain high levels of performance, thus successfully achieving its purpose and objectives while also meeting its responsibilities to its stakeholders"

It should be noted that although a definition of *effectiveness* has been made, its measurement might be somewhat elusive.

Performance management has become an increasing focus for the NHS. However, until the late 1990s, effectiveness in the NHS had largely been measured on the basis of outputs rather than outcomes of healthcare interventions although the use of Health of the Nation Outcome Indicators was believed to be a welcome example of future emphasis. Some innovative work has been done internationally on Outcome Related Performance Indicators (ORPIs) but this is still in the academic stage.

One of the key factors upon which effectiveness of organisations was believed to be dependent was the management of relationships between health care partners. The management of conflict has been explored (Fritchie and Leary 1996) but this appears to be somewhat after the event. Early evidence in the research suggested that together with *managing relationships*, there were two other factors of *knowledge* and *self-reference* that together formed *emergent dynamics*

that defined a focus for organisational development in successful organisations in the future. A review was made in the research as to how a diagnostic framework might be developed against which 'health checks' could be made by a Health Authority in this respect.

Summary

The assessment of 'effectiveness' is complex and does not readily lend itself to being defined at a top level as Tompkins found.

The generic description proposed by Armstrong is to be used for the purposes of this research. This description encompasses the nature of the NHS and the ways in which Planning and Priorities Guidelines, corporate contract development, performance management and review, and national performance tables provide the necessary checks and balances to ensure that any NHS organisation is 'successfully achieving its purpose and objectives while also meeting its responsibilities to its stakeholders'.

The assessment of 'effectiveness' and performance can be assessed in different ways by the various stakeholders in the NHS. Outcomes rather than outputs will become increasingly important as measures of effective health care planning and delivery.

'Management of relationships', 'knowledge' and 'self-reference' have been identified as emergent organisational dynamics that were a focus for future organisational development.

Organisational Effectiveness

To be effective organisations need to manage a number of competing issues. All organisations exist in an environment which puts certain demands upon them and into which they offers services and/or products. To survive in the longer term the organisation must provide something useful i.e. a benefit to someone inside or outside the organisation.

Organisations set out to be effective and yet Boldy *et al* (1996) concluded that there was no empirical research specifically related to national definitions of organisational effectiveness and that there were significant variations in perception of what constituted *effectiveness* when comparing responses from those inside the NHS and those in government. Tomkins (1997) found that *effectiveness* tended to be measured by centrally implemented public sector controls for public sector organisations and by the organisation's goals. The Chartered Institute of Public Finance and Accounts (CIPFA) (1994) found a need for increased emphasis on getting performance indicators that reflected real success in meeting needs. Smith (1993) concluded that public sector control was more difficult than in the private sector and found five difficulties particularly resistant to resolution in the public sector:

- getting consensus as to what the output and objectives should be
- measuring outputs and outcomes of intervention
- interpreting any output or outcome measures that can be produced
- persuading the public to take any interest in these measures or their meaning
- ensuring public sector managers use outcome related performance indicators (ORPIs) in positive and not perverse ways

Outcome management initiatives such as ORPIs have been proposed to improve effectiveness but both Guadagnoli and McNeil (1994) and Proenca (1995) concluded that ORPIs had been unable to substantially improve the performance of health care organisations. Proenca suggested the possibility that health care organisations might develop outcomes management structures to meet the approval of those that determine their fate rather than to improve outcomes although some empirical research was suggested to test these links. Outcomes management in a team environment where this was understood would be recognised by the existence of outcome measures that were achieved and where individuals and teams had a *self-reference* framework that was built on an understanding of the organisational environment, vision, mission etc. *Provider compliance* would also be evident. Outcomes would also be framed in ways that were consistent with the core beliefs of members of the organisation.

Dawson *et al* (1995) concluded that effectiveness was also determined by expectations of stakeholders, patients and carers which have been raised by Patient's Charters and hospital league tables. Proenca saw encouraging and measuring change in patient satisfaction as an essential ingredient in measuring effectiveness. For this and other reasons Osborne & Gaebler (1989) argued that there should be more ownership and control of public sector institutions by the public rather than by bureaucrats and government professionals.

CIPFA, Proenca and Carle (1996) have concluded that for organisations to be effective employees would increasingly and continuously need to contribute to 'learning and doing'. The link between learning organisations and knowledge management was firmly made by Scarborough, Swan and Preston (1999) who undertook their review of knowledge management literature on behalf of the

Institute of Personnel and Development. O'Brien *et al* (1995) investigated the learning dimensions as part of Continuous Quality Improvement (CQI) and characteristics of effective organisation-wide effort. This research highlighted the importance of aligning four dimensions (Structural, Cultural, Strategic and Technical) and not over- or under-emphasising any particular one (Table 2).

Table 2 **The dimensions of CQI and Characteristics of an Effective Organisation-wide Effort**

Technical Dimension	Cultural Dimension	Strategic Dimension	Structural Dimension
• Solid foundation of CQI expertise among staff • Ability to recognise opportunities for improvement • Comprehensive understanding of how services are produced and delivered • Routine use of expertise in daily work	• Commitment to a shared purpose • Commitment to scientific principles and practices • Teamwork, co-operation and participation • Flexibility • Continuous learning	• Strategic plan and CQI efforts integrated • CQI efforts devoted to processes that are central to achieving strategic priorities • Roles and responsibilities defined in terms of integrated strategic and quality-related goals	• Efficient and effective steering council • Information systems; easily accessible data • Single department to facilitate CQI • Structures in place to diffuse learning throughout the organisation

O'Brien *et al* – 1995

Research by O'Brien *et al* identified that when cultural aspects were under-emphasised, efforts were not directed at solving inter-departmental problems either because the organisation did not have the culture to sustain change or because staff effectively block implementation. This *turfism* described by O'Brien *et al* is similar to the defensive routines described by Argyris.

Birchall and Lyons (1995) researched links between personal and organisational competence and effectiveness. They concluded that organisational

competence came about when the appropriate technology, appropriate management processes and collective learning were present. However, they also found that these were not easily observable and that barriers to collective learning included lack of the recognition of need, functional and geographic divisions, risk-averse cultures, and lack of example and encouragement from those in leadership positions.

Proenca hypothesised that for organisations to use ORPIs effectively particular organisational features would need to be in evidence. These features were:

1. **Organic structures not mechanistic structures:**
    - Employee involvement
    - Supportive not controlling orientation

2. **Organisations with information cultures that emphasise the following are more likely to promote information sharing behaviours:**
    - mutual respect
    - trust
    - teamwork
    - delegation
    - autonomy
    - empowerment

3. **Success in changing to culture conducive to information seeking, sharing and using information if change efforts are:**
    - linked to organisational survival
    - spearheaded by a *popular personality*
    - perceived as being voluntary

4. **Organisations will increase provider compliance if outcomes management initiatives are complemented with a teaming environment that improves comprehension.**

5. **Compliance increased where outcomes management initiatives are framed in and consistent with core beliefs of Organisation members**

A Model for Analysing Organisational Dynamics

In this section a model is developed for analysis of organisational dynamics to accommodate emergent organisational dynamics of knowledge and information, relationships and self-reference. Definitions of the elements in the organisational analysis model are made.

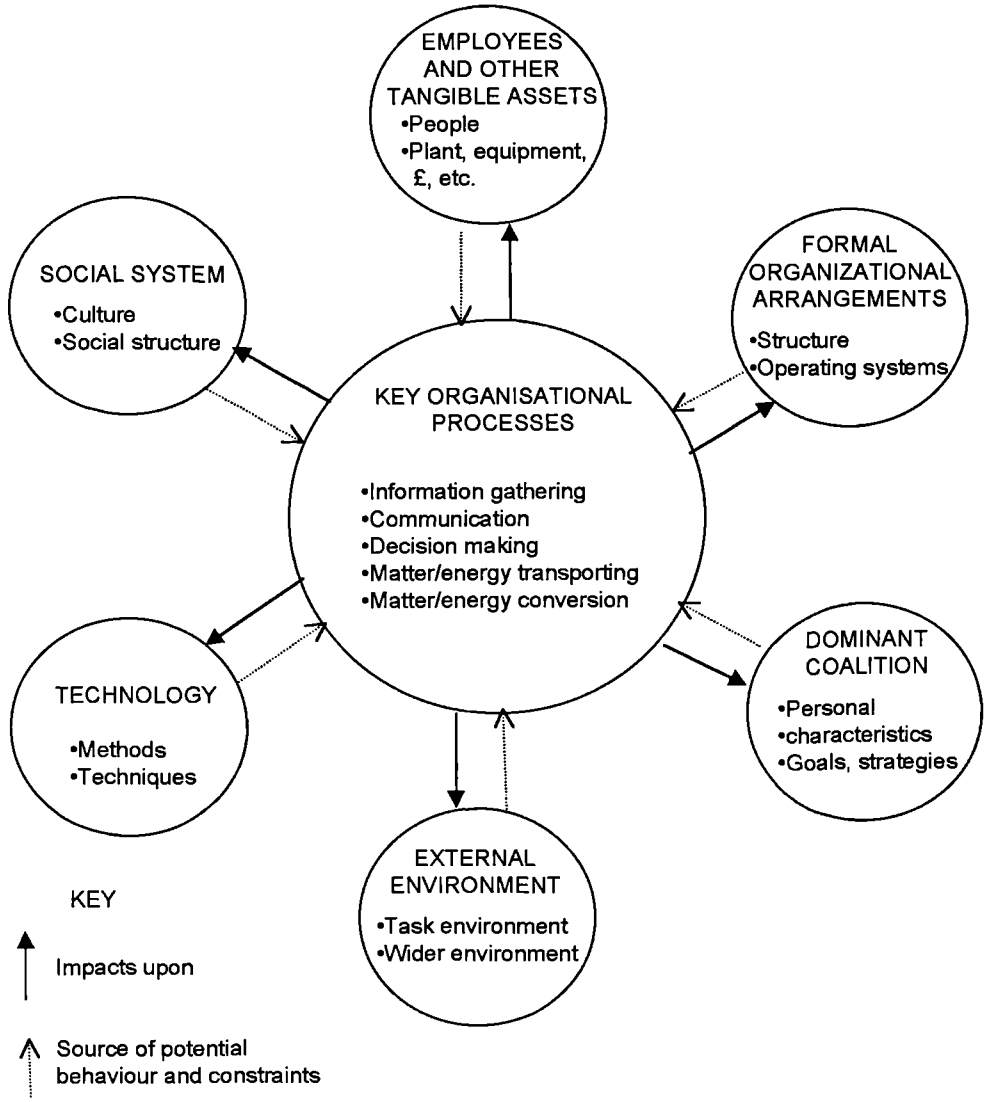
One of the problems faced by those seeking to analyse organisational dynamics is the lack of overview models to diagnose what is going on (Schein). Schein (1988) makes reference to the model developed by Kotter (1978) and which Schein adapted (Figure 1). This model was based on six basic conceptual elements.

What Kotter, Schein and other theorists could not have foreseen a decade ago was the rapid expansion in the volume and accessibility of information, and opportunities that information technology in particular made possible, to change the ways in which business is now transacted and organisations consequently structure themselves in response or anticipation.

The development of knowledge- and information-reliant organisations and the opportunities offered by information technology to move away from the

conventional office-based organisational structures have been both rapid and frequently unpredictable other than in general terms.

Figure 1 Adaption of Kotter's model of organisational dynamics



It is clear that knowledge and information sharing will become even more necessary for effective organisations in the future as people increasingly work using networks and virtual offices. The more dissociated the organisational arrangements, the more important it has become to communicate well, have good

relationships and have a clear personal reference framework of personal, professional, organisational and customer values, culture and beliefs.

Kotter's model could therefore be expanded to incorporate the three additional ***emergent*** organisational dynamics of knowledge and information, relationships and self-reference.

Kotter highlighted the potential existence of both short term and longer-term organisations. His model accommodates both short-term organisational dynamics (up to a few months) as well as moderate and long-term dynamics. For short-term dynamics Kotter identified that his model had cause-effect relationships with just four of the basic conceptual elements – *formal organisational arrangements, external environment, employees and other tangible assets* and *social system*. For moderate and long-term dynamics Kotter's model has a cause-effect relationship with all the basic conceptual elements. This suggests that there is a basic *organisational framework* that must exist in order for an organisation to function at all and is a pre-requisite to longer-term survival and effectiveness. From Kotter's model of short-term organisational dynamics the elements of this organisational framework emerge as:

- formal organisational arrangements
- external environment
- employees and other tangible assets
- social system

Lamming (1993) also stressed the importance of short- and long-term dynamics. He identified *power, co-operation, closeness* and *expectations* as short-term dimensions that needed satisfying and *institutionalisation, adaptations* and

relationships as dimensions that needed satisfying for longer-term survival. Lamming also identified *environment* and *atmosphere* as other essential dimensions. He described *environment* as "market structure, dynamism, internalisation and social system". *Atmosphere* he described as "power/dependency, co-operation, closeness and expectations".

Summary

An organisation can be established to satisfy just a short-term goal or be established to satisfy both short- and long-term goals. Survival in the short-term is common to both and suggests that there is a basic organisational framework that must exist as a pre-requisite to longer-term survival, effectiveness, growth, development and response to a rapidly changing world as part of overall organisational dynamics.

Organisational Framework

This section describes in more detail the organisational framework identified as a pre-requisite to organisational existence. A model of organisational framework is synthesised from the Kotter's full model for analysing organisational dynamics. Key characteristics of organisational structures are identified and their effect on organisational dynamics assessed. The impact of environmental influences is explored and the impact that employees and other tangible assets can have on organisational dynamics is identified.

Synthesis of a Model of Organisational Framework

Analysis of Kotter's Model identifies that just four of the basic elements have cause-effect relationships and form an organisational framework essential for short-term survival of an organisation.

These are:

- formal organisational arrangements
- external environment
- employees and other tangible assets
- social system

Formal Organisational Arrangements

" We shape our houses and our houses shape us"

Winston Churchill (attributed)

Nunn (1994) stressed the need to recognise that trends were now towards organisational structures that needed to make the most of people's skills and knowledge. Mintzberg (1979) explored the influence of organisational structure on effectiveness and in particular on individual and team dynamics. Building on the work of other theorists he proposed five types of *organisational form* (Kotter's *formal organisational arrangements)* of which the *adhocracy* form was the one he suggested was now prevalent in most organisations (Table 3). Mintzberg found the adhocracy form to offer many potential advantages in terms of its flexibility to change, the ability to maximise along several dimensions, strong cultures and empowered employees. Potential disadvantages include unpredictability, inefficiency, potential inconsistency and employee stress. Mintzberg extended the

adhocracy form into six sub-forms each having advantages and disadvantages in terms of the potential way people dealt with each other and barriers that existed or developed as a result. These are summarised in tables 3, 4, 5 and 6, with advantages and disadvantages categorised by the conceptual elements that Kotter proposed for organisational analysis, adapted to take account of emergent organisational dynamics. Buchanan & Huczynski also concluded that human consequences depended upon how organisations were designed and run.

It is important to differentiate between these different types as many people refer to all these forms generically as *matrix* and make links to the matrix structures of the 1970s and 1980s. These early matrix structures were frequently impositions on existing functional hierarchies and no real organisational change was usually associated with the introduction of the matrix arrangements. This frequently meant that functional power co-led with other power centres in the matrix resulting in conflict and confusion. Those at the top of the functional tree frequently exerted their decision-making power thus usurping any decision-making abilities that may have usefully been within the matrix.

Whitfield (1999) found that senior managers were concerned about a return to a *command and control* culture in the NHS and that some managers were now having difficulty in coping. Whitfield interviewed health authority and Trust Chief Executives on the issue of having to continually bid for funding for initiatives. All spoke on condition of anonymity. There was widespread support for government initiatives but concern over the volume of guidance. One Chief Executive was quoted as saying the Department of Health "are pulling levers and seem not to have noticed that they are not necessarily getting the desired effect, or any effect, at the other end". Whitfield found that managers were dealing with guidance by

"ignoring it.....or delegating ruthlessly". One health authority Chief Executive as saying the Department of Health were "writing for the people who last shouted most loudly".

Table 6 **Expansion of Mintzberg's *adhocracy* form aligned with the basic elements of Kotter's model**

		FLEXIBLE	DYNAMIC NETWORK
	Size >>	Any	Small
	Environment >>	Moderate to high uncertainty	Moderate to high uncertainty
	Kotter basic elements		
Key Dimensions of Organisation		• Multi-skilled staff • Flexible pay and rewards • Contract & part-time workers	• Reliant upon other organisations for delivery of key business areas • Information sharing essential • Managers 'broker' instead of traditional planning and direction • Members must be willing to co-operate • Strategic alliances essential • Clear reference frameworks essential
Advantages	Key organisational processes Formal organisation arrangements External environment Social system (Information and) Technology Dominant coalition Employees and other tangible assets	 • Gives teams scope to respond to new demands • Less concern about sick pay, bonuses etc. • Unsatisfactory non-permanent workers can be easily discarded	• Entrepreneurial in character • Flexibility • Readily adaptable to changing environments • Less capital intensive • Lower overheads
Disadvantages	Key organisational processes Formal organisation arrangements External environment Social system (Information and) Technology Dominant coalition Employees and other tangible assets	 • Staff usually have less training • Casually employed staff often lack commitment to their work • Morale may be low	• Have to rely on full disclosure • Less control over production process • Vulnerable to competition from suppliers • Less security of supply • Survival depends on trustworthy transactions • Volatile earnings

Table 5 Expansion of Mintzberg's *adhocracy* form aligned with the basic elements of Kotter's model (continued)

		MATRIX	HYBRID
	Size >>	Moderate	Large
	Environment >>	High uncertainty	Moderate to high uncertainty
Key Dimensions	**Kotter basic elements**	• Variable technology	• Routine or non-routine technology
Advantages	Key organisational processes Formal organisation arrangements External environment Social system (Information and) Technology Dominant coalition Employees and other tangible assets	• Lots of communication between managers with similar interests • Project teams can be disbanded immediately after completion • Departmental boundaries do not interfere with the completion of projects • Achieves co-ordination necessary to meet dual demands of environment • Suited to an unstable environment • Flexible use of resources • Specialised professional knowledge relevant to the project is available • Contributes to high innovation	• Complex webs of communication formed • Can process information in multiple directions • Allows organisation to achieve efficiency in functional divisions • Allows organisation to achieve adaptability in product divisions • Results in better alignment between corporate level and divisional level goals
Disadvantages	Key organisational processes Formal organisation arrangements External environment Social system (Information and) Technology Dominant coalition Employees and other tangible assets	• Complex and slow decision making • Unclear accountability • Duplication of effort across the organisation • Teams rather than individuals are appraised • Role conflict due to dual loyalty • Needs high level of inter-personal skills • Time consuming	 • Leads to conflict between divisions and corporate departments • Key managers may be severely over-worked • Has potential for excessive administrative overhead

Table 4 **Expansion of Mintzberg's *adhocracy* form aligned with the basic elements of Kotter's model**

		FUNCTIONAL/ PROCESS	GEOGRAPHIC/ PRODUCT
Size		Small to medium	Large
Environment	**Kotter basic elements**	Stable, little uncertainty	Unstable, moderate to high uncertainty
Key Dimensions of Organisation		• Routine technology	• Non-routine technology
Advantages	Key organisational processes Formal organisation arrangements External environment Social system (Information and) Technology Dominant coalition Employees and other tangible assets	• Simple communication network • Economies of scale • Simplifies training • Concentration of expertise	• Decentralised decision making • Risk reduction across range of products • Adds flexibility to structure • Allows units to adapt to differences in products, regions, clients • Increased customer satisfaction • Is suited to fast changing and unstable environments • Develops broadly trained managers
Disadvantages	Key organisational processes Formal organisation arrangements External environment Social system (Information and) Technology Dominant coalition Employees and other tangible assets	• Top decision overload • Co-ordination across functional areas is difficult and costly • Slow to change • Professional loyalty rather than customer/product loyalty • Results in less innovation	• Decreased communication • Contributes to duplication of services in each division - elimination of economies of scale • Divisions may develop at unequal paces • Leads to poor co-ordination across divisions • Product standardisation difficult • Divisional rather than company loyalty • Lose in-depth skill development

Table 3 **Mintzberg's *five organisational forms***

	ENTREPRENEURIAL/ SIMPLE	MACHINE BUREAUCRATIC	PROFESSIONAL BUREAUCRACY	DIVISIONALISED	ADHOCRACY
Size of organisation	Small	Large	Medium to Large	Very Large	Medium to Large
Environment	Simple and dynamic	Simple and stable	Complex and stable	Diversified by product or market but relatively simple and stable	Highly complex and dynamic
Key Dimensions of Organisation	• Top management	• Technical support staff	• Professionals; • Administration staff	• Middle management	• Technical professionals • Support staff • Team based
Product/Size	Simple; single product	Relatively simple; Single product	Relatively complex; Often service orientated	Diversified; Multi-product/service	Diversified; Multi-product/service
Formalisation	Little formalisation	Extensive formalisation		Quite formalised within division	Not formalised
Advantages	• Low cost • Work is responsibility of all members • Accountability is clear • Adaptable	• Efficiency • Work specialisation • Economies of scale	• Efficiency • Work specialisation • Economies of scale • Professional autonomy and control • Strong culture	• Meets needs for many different product lines • Autonomous divisions	• Flexibility to adapt to change • Ability to maximise along several dimensions • Strong culture • Empowered employees
Disadvantages	• Limited capacity to cope with complexity • Power concentrated in one person	• Lack of innovation • Employee alienation • Weak culture • Less adaptable	• Long training • Less adaptable	• Duplication of activities leads to higher costs and decreased efficiency	• Unpredictability • Inefficiency • Potential inconsistency • Employee stress

Early matrix structures were often imposed by senior management and introduced with insufficient thought given to the workforce and how to motivate them to change, especially in relation to attitudes. As a result, accountability became blurred. Decisions tended not to be made or, if made, were of a low order so as not to incur criticism or over-ruling by functionally senior managers. Scott & Jaffe (1991) showed that top-down imposition often makes people negative, afraid to take risks, be innovative or try new things.

It has been argued that matrix management was before its time (Bullet Point, July-August 1995). This Bullet Point review pointed out that matrix management was copied from the US aerospace and computer industries during the *space race* era. In this environment of project-based team working, matrix management worked well because of many factors that today would seem familiar:

- stretch goals
- ever tightening schedules and deadlines
- rapidly changing technology
- need to utilise effectively alerted and costly organisational resources
- diverse groups of people working to achieve results
- dynamic, changing, hectic work environment
- strong competition

Proposed change is often supported by arguments that reflect the advantages. However, it is the disadvantages that will potentially create barriers to organisational effectiveness in general and the sharing and use of knowledge in particular. However, many of these disadvantages are not adequately addressed,

particularly as several are those issues that are undiscussable and/or reflect turfism. Birchall and Lyons (1994) found the causes of failure in networked organisations to be:

- **In stable networks:** The benefits are oversold to partners and false expectations created
- **In dynamic networks:** Culture clashes often become apparent some time after the initiation of the relationship
- **In internal networks:** Individuals who are not constantly learning how to set up relationships and manage them better do not result in successful organisations

Many organisations currently experiencing such pressures have revisited matrix management but have not given adequate regard to the people issues. The move to multi-functional teams has been seen by these organisations as providing empowered, cross-functional, self-managed teams. This represents a new way of working with skills and measurement disciplines built in.

However, many organisations have decentralised structures on paper but in practice become re-centralised because of dominant factors, such as finance, through complex centralised control systems (Peters1989). Today's matrix organisations are seen as:

- being people-led not systems or science-led
- making clear that functions follow process, product and project and not vice-versa
- stressing co-operation and simplicity

- giving most power to product managers; geographic and functional management being relegated
- being flexible so that the matrix can evolve over time
- not just being limited to product, geography and function but also stretching to include customers, markets, technologies, service units and external alliances
- using thinking; matrix *structures* seen as unwieldy but matrix *thinking* as inescapable.

It is therefore important to identify which type of organisational form, or forms, exist. The advantages and disadvantages can then be identified and associated strengths and weaknesses of, opportunities for, and threats to organisational effectiveness dealt with appropriately. What can readily be identified in some organisations is that there are dichotomies as to which organisational form or forms are being used.

This risk is that without clarity, and an agreed developmental path, the organisation will become a melting pot in which any or all of these forms may develop without any understanding of the organisational dynamics that may form barriers to it being effective in general and the barriers to knowledge sharing in particular. The risks are that advantages will be minimised and disadvantages maximised resulting in defensive behaviours both individual and organisational. Even if these risks are minimised, organisations have built-in protective devices to maintain stability (Katz & Khan, 1966).

Alignment models of organisational form suggest that by satisfying (aligning) specific organisational factors, the effectiveness of organisations is more likely to be in evidence. In the 1980s McKinsey's '7S' model suggested the need to align

Strategy, Shared values, Skills, Staff, Systems, Style and Structure. Morton (1991) recognised the influence of emerging technology to suggest five interrelated factors: Strategy, Structure, Technology, Management processes, and Individuals and roles. O'Brien *et al* highlighted the importance of aligning four dimensions (Technical, Cultural, Strategic and Structural) and not over- or under-emphasising any particular one. Characteristics of organisations that over- and under-emphasise these dimensions are shown on Table 7:

Table 7 **Characteristics of organisations that over- and under-emphasise the dimension of CQI**

Dimension of CQI	Issues encountered when under-emphasised	Issues encountered when over-emphasised
Technical	• Projects likely to flounder because of lack of expertise or experience • Inappropriate use of tools	• Over-reliance on adherence to project methodology • Greater concern with collecting appropriate data than solving problems
Cultural	• Projects avoid problems that cut across departments • Root causes of problems avoided due to lack of trust or communication • Staff block implementation of solutions requiring changes in routines; "turf" issues • Improvements not long-lasting	• Tendency to wait on actively doing quality improvement work until the culture has changed • An over-emphasis on process to the neglect of substantive issues
Strategic	• Pockets of uncoordinated activities and projects throughout the organisation • Little overall organisational effort • Employee motivation wanes because projects are not strategically important	• An over-emphasis on cost-cutting activities • Neglect of spontaneous quality improvement efforts by lower-level employees
Structural	• Project recommendations not acted on for long periods of time • No system to prioritise efforts • Inability to transfer learning across groups, divisions and settings	• Inflexible bureaucracy

A limitation of these and other alignment models is that it is not always clear what the words and language used to describe these factors actually means (Morton). In spite of many articles and books having been written on the subject of emerging organisational forms we are still at an early stage of understanding or agreeing its true nature (Morton).

There is a need for more research into the dynamics and effects of new organisational forms (Porras and Silver, 1993), especially in the NHS, and explore the link between downsizing and morale (Oakley and Greaves, 1995). Rajan, Lank and Chapple (1998) and Calder (1998) also found that extensive delayering and downsizing in the 1990s had resulted in the loss of *corporate memory* (retained organisational knowledge) and informal networks. Walshe (1998) found that nearly half of all NHS managers were showing worrying degrees of stress with lower rates of psychological disturbance being evident in smaller health trusts and where there was greater co-operation, better communication, more monitoring of performance and a stronger emphasis on training and on allowing staff increased control and flexibility in their work. Walshe called for the creation of a culture in which staff were valued. *Organisational form* can therefore be assessed as *healthy* if the following are satisfied:

- Organisational arrangements predominantly organic/network in nature with the minimum of functional arrangements and/or arrangements that fail to integrate geographic teams
- Management decisions should be made, and felt by employees to be made, at appropriate levels of managerial responsibility
- The power-base structure should not be significantly different from that which might reasonably be expected
- The organisation achieves what it set out to achieve

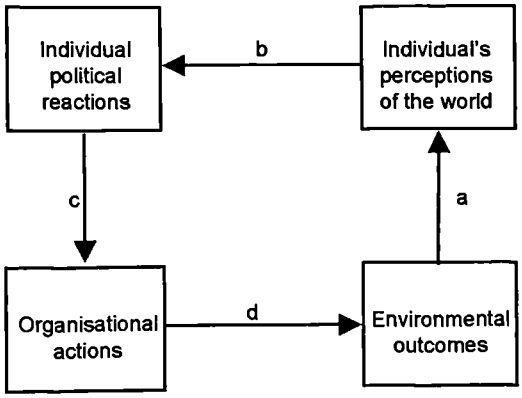
External Environment

> "The major misconception is the failure to recognise fully that the organisation is continually dependent upon inputs from the environment."
>
> **The Audit Commission**

Organisations have a symbiotic relationship with their environment that is a determinant of organisational structure that changes dynamically over time (CIPFA, Argyris). Senge (1990) found that to remain competitive and effective, organisations needed to learn faster than their competitors. Kanter (1991) suggested that the principal management task of the 1990s would be outward looking, concerned with all the things happening outside the organisation to which it should "respond and not ask".

Hofstede (1984) stressed the importance of taking individuals' perceptions of the world into account and CIPFA concluded that there needed to be an increased emphasis on consulting service users in public bodies compared with private companies. Dawson *et al* stressed the importance of maintaining stakeholder confidence that Smith found considerably more complex in the public sector compared with the private sector. Hofstede's cybemetric model of organisational control (figure 2) demonstrated links between stakeholder and environmental influences on organisations. His model of organisational control could be argued to be supportive of the 'push-pull' model developed by Zairi and Leonard (1996) and of the use of Outcome Related Performance Indicators - ORPIs (Proenca):

Figure 2 **Cybemetric model of organisational control**

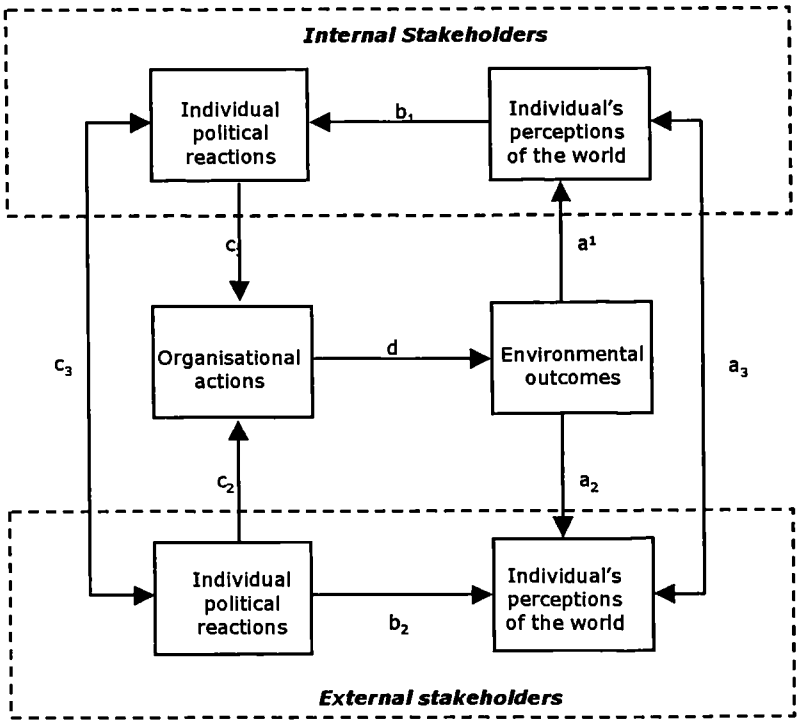


Hofstede argued that environmental outcomes shaped individual interpretations of the outcome of public sector activity. This process would be undertaken within a NHS organisation and external to it by consumers and other stakeholders. These interpretations were most likely to be reflected in local or national voting or other political influences such as lobbying of MPs. Moving political reaction into organisational action is complex and arguably not well understood (process 'c'). Finally, organisational actions result in an environmental outcome through a programmed changed (d).

Hofstede's Model is simplistic and assumptions that, for example, an individual's political action is always effective seem poorly founded. Furthermore, the model omits the reflection of internal versus external (to the organisation) perceptions that may be different and require processes of validation for actions and reactions to take place effectively. This appears particularly applicable for the NHS where public perceptions are frequently based on outputs and outcomes that may be interpreted without being in context or without complete information or

understanding. Hofstede's model could be adapted to reflect these additional influences (figure 3).

Figure 3 Adaptation of cybemetric control model to reflect internal/external stakeholder split

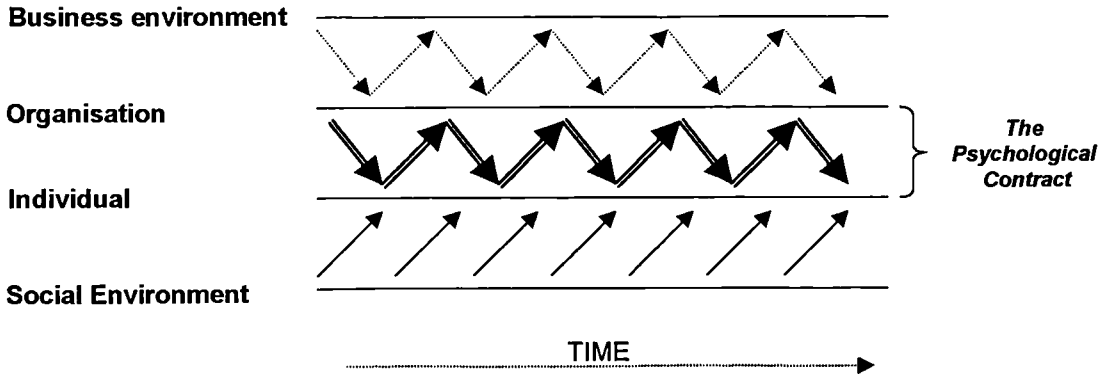


In this model internal stakeholders and external stakeholders may each use their own indicators to shape their respective views of outcomes but processes a_3 and c_3 then allow external stakeholders to contribute to, and gain feedback from the organisation. In this way a shared understanding of priorities and constraints could be developed. Outcomes and actions/reactions are also more robustly interpreted and a greater mutual understanding of issues developed. This approach acknowledges personal *turf* and the values and beliefs that underpin defensive routines. The model could be further developed to account for relationships with all internal and external stakeholders e.g. family doctors, carers,

and providers of healthcare into a multi-dimensional model which demonstrates the complexity particular to the NHS. This management of relationships is believed to be one of the key features of effective organisations. Faucheux and Mákridakis (1970) argued that the environment is too complex to formally model and suggested that a constant dialogue was needed between people and between people and their environment. The views of Faucheux and Makridakis are not necessarily in conflict with those of other theorists and researchers since there are common requirements for communications, management of relationships and the personal capacities for self-reflection, defining one's own boundaries and developing a sense of belonging.

Herriot (1992) described the environment for employees in this decade as "careering through the 90s". Herriot drew the distinction between internal and external environmental pressures and represented this as shown in figure 4.

Figure 4 "Careering through the 90s"



Herriot p9

Herriot made the point that cultural change and commitment were often expected by organisations but they failed to take account of individuals' points of view. To overcome this Herriot made reference to a 'psychological contract'

between employers and employees whereby their employer met their career aspirations. Herriot used the example of people whose career expectation was being able to meet patients' health care needs in the NHS. Herriot found that this need was not met where there was an overriding requirement for the organisation to be cost efficient and as a result the required cultural change would not then take place. Evidence by Rigby to the Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine (1998) suggested there were strong links between staff shortages and low morale because of the "much bruised, psychological contract between professional staff and the NHS".

Pollock (1993) describes this approach as one *of psychological effectiveness* that he saw as both a process and a goal:

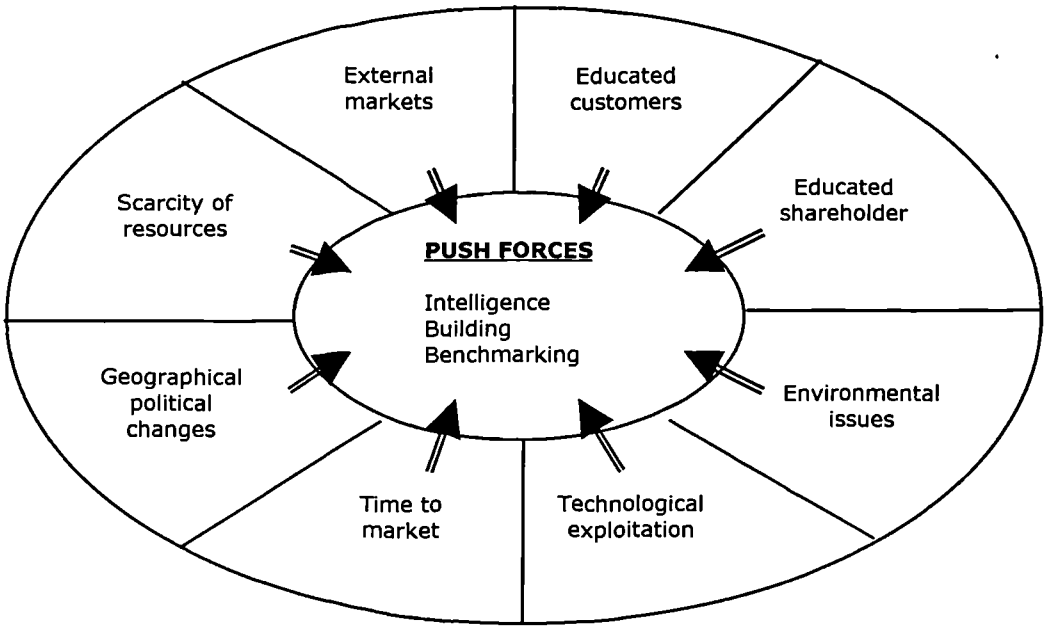
- a process of creating conditions and opportunities in which people can work together in a spirit of co-operation to establish and accomplish common goals and objectives

- a goal of creating organisations in which trust, dignity, respect and basic democratic values are standards of personal conduct

Prickett (1998) also stressed the importance of increasing staff morale through buying their loyalty with career opportunities and also saw team building and multi-skilling to be important. Prickett especially saw the need for managers to be trained in core skills and process development.

The environmental *best fit* is described well by the Push-Pull model developed by Zairi and Leonard and shown in figures 5 and 6:

Figure 5 Push-pull environmental model – stage 1: Demand



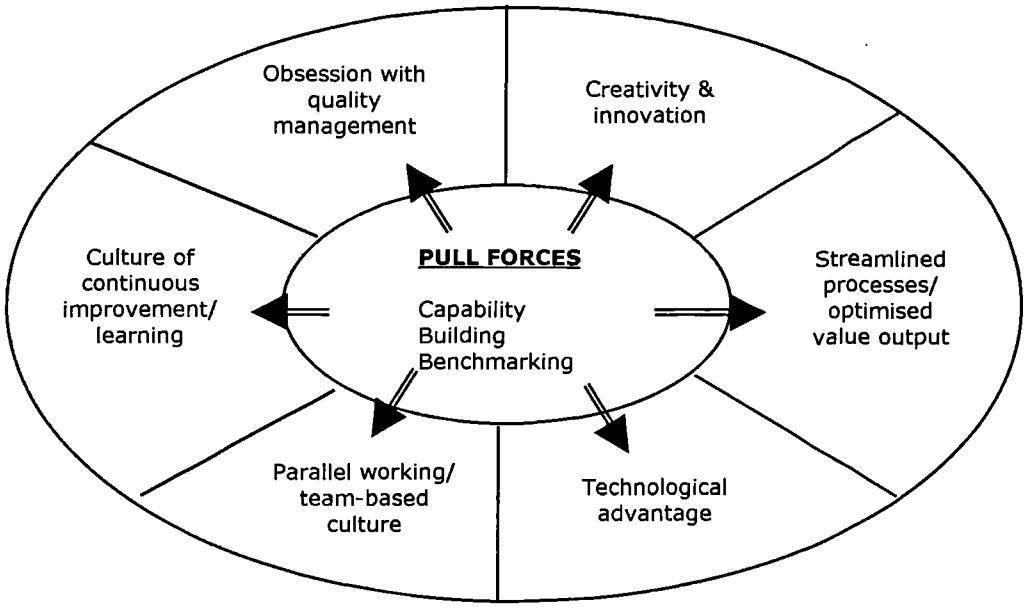
Zairi and Leonard described this stage as the essential steps for scanning the business environment continuously to establish levels of demand for services. They noted in particular that *intelligence* was core to the success of the organisation – their description of *knowledge* – and is thus a major organisational dynamic that needs testing for as a determinate of organisational health. Zairi and Leonard saw intelligence as a Push force, a driver for evolution and change along with other core requirements for benchmarking and building (for the future) – Kotter's long-run organisational dynamics. Clearly for the NHS there are differences such as, for example, the concept of *shareholders*. In the private sector the drive is to satisfy shareholders requirements for financial return on investment.

The NHS does need to satisfy its stakeholder, in the form of Government, but this is achieved by staying within budget, delivering services to agreed levels of quantity and quality, and working towards targets for health improvement i.e. be

effective. Other comparisons between private and public sector are very similar when using this model for analysis.

The Push forces were described by Zairi and Leonard in a similar model (figure 6) that represented the essential steps for feeding back to the business environment. What is immediately notable is that at the core the organisation had to have *capability'* – organisational and personal competencies. This suggests that *capability* is another major organisational dynamic that needs testing as a determinate of organisational health. The Push model and Pull model could be applied to both the NHS and private sectors and both are supportive of conclusions drawn from other literature of the major determinates or organisational health in general.

Figure 6 Push-pull environmental model – stage 2: The Offering



Organisations can therefore be influenced by both internal and external factors. Kotter's model therefore needs to be extended to accommodate **internal** environmental influences.

Ensuring that environmental influences are recognised and responded to appropriately, can be tested by ensuring that:

- adequate attention is paid to obtaining the views of service users.
- the organisation has a proactive approach to change
- the number of objectives that satisfy local needs are maximised
- stakeholders have confidence in the organisation (for the NHS this includes regional offices, local trusts, health authorities, GPs, social services, politicians, media and general public).

Employees and other tangible assets

This research project focuses on health authorities that usually have few tangible assets other than the physical buildings they occupy, their employees and the financial resources they receive and manage. Physical buildings are usually a minimal asset compared with the budgets that are managed. Funding is from the public purse and its use largely prescribed politically or by national Planning and Priority Guidelines. The assets of a health authority are therefore their employees whose primary assets are their skills, knowledge, experience etc. and the necessary competencies to do their jobs efficiently, effectively and economically.

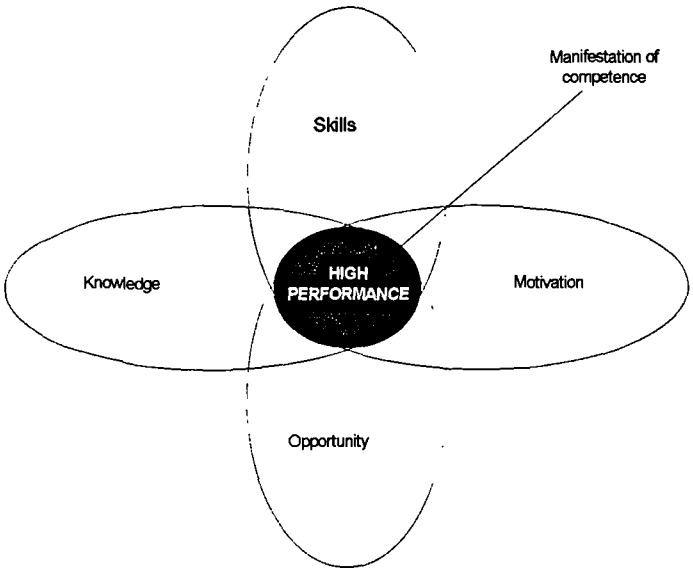
Organisational and personal competencies

Herriott found that there was not much clarity about what was meant by *competencie*' although generally personal competencies were considered to be people's capabilities in the various areas of their functioning considered part of their work. This is the concept of *personal competence* and this relies on the

organisation knowing what levels of competence it requires of employees as well as what organisational competence is necessary.

Birchall & Lyons defined *personal competence* in terms of "the qualities that an individual brings to a job in order to perform its various aspects at the required standard of performance". They described *personal competence* as an 'input model' formed of competencies expected of an individual before appointment. These include style, motivation, values, skills and abilities, knowledge and understanding. Birchall & Lyons developed a Process Model that described individual behaviours, tasks and actions as well as an Output Model which they described as *standard* which were statements of what an employee achieved as a result of their actions. The Input, Process and Output Models combine in a Job Performance Model (Figure 7).

Figure 7 Job Performance Model



The elements of the Birchall and Lyons' model are similar to those identified by Armstrong, and Atkinson *et al* (1990).

Jacobs (1989) stated nine corporate *core skills* and *competencies* identified through research with WH Smith plc and summarised in Table 8.

Table 8 Nine corporate *core skills* and *competencies*

Written skills
Communicate easily on paper with speed and clarity. Present ideas concisely and in a structured way. Use appropriate language and style. Grammar and spelling are correct.

Oral communication
Speak to others with ease and clarity. Express ideas well and present arguments in a logical fashion. Give information and explanations which are clear and easily understood. Listen actively to others.

Leadership
Show skill in directing group activities. Have natural authority and gain respect of others. Capable of building an effective team. Involving all team members, give advice and help when required.

Team membership
Fit in well as a peer and as a subordinate. Understand own role and the role of others within the team. Share information and seek help and advice when necessary. Offer suggestions and listen to the ideas of others.

Planning and organising skills
Make forward plans and forecasts. Define objectives and allocate resources to meet them. Set realistic targets and decide priorities. Devise systems and monitor progress. Make good use of time.

Decision-making
Evaluate alternative courses of action and make appropriate decisions. Identify degrees of urgency for decisions. respond to situations quickly and demonstrate flexibility.

Motivation
Show energy and enthusiasm. Work hard and be ambitious. Work on own initiative with little detailed supervision. Set own targets and be determined to achieve them.

Personal strength
Self-confident and understand own strengths and weaknesses. Realistic and willing to learn from past failures and successes. Reliable, honest and conscientious. Able to cope with pressure and control emotions.

Analytical reasoning skills
Can quickly and accurately comprehend verbal and numerical information. Able to analyse arguments objectively and reach logical conclusions. Present well-reasoned and persuasive arguments.

based on Jacobs 1989 (pp32-37)

Dearden *et al* (1995) identified skills and competencies believed to be essential for employees of health authorities (Table 9) and arguably for Trusts and other organisations, although this would need testing empirically.

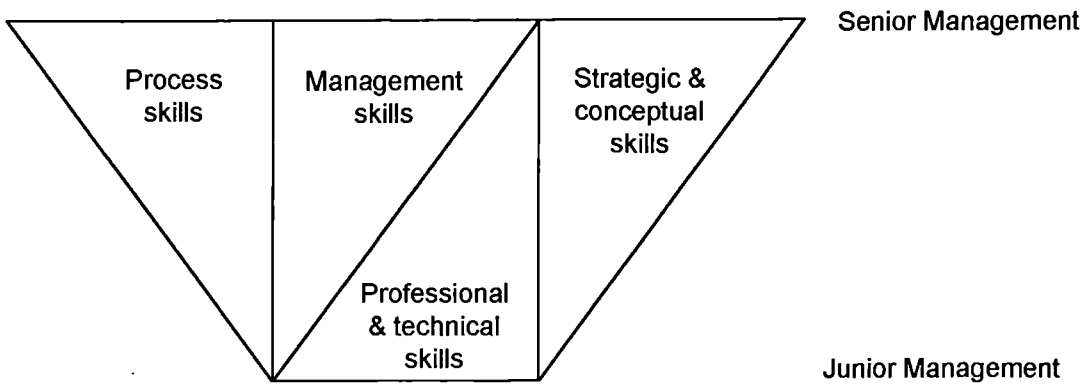
Table 9 Core skills and competencies for employees of health authorities

1	**Corporate management:** The following skills will be needed in all corporate management activity and might also be found under some of the other headings: leadership, team working, information management, courage and confidence, speed reading, oral and written communications, strategic thinking and vision, creativity, balance of "tough and tender"
2	**Needs assessment:** Research skills, applied epidemiology, securing and sifting clinical advice, community development skills, survey design, market research, understanding the patch, empathy with user
3	**Achieving health goals:** Influencing, networking, political nous, working with voluntary groups and community, multi-agency working, achievement without control
4	**Service prioritisation:** Health economics, applied epidemiology, decision making, political interface, analytical skills, independent validation, judgement, user advocacy, strategic view, multi-agency working
5	**Service specification and outcome measures:** Plagiarism, service knowledge base, research skills, clinical understanding/expertise, problem solving, analytical skills, understanding clinical effectiveness/R&D, ability to translate service need to service commissioning statement to service specification with outcome measures
6	**Negotiating contracts:** Clarity and consistency, negotiating skills, inter-personal skills, working to deadlines, analytical skills related to market intelligence and market forces
7	**Managing and monitoring contracts:** Numeracy, inter-personal skills, giving and taking feedback
8	**Achieving income and expenditure balance:** Numeracy, accountancy, problem solving, business planning, Value For Money analysis, giving & taking feedback, entrepreneurism
9	**Multi-skilling:** Skill mixes will be as important as the actual skills themselves. We expect to see an increase in the number of generic practitioners, able to work across the board in purchasing agencies; a general rise in the level of expertise; and willingness and comfort levels working in task force arrangement.

Despite the existence of these models and frameworks, it appears that the translation into practice has been generally slow. The Institute of Management (1998) found from their survey of over 1000 managers that there was a general belief that employees lacked the right mix of skills and experience needed to cope in a changed environment.

People are frequently appointed to posts because they have demonstrated skills and competencies in their previous post. Fritchie and Leary proposed a management skills profile (Figure 8) in which the transition from junior managerial through to senior managerial competencies was mapped. At junior management level the relevant competencies related to professional and technical skills with minor use being made of process, management, strategic and conceptual skills. With promotion the relevant competencies focused increasingly less on the professional and technical skills for which they were originally appointed and upon which their reputation, and promotion, are based. This could leave individuals deficient in skills and competencies relating to process management, strategic planning and conceptualising. However, these are the skills and competencies required to manage relations, and manage conflict should it arise.

Figure 8 Skills and competencies framework



Team competence becomes increasingly important as project-style working becomes more prominent. Birchall and Lyons identified nine team competencies that they considered basic:

1. Team members have complementary and overlapping skills and competencies
2. The team leader is a facilitator rather than supervisor
3. Problems are owned by the team with management rather than top management making all decisions
4. The team solves as many problems as possible
5. The team participates in setting its own targets rather than have targets imposed on them
6. The customer is the prime focus of attention
7. Team members have direct customer contact wherever possible
8. Continuous learning is encouraged
9. Rewards are diverse and situational

Birchall and Lyons defined organisational competence as "that blend of technologies, understanding of clients/customers and product/service knowledge that uniquely apply to that organisation and which give it a commercial edge".

The presence (or absence) of personal, team and organisational competencies would therefore be a key indication of personal barriers to organisational effectiveness being absent or present and consequently indicative of barriers to the sharing and use of knowledge being present. Birchall and Lyons, motivational theorists and many other researchers have identified that without

personal motivation an individual's skills and knowledge would remain underemployed and performance fall short of what could be achieved.

As the *tangible assets* of Health authorities are predominantly their employees, it is concluded that Kotter's model needs modifying. As a result, *Competencies* will henceforth be used as a concept in a modified Kotter model and be defined as "the individual, team and organisational competencies" in that organisation.

It is concluded that competencies can be assessed by testing the extent to which employees perceive that:

- the skills and knowledge necessary to do the job adequately have been identified by the organisation
- job-related skills are at high levels
- job-related knowledge is at high levels
- there are adequate opportunities to develop job-related skills and knowledge
- they are motivated

Organisations and managers need to be competent in the *soft* skills necessary to achieve these outcomes. Schofield (1998) believed that organisations needed to be educated to recognise that investment in management development contributes directly to long-term competitiveness.

Social Systems

Kotter assigned to this element the characteristics of *values and norms shared by most employees* and *relationships that exist between workers in terms of*

power, affiliation and trust. People confuse loyalty to their jobs with loyalty to their own identities (Senge) and it is important that this differentiation is clear. These elements will be further discussed when addressing **Individual-Organisational Defensive Routines**.

With organisational frameworks established that provide a safe, secure environment for individuals to work and develop, it is then necessary for organisations to ensure that they develop and maintain focus on specific aspects of their business and emergent organisational dynamics.

As individuals increasingly become self-managing business centres, personal competencies and skills will need to be finely honed as individuals will need to work with various time-limited project groups as well as simultaneously work corporately, functionally and geographically.

Organisations will need to identify those organisational competencies and skills required both permanently and for specific projects or other time-limited tasks. The result of not doing this is likely to be mismatches between expectations, low morale, high staff turnover, non-achievement of objectives, and not having effective individuals, teams or organisations.

Summary

With organisational frameworks established that provide a safe, secure environment for individuals to work and develop, it is necessary for organisations to ensure that they develop and maintain focus on specific aspects of their business if they are to be effective by addressing emergent organisational dynamics.

As individuals increasingly become self-managing business centres, personal competencies and skills will need to be finely honed as individuals are

required to work with various time-limited project groups as well as work corporately, functionally and geographically simultaneously. Organisations will need to identify those organisational competencies and skills required both permanently and for specific projects or other time-limited tasks. The result of not doing this is likely to be mismatches between expectations, low morale, high staff turnover, non-achievement of objectives, and not having effective individuals, teams or organisations.

EMERGENT ORGANISATIONAL DYNAMICS

This section develops the concepts of knowledge, relationships and self-reference as emergent organisational dynamics and investigates their symbiosis with organisational forms. Professionalism and tribalism are examined as significant factors as well as the role that 'games' play. Conflict and associated escalation processes are examined. The need to understand and develop alignment of personal, professional and organisational frames of reference is analysed.

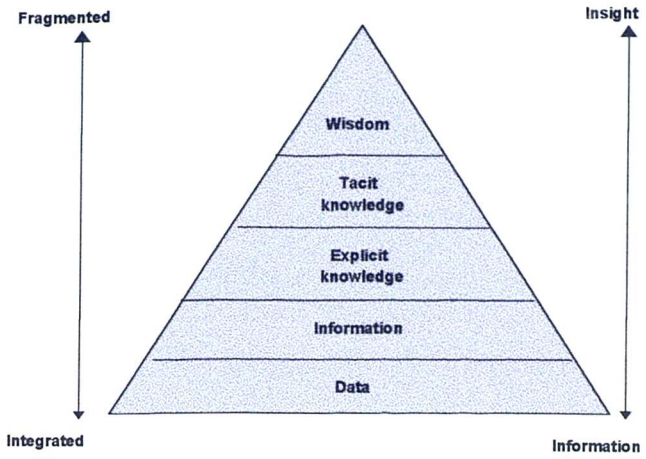
Knowledge

"By counting trees what is significant about the forest may be missed."

Peter Robinson

Managerial decision-making is unique to each individual because we possess different knowledge and perceive, organise and process information differently (Lynch 1992). Rajan, Lank and Chapple represented and described knowledge as part of a hierarchy shown in figure 9.

Figure 9 **A hierarchy of knowledge**



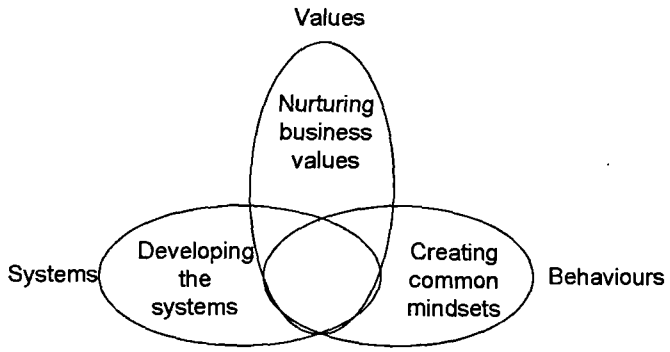
The survey that Rajan, Lank and Chapple carried out was international and sought views from senior managers about encourages, and what creates barriers to the acquisition and retention of corporate knowledge. Although focusing on *corporate memory* as being that which is retained and distributed solely via information technology, it does provide some useful indicators of what senior managers consider to be the constraints to sharing knowledge. The survey concluded that the major constraints were, in order:

- time pressures on key personnel
- the *knowledge is power* syndrome
- the *not invented here* syndrome
- lack of coherent knowledge vision
- lack of ownership of the vision (at all levels)

The survey concluded that first and foremost there was a need to align values, systems and behaviours such that systems operationalised the values and

values became incorporated into behaviours. The interrelation of these variables is shown in figure 10.

Figure 10 Alignment model for values, systems and behaviours



Knowledge is frequently perceived by individuals as giving them power and sharing knowledge is seen as giving individual power away but there are arguments (Coles(a) 1998) that this is a myth as long as employees can see what is in it for them. Earl (1998) also argued that if information is passed on to someone else, the receiver may gain value but the sender does not automatically lose value. Proenca found that organisations with cultures emphasising mutual respect, trust and teamwork were more likely to achieve information sharing. He found this to be especially true if there was co-ordination of, and focus on training and development. Farendon (1994) found that this required awareness of, and commitment to information at Board level, a clear strategic plan, and networking/learning from other organisations. High levels of staff turnover were also found to act as barriers. CIPFA suggested that it was also essential that information systems supported feedback and review processes.

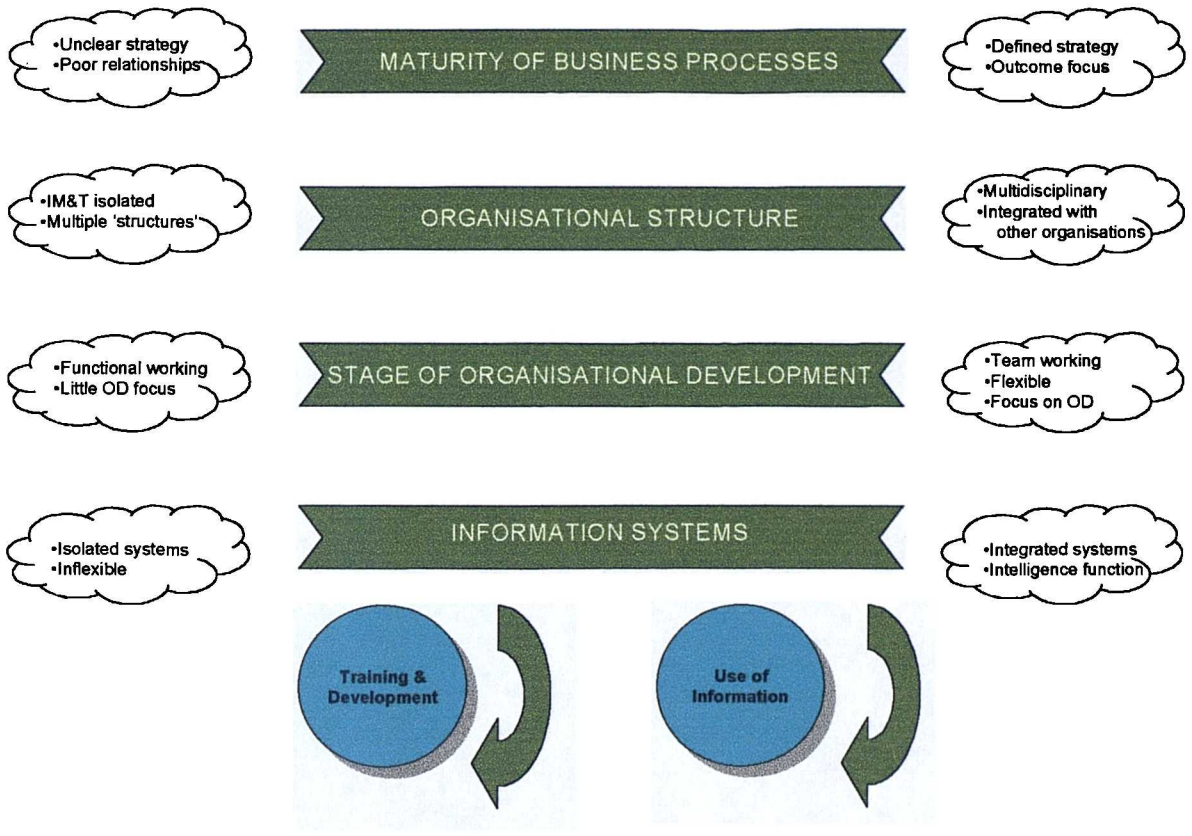
Dawson *et al*, Farendon, Schein, and Saville & Holdsworth (1995) suggested that corporate knowledge and reliable information will increasingly become a primary organisational asset with more work done in multi-professional project groups rather than having a hierarchical structure. However, Wall (1996) noted that providers of health care in the NHS "still do not share information readily with commissioners" and Conway (1995) noted the mismatch between lay and medical knowledge.

Rajan, Lank and Chapple concluded that managing knowledge was "10 per cent technology and 90 per cent people" which suggests that interpersonal relationships and personal competencies will become increasingly important and are directly linked to overcoming barriers to the sharing and use of knowledge. Mumford (1997) emphasised that unless the needs of individuals are met it is unlikely that organisational learning will be effective.

Davenport (1992) and Proenca both stressed that simply providing information does not guarantee its use since people do not share information easily. However, Handy (1994) and Mintzberg (1996) both suggested that if successfully developed, working in multi-professional project groups should facilitate the sharing of information and its use.

Farendon (1986) produced a comprehensive matrix for measuring the key dimensions of NHS organisations (Figure 11).

Figure 11 Matrix model for measuring key information dimensions of NHS organisations



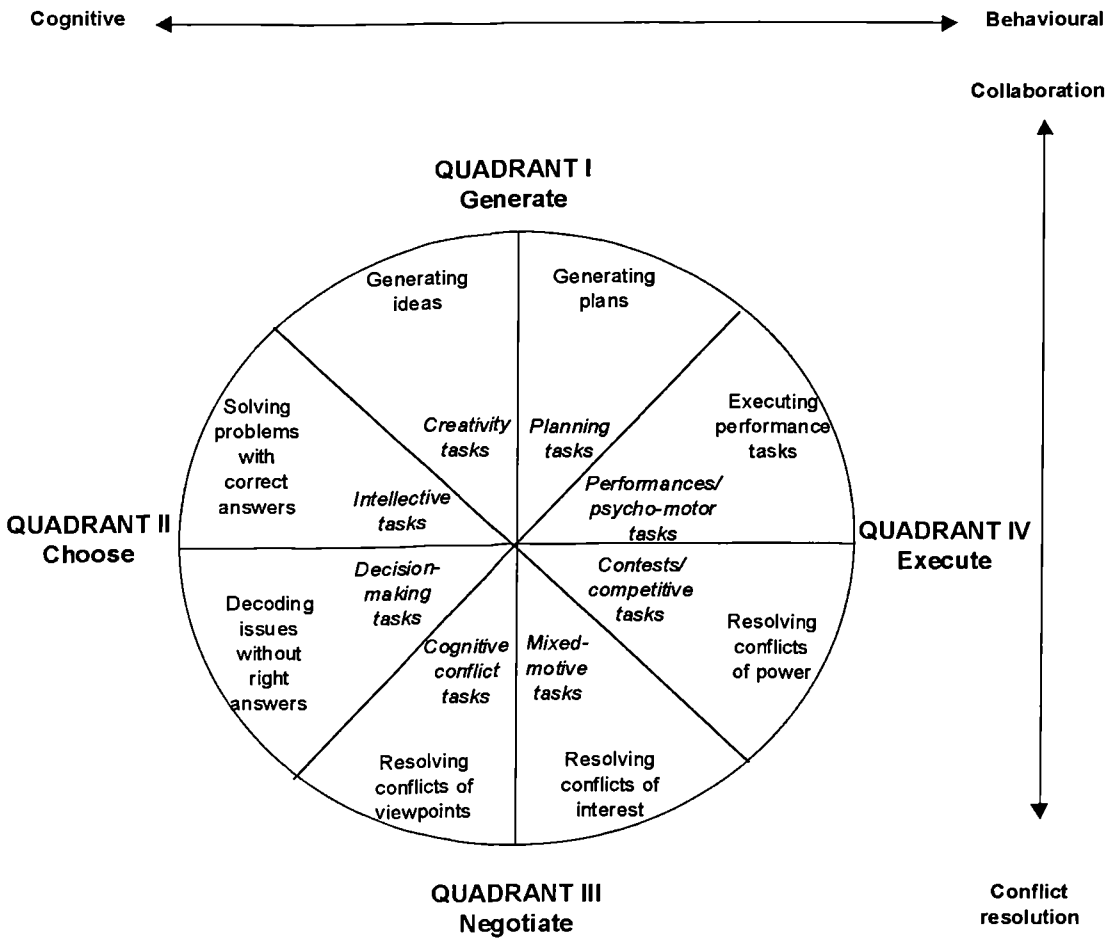
Kotter's model reflects the organisational framework and additionally incorporates the dynamic nature of the organisational component of 'information' (including Information Technology). Proenca found organisational effectiveness linked to cultures where information seeking, sharing and use were linked to organisational survival, spearheaded by a 'popular personality' and perceived as voluntary. Information cultures that emphasise mutual respect would be recognised where there was evidence of trust, teamwork, delegation, autonomy and empowerment. As a result there would more likely be 'sharing' behaviours generally and specifically knowledge sharing.

Communications strategies and programmes to achieve two-way flows of information were found by CIPFA to be essential and Farendon (1992) also

stressed the need for development of relationships with outside organisations as providers of information. Birchall & Lyons highlighted the potential danger of not recognising or declaring the full extent of IT side effects, both inside and outside the organisation. It is therefore essential that the importance of knowledge as 'intellectual capital' be recognised as a potential barrier to sharing.

McGrath and Hollingshead (1994) researched the interaction of groups who used technology and produced a useful model of group processes (Figure 12). The McGrath model reflected the multi-factor influences and usefully integrated the technological impact with other emergent organisational dynamics and the impact of organisational forms on working practices both organisational and personal.

Figure 12 McGrath model of group processes



The foregoing suggests that information as an emergent organisational dynamic can be assessed for *health* by testing if the organisation has a focus on ensuring that:

- Corporate knowledge is not scattered
- Organic structures are in place rather than hierarchical structures
- Information/IT strategic plans are clear
- Relationships with providers are good
- There is co-ordination of and focus on training and development
- There is networking and learning from other organisations
- There is awareness of and commitment to information at Board level

Relationships

> "The inherent preference of organisations are clarity, certainty and perfection. The inherent nature of human relationships involves ambiguity, uncertainty and imperfection"
>
> **Pascale**

The NHS, in common with many public sector organisations has, arguably, more stakeholders than most private sector organisations. These stakeholders may be internal, external or somewhere in between and will both affect, and be affected by, the strategies that the organisation develops. The conflicts that frequently need managing are often dissimilar claims and concerns of the diverse constituencies. The challenge is to ensure that whilst responding to one or two powerful players one does not overlook the need to appreciate other, essential constituencies and secure their co-operation. Zairi and Leonard stressed the need

to have an alignment of views, beliefs and values between stakeholders. This was found by Forrest (1992) to be more likely to lead to strategic alliances and partnerships both short- and long-term. However, there is a real danger that even after several years of effort put into developing relationships, partners will eventually exploit the relationship and deceit then becomes evident (Hamden-Turner and Trompenaars 1993).

A survey of the private sector by Coulson-Thomas & Brown (1990) found that 68% of customers were lost because of poor customer/supplier relationships. Neuhauser (1988) also highlighted the time wasted in dealing with conflicts or fallout from related problems. Dawson *et al* and Schein both stressed the importance and long-term implications of developing partnerships and strategic alliances. Rajan, Lank and Chapple found that delayering and downsizing of organisations was directly responsible for the loss of informal networks and decline in business relationships.

Organisational effectiveness relies on developing partnerships/alliances, managing relationships, identifying and effectively managing potential/actual conflicts. Relationships and conflict need managing. There has been a slow realisation that effectiveness is determined as much by attitude and appreciation of cultural differences as it is by organisational arrangements (Wall). Only recently had the quality of relationships become a topic for systematic study in business schools despite the importance of relationships in business being recognised at least a decade earlier. This view was supported by O'Connor and Seymour (1993) who stressed the importance of relationships and the wider identification of stakeholders as individuals become more empowered as "the unique network of relationships may well be the basis of a company's competitive advantage".

Zairi and Leonard suggested that characteristics of not juggling these political balls might be that failures become visible and success goes unrecognised. Mumford agreed that people learn from both successes and mistakes in their work but highlighted that mistakes were often covered up or punished rather than treated as occasions for learning.

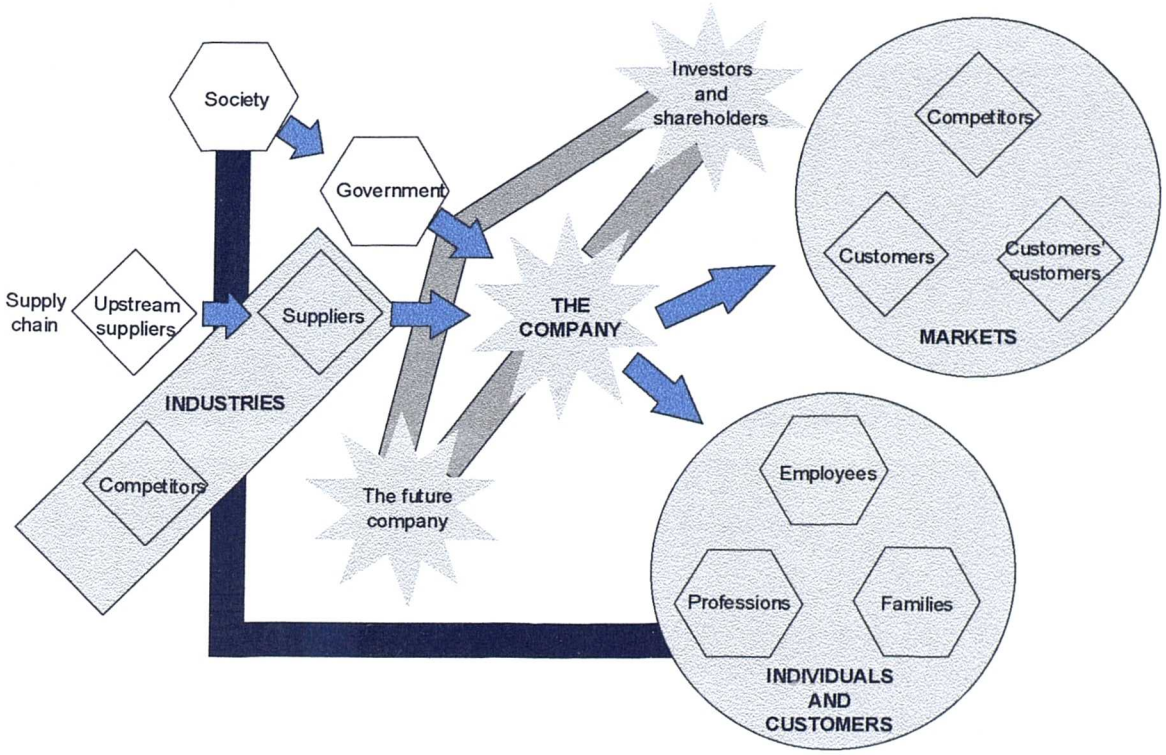
The identification of key players is essential. Some key players may be self-evident to all but identifying other key players may be a more subtle process. This identification process might include finding the answers to questions such as: who makes things happen around here?, who are the best friends/worst enemies to have around here?, and who can you count on to make things happen?. Levitt and Wall stated that what matters is not who you know but how they are known to you.

As competition intensifies there is increased pressure to deploy more resources and expand effort to maintain the current position l*et al*one improve on it. Collaborations, developed for strategic reasons, and strategic partnerships were found by Forrest to evolve either partially or contractually for both the short- and long-term. This goes beyond specific process changes into sharing the benefits from joint strategies in a win-win fashion.

The importance of stakeholder confidence cannot be overstated. In a study of senior executives by Dawson *et al* it was found that several factors were essential to successful management in the NHS, with the effect of stakeholder influence noted and also the importance of developing partnerships and alliances. Forrest also stressed the essential factor of having an alignment of views, beliefs and values between stakeholders. However, alignment models find it difficult to accommodate conflict (Morton).

Birchall & Lyons produced a comprehensive model of stakeholder/organisational interactions that is useful in understanding the influences and their interaction (Figure 13).

Figure 13 Model of stakeholder/organisational interactions



Hudson (1998) concluded that partnerships were required in five ways for the health agenda set out in the 1997 White Paper *(The new NHS: modern, dependable*) to be effectively delivered (Table 10).

Table 10 Five types of health partnership

• **Programme partnership**	through health improvement programmes
• **Professional partnerships**	both within trusts and between trusts and, for example, professionals in social services
• **Administrative partnerships**	achieved through co-terminosity of social service boundaries with those of Primary Care Groups and generally through use of 'natural boundaries'.
• **Performance partnerships**	achieved through the new national performance framework
• **Governance partnerships**	achieved through making NHS bodies more representative of local communities

In addressing the issues of relationship and conflict management Fritchie and Leary believed it important to have a clear understanding of distinctions between Allies and Bedfellows, Opponent and Enemies:

> **Allies** are people who are joined in league for co-operation in a common purpose, whereas **Bedfellows** are people agreeing for their own reasons. **Opponents** are those oppose a proposed course of action whereas **Enemies** are those who dislike or even hate the individual(s) proposing the course of action. Opponents can be useful to show flaws in one's own arguments and can thus be useful in preparing robust proposals. We may, however, perceive opponents to be enemies.

One might seek to have no opponents or enemies to a proposal but Fritchie and Leary pointed out that if all change went through with no comment or resistance (because everyone agreed), would the outcome of change be robust and would all issues be addressed or even seen?

Fritchie and Leary proposed a 3 phase, 9 level of conflict escalation and diagnosis. They argued that if the process of escalation was to be reversed then regression must first be halted with the individuals involved in the conflict recognising and accepting the consequences of their behaviour and the responsibility for what they do. The three phases described by Fritchie and Leary were:

Nervousness; characterised by the parties being mostly problem orientated, just having different views of what the problem is, still being able to solve the problem, aware of each other's weaknesses but seeing them as greater than their own, unwilling to abide by existing norms and standards to resolve the issue.

The escalation process at this stage moves from Discussion (verbal confrontation, rational solution possible, basic attitudes one of co-operation), through Debate (unfair tactics becoming acceptable, "points" being scored, motives become mixed) to Deeds not words ("we are not going to be pushed around", saying one thing and doing another, mostly competitive).

Neurosis; characterised by interactions highly competitive, mechanism of the conflict itself is the focus not the underlying problem, mutual

doubt of integrity, revenge sought, parties seek to bend rules, and seek advantages.

The escalation process moves from fixed images (parties seek supporters and build coalitions, sometimes by making promises to gain support) through loss of face (not being seen to lose, parties degrade each other, behaviour is ritualised) to strategies of threat (negative opportunity threats, sides taken, trip wires laid).

Pathological; characterised by destination of other party more important than gaining anything for oneself, norms and standards can be violated and broken legitimately, compulsion to push on at any cost.

The escalation process moves from inhuman (concentrate on destroying the other side, goals mainly preventative and defensive) through attack on nerves (cut off means of retreat, cut them off from their supporters) to no way back (destructive goals dominate, calculations irrational, withdraw and worse fate than self-destruction).

Fritchie and Leary proposed four steps in resolving conflict:

1. **Change behaviour** - of self and others e.g. challenge, listen, question
   - stop during something e.g. acting like critical parent
   - put a ban on unacceptable behaviour
2. **Work on attitudes** - encourage a softening of attitudes and rebuild trust
   - explore feelings and stances

3. **Alter perceptions** - how people see things and one another
   - negative images, stereotypes
   - pinning people to their double - their worst self
4. **Tackle the issues** - problems and issues concerned with time, money, resource allocation, priorities, professional and technical issues can now be tackled

In December 1998, the British Medical Association (BMA) produced a booklet entitled *Maximising your Influence* in which the BMA outlined how GPs could make the most, personally, out of the newly forming Primary Care Groups. Chief Executive of the NHS Confederation, Stephen Thornton, described this booklet as one of the most sectarian documents he had read in a long time. The book offers advice on how to "maximise GP influence whilst working within the constraints of the allowances payable and current political realities".

Gould (1998) saw this booklet as potentially inflammatory since it warns GPs, for example, to sift requests for a representative from the PCG since "this can be a deliberate diversionary tactic of some organisations, including HAs". Thornton was quoted as saying "PCGs are about partnership. The BMA is using the language of conflict".

In summary, one must be careful to differentiate between allies and bedfellows, opponents and enemies, and there must be an emphasis on good communication. Failure to achieve, or the breakdown of, relationships may result in interpersonal tensions and result in individual-organisational defensive routines developing. Schlutter & Lee suggested that skills in managing relationships are often *caught* suggested it rather than *taught*.

Organisations therefore need to ensure that they know who their stakeholders are and that:

- their relationships with stakeholders are good
- organisational values, beliefs and views are known and understood by stakeholders
- organisational values, beliefs and views are shared by stakeholders wherever possible
- success is recognised within the organisation
- failure is not apparent to those outside the organisation

Self-Reference

Experience tells us that organisations frequently have motivated people and the 'right' organisational structure but individuals perceive over time that their contributions are not valued and/or their values and beliefs are not the same as the organisation for which they work. Dawson *et al* found that if there were circumstances beyond personal control e.g. top-down imposed change, this would form a barrier to personal effectiveness. The importance of having business rules that are known and worked to has been found to be essential (Hadridge 1995). Levitt and Wall (1996) concluded that there had only been a slow realisation that effectiveness was determined as much by attitudes and the appreciation of cultural differences, as by management arrangements. As a result, inertia can develop to working in purposeful and productive ways as people organise themselves in line with their personal reference framework, and they respond to proposals for change in ways that perpetuate the *status quo*. Fischer (1996) described this as people

wanting the organisation to become again what it was. Fischer wrote his discussion paper as a result of exploring this paradox with members of a learning set at the King's Fund College. This group found four implicit *self-referencing* rules that govern the behaviour of a system in the NHS:

Can do, should do – The original 1948 premise was that the NHS should do what it could do. However, not all treatments are clinically effective and some treatments are unkind, unnecessary and inappropriate. Brooks (1996) found a correlation between organisational competence and good patient care i.e. an organisation that is clear about its purpose achieves ownership of it by its workforce.

Doing means providing treatment – Whilst the introduction of the NHS was political, the actual provision of services was for many years led by those in the medical professions and organised to provide medical treatment regardless of cost and with no regard to equity. The learning set members saw the intrusion of politics as being rejected by many as 'invalid' in the health care setting and that individuals conducted themselves accordingly when dealing with directives that they perceived were political directive. As an example, there was a large body of evidence found that supported the preventative nature of certain interventions but this evidence was seen as inadmissible by those who had to make decisions about allocating resources as *doing* meant treating and not preventing. This suggests that cultural changes are

needed in order for knowledge to be shared freely and as a result for organisations to become fully effective.

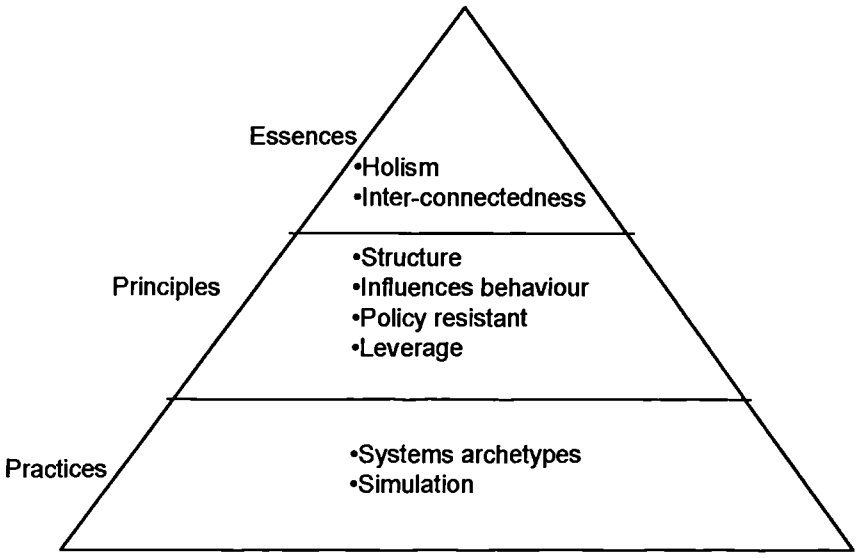
I'm responsible for the treatment – Following on from the previous 'rule', many professionals used to believe in doing things to people rather doing things with them in partnership. It was suggested by those involved with the study that the professionalism of those involved at times became an overriding factor and has an adverse affect on relationships, information flows, multi-disciplinary working and team work generally. Many sub-cultures have been lovingly nurtured by professional education and training which have provide traditions, career paths, rewards (and punishments) of great power and standing. Morris found that sub-cultures cut across the dormant culture of the business, often providing opportunities for development, and sometimes unintentionally producing inertia, confusion and cynicism. Unless real partnerships can be developed and tribal barriers broken down then it seems likely that this paradigm will continue. However, Hamden-Turner and Trompenaars found that "we never really escape from the culture that trained us". This suggests that achievement of this paradigm shift is never going to be easy, or, if achievable, then only partly successful with the chances of regression to pre-partnership conditions being high.

Treatment should fix it - Power in the NHS has rested with the medical professions for many years and most power has been in the hands of hospital consultants – the *fixers* – with GPs often finding themselves to be the poor relations until the advent of GP Fund Holding. Again, there

needs to be a paradigm shift away from *treatment means doing* and movement from preoccupation with short-term goals to long-term goals as emphasised by Dawson *et al.*

Senge described self-reference as part of *systems thinking* – a conceptual framework (Figure 14) made up of a body of knowledge and tools developed by individuals over many years.

Figure 14 Systems thinking



Senge 1990

Senge described systems thinking as *the fifth discipline* integrating four other disciplines:

'Personal mastery' - high levels of personal proficiency

'Mental models' - deeply ingrained assumptions, generalisations, personal values and culture

'Building shared vision' - alignment of personal and organisational vision

'Team learning' - thinking together rather than as individuals.

The requirement was for people to examine their personal frames of reference and to ensure they were aware of how this aligned with organisational reference frameworks. This may require a paradigm shift that Senge called *metanoia* - a shift of mind. Senge concluded that there was a need to ensure that skills and competencies were identified for the new organisation, that these were tested with staff to determine their personal skills and competencies and that an organisational development programme was prepared for each person as a result. There was also an identified need to test for the presence of, and an ability to overcome inertia. Senge also concluded that there was a need to test for shared vision and awareness of individual values and beliefs.

The time and effort involved in achieving metanoia should not be underestimated. Coles (1998) found that whilst there was a need to align business and people management strategies, it had taken Glaxo seven years of sustained effort and investment to create the reward mechanisms and develop the skills that people needed to work in this way.

Pickard (1998) suggested that adopting the concept of Neuro Linguistic Programming (NLP) could shorten the time taken for change by teaching people methods of changing their behaviour by modelling their behaviour on others. Pickard found NLP to have been used in education and health sectors, among others.

For self-reference to be in evidence, organisations therefore need to ensure that:

- Individual, professional and organisational values, culture and beliefs are aligned

- Individuals have the required personal competencies
- Organisations know the competencies they require
- Personal relationships are excellent
- Individuals understand the purpose and goals of the organisation and teams of which they are part
- Individuals feel secure and motivated

Summary

Emergent organisational dynamics of knowledge and information, relationships and self-reference have been identified as key elements in organisational effectiveness. Barriers to personal, team and organisational effectiveness associated with the impact of relationships on information sharing (relato-infomatics) have been clearly identified and linked to issues associated with personal motivation. The management of knowledge, corporate and individual, has also been identified as key elements in identifying and managing personal Intellectual capital.

INTELLECTUAL CAPITAL

This section examines the concept of knowledge management, the identification of personal intellectual capital. Links to personal motivation need are more fully explored in relation to current organisational and working practices.

Jobs for life used to be quite common. If you joined a company and worked hard you would probably climb your chosen career ladder eventually. The trend now is towards *portfolio careers* - part-time working on a number of projects and

less job security. It is likely that this trend will continue. The traditional career may well become a thing of the past for many people who now find this brave new world to be very threatening.

Each person is a unique individual that could be described as being made up of four elements:

- ***preferences*** in behaviour; values, cultures and beliefs, some shared with others (for example, religious beliefs, professional standards or national culture) but others unique to the individual.

- ***talents***; skills and competencies that enable individuals to work or play in ways that make that individual feel able to do things well and get pleasure from them. This may be the ability to play football or cricket, to be an actor, or for example, the ability to set direction for other people at work and lead them effectively.

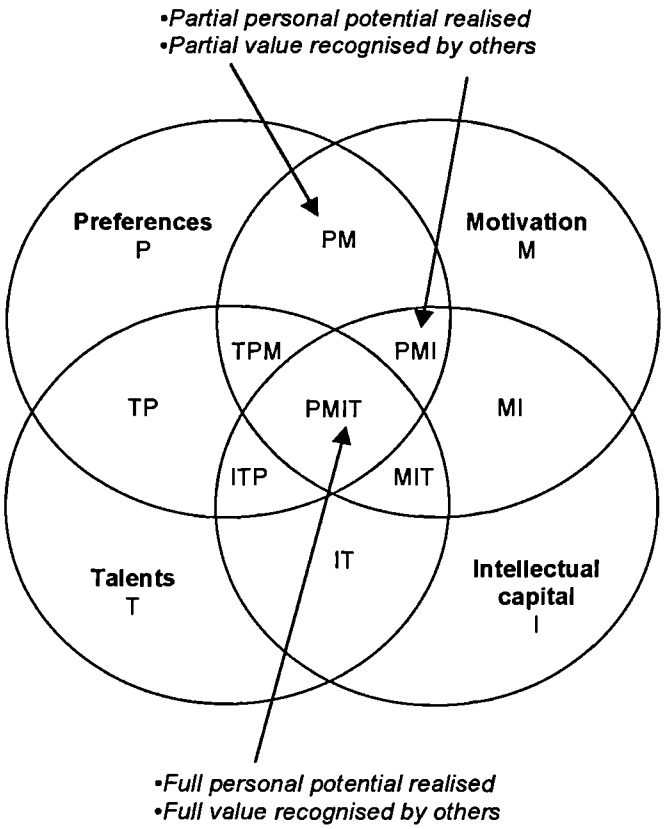
- ***motivations*** that encourage individuals to do things; the attraction of some reward or the fear of some punishment. The reward may be financial, material or personal (for example, pay rise, new car or feeling valued), the punishment may be professional, organisational or personal (for example, sanctions by professional organisation, demotion by the company you work for, reduction in salary and other material benefits, or being ostracised by colleagues).

- ***intellectual capital;*** skills, competencies, knowledge that are in demand and yet are unique to an individual or at most available from just a limited number of individuals.

The inter-relation of these elements has been modelled in figure 15. The model suggests that the more an individual can make effective use of the four

elements concurrently, the more personal potential is realised and the more their value is recognised by others.

Figure 15 **Model of interactions of preferences, talents, intellectual capital and motivation**



Dale (unpublished 1998)

Bryant (1998) saw it as innocuous that whilst stressing the need for openness and honesty, "leaders are frightened to state their views". We all have knowledge that we apply to our work and in our social lives. Much of this is generally possessed by many other people and may, for example, enable two people to have a meaningful discussion with others about politics or sport. Equally, it could enable a person to understand, and contribute to, general discussions at work about how products and services should be developed.

Whilst some of these will be common to some or even many people, there are aspects which are unique to each individual. This has value if others need it whether they are aware they need it or not. This uniqueness is part of personal intellectual capital. It has value but it can often be like family heirlooms – never discovered, hidden away, only brought out on special occasions, in need of restoration, their true value never known to the owner or its existence hidden from the view of those who would value them most.

As we go through our lives we find out more about ourselves. This is like standing on an iceberg. Initially only a small proportion is known to exist (that portion visible above the water) but by exploring we may be able to determine, by sticking our toe in the water or using other senses such as sight or touch, that there is some of the iceberg below the surface. However, we cannot go below the surface of the water without help from others nor without some sort of life-support system. The environment is alien and frightening. The fear for some may be difficult to overcome.

What each of us needs to really understand is what we have to offer in general and, in particular, what intellectual capital we have that others need. There is considerable personal strength and resilience to be gained from this process.

For the individual, being seen as an expert can raise self-esteem. However, once this knowledge has been shared fully this becomes more general knowledge. Individuals may then feel that their status has been eroded. What motivates them then? Perhaps acquiring more knowledge and entering the cycle again but how long can this go on? Once the ability to supply knowledge dries up, many people would fear being 'redundant'. This fear then forms a barrier to knowledge sharing.

Ernst and Young, and Price Waterhouse Coopers are two organisations that have made it contractually explicit that their employees are required to share knowledge (Rajan, Lank and Chapple). Many people might find this threat at odds with their own values – not the concept of knowledge sharing but the means of implementation.

The current trend towards portfolio careers makes people thirsty for that knowledge and talent that will make them unique. However, if they have shared all they know what then do they to offer? *Downsizing, re-engineering* and other euphemisms do not fool people – it means them potentially losing their jobs. People are now starting to question how they will manage their portfolio careers and especially how confident they are about the intellectual capital they hold.

Rajan, Lank and Chapple provided a valuable insight into the management of knowledge. However, further value would have added by obtaining views from people other than Chief Executives, Directors and senior managers to identify the views of the people that knowledge management affects most – the employees – but would real views be obtained? There is evidence that senior and top managers are <u>not</u> made fully aware of their employees' real (unpalatable) views as doing this might put the employees' jobs at risk by being seen as a non-company worker, a maverick, trouble maker or being disloyal to their manager or profession.

Failure to align personal, organisational and professional cultures, customs, values and behaviours can also act as barrier. Professional organisations can offer career paths and incentives of great power and standing but can also impose significant sanctions on members who transgress. Transgression may take the form of disloyalty to that profession but for those professionals who increasingly work on

project-based tasks in dynamic matrix organisations the split loyalties these cause produce extreme personal conflicts of trying to make the right decisions.

This is not to imply that what is done by these professionals is in any way immoral or illegal but rather that their cultures, customs, values and behaviours may be particular to that group of professionals. If those who come into contact with these professionals have poor knowledge about their cultures, customs, values and beliefs this can give rise to suspicions of their motives. This suspicion may be such that the non-professional feels unable to discuss the issues with that individual or any member of that profession. Ultimately the issues become undiscussable and this leads to chasms in the road to knowledge sharing that are hard to understand and even harder to bridge.

Change is often sold on the basis of the benefits it will bring but the disadvantages receiving scant regard. Comments on change proposals are frequently sought from employees but if employees feel their job are at risk or their comment could be ridiculed, one must question how willing they will be to speak up next time.

Knowledge management should bring real benefits to employers, employees and those embarking on portfolio careers. Those who are young high-fliers may be willing to sacrifice themselves by full disclosure of knowledge or through naivety be too honest for their own good. Those who know themselves well, and have knowledge and expertise that is a sought-after, may also have the self-confidence to speak out as will those who, for any reason, feel they generally have sufficient self-confidence. These are the types of people that are likely to share knowledge more readily but for many this is not the case.

If employees perceive that they are not receiving the appropriate recognition and rewards for the effort they put in, then they may feel that they are being treated unjustly and this may make them become defensive. Employers need to address these issues in relation to the people issues connected with knowledge management and ensure that there is a psychological contract with their employees, contract workers and others with whom they do business. There is then a clear contract between employer and employee which ensures that both sides have expectations that are aligned – the degree of the expectation and the nature of what is to be exchanged.

Knowledge management is often viewed as a single concept but in reality is a dichotomous concept – corporate versus individual. The capture and development of corporate knowledge may be pursued by those who fear employees leaving as knowledge is then lost (i.e. not captured by corporate knowledge management systems). Corporate knowledge may also be sought by those with profit motives of working in more cost-effective and cost-efficient ways. This is not wholly misguided as Boards in the private sector have a responsibility to shareholders. However, it must be questioned what the medium- and long-term effects may be when, for example, there is a constant, inherent 'threat' of personal job loss hanging over employees' heads as a result.

The effective management of corporate and individual knowledge is therefore essential elements to the future success of organisations. The identification by individuals of their intellectual capital will be a major factor in maintaining personal motivation and consequently facilitating the sharing and use of knowledge.

Summary

The effective management of corporate and individual knowledge is an essential element for future organisational effectiveness and success. The development of a psychological contract and identification by individuals of their intellectual capital will be major factors in maintaining personal motivation and consequently facilitating the sharing and use of knowledge.

REVIEW

It is appropriate at this juncture to take stock of the literature already reviewed before considering defensive routines in more depth and the potential to overcome barriers to knowledge sharing.

The NHS could be viewed as a *service organisation* whose effectiveness is assessed by the extent to which it meets its operational and strategic objectives. There is local interpretation and implementation of action but all broad objectives are set within the context of national Planning & Priority Guidelines. Politicians and their civil servants set and assess these broad objectives. The degree of subsequent achievement through local implementation and the associated degree of success will be assessed, largely, by the extent to which local people perceive their local NHS is providing services that meet their expectations. This can lead to competing claims where, for example, there is a national imperative to keep within budget whilst patients perceive that treatment should be available when it is needed, without delay and regardless of cost. Stakeholders therefore assess achievement in various ways because they have different sets of values and beliefs by which they judge effectiveness.

Kotter's model for analysis of organisational dynamics has been used as a robust tool for analysing health authority organisational dynamics. It has been identified that the human elements in most organisations will probably result in barriers to full co-ordination of effort because of functional and professional differences in values, cultures and beliefs unless there are particularly strong or influential reasons which override these differences. The way that organisations are structured has been shown to have a strong influence on working arrangements that can facilitate or form barriers to knowledge sharing.

One overriding influence can be the extent to which cultural and professional values and beliefs differ from those who hold the purse strings. For example, clinicians rely on knowledge sharing to benefit their patients. Clinical failures may result in their professional organisations taking punitive action that could result in loss of registration and consequent loss of career. The motivation is thus to minimise the threat of punishment and maximise benefits to patients (and consequently themselves). This motivation is usually sufficient to override any potential defensive behaviour. Health authorities have very few clinical professionals and do not provide treatments or clinical interventions directly. It is relevant therefore to determine to what extent the clinical imperative is overwhelmed by non-clinical imperatives at the level where strategic planning of local services is developed.

It has been determined that organisations can be established to satisfy just a short-term goal or be established to satisfy both short- and long-term goals. It has been identified that there is a basic organisational framework that exists as a pre-requisite to longer-term survival, effectiveness, growth, development and response to rapidly changing environments. Organisational health can therefore be assessed

by determining the degree of conformance to good practice in the organisational framework identified through the literature search as necessary to overcome barriers to effective working in general and knowledge sharing in particular.

Once 'good health' within the organisational framework provides a safe, secure environment in which individuals can work and develop, organisations can then focus on specific aspects of their business in order to become effective in the longer term. Knowledge, relationships and self-reference have been identified as the emergent organisational dynamics which organisations need to develop as new ways of working evolve.

Individuals need to increase personal competencies generally, and management of relationships in particular, as they are increasingly required to work with various time-limited project groups as well as work corporately, functionally and geographically simultaneously. Organisations need to identify those organisational competencies and skills required both permanently and for specific projects or other time-limited tasks. The result of not doing this is likely to be mismatches between expectations, low morale, high staff turnover, non-achievement of objectives, not having effective individuals, teams or organisations and barriers to knowledge sharing being present.

The management of corporate and individual knowledge has been identified as a key element in overcoming barriers to the sharing of information and knowledge and as organisations become increasingly information and knowledge reliant.

The identification by individuals of their intellectual capital will be a major factor in maintaining personal motivation and consequently facilitating the sharing and use of knowledge.

People either see progress or change as an opportunity or a threat, dependant upon whether they see themselves as having weaknesses or strengths that will enable them to win. Whilst efforts can be made to overcome defensive routines, Argyris found personal opportunity or threat to be the over-riding motivation for people to be overtly and/or covertly supportive or defensive towards proposals which they found threatening to deeply held personal or professional values, culture or beliefs.

People also need to be confident that their own expectations of employment are matched with those of their employer. This goes beyond the economic contract (hours, rate of pay etc.) to reflect:

- social need satisfaction
- security in exchange for hard work and loyalty
- opportunities for self-actualisation
- challenging work in exchange for high productivity
- high quality work and creative effort in the service of organisational goals

In summary:

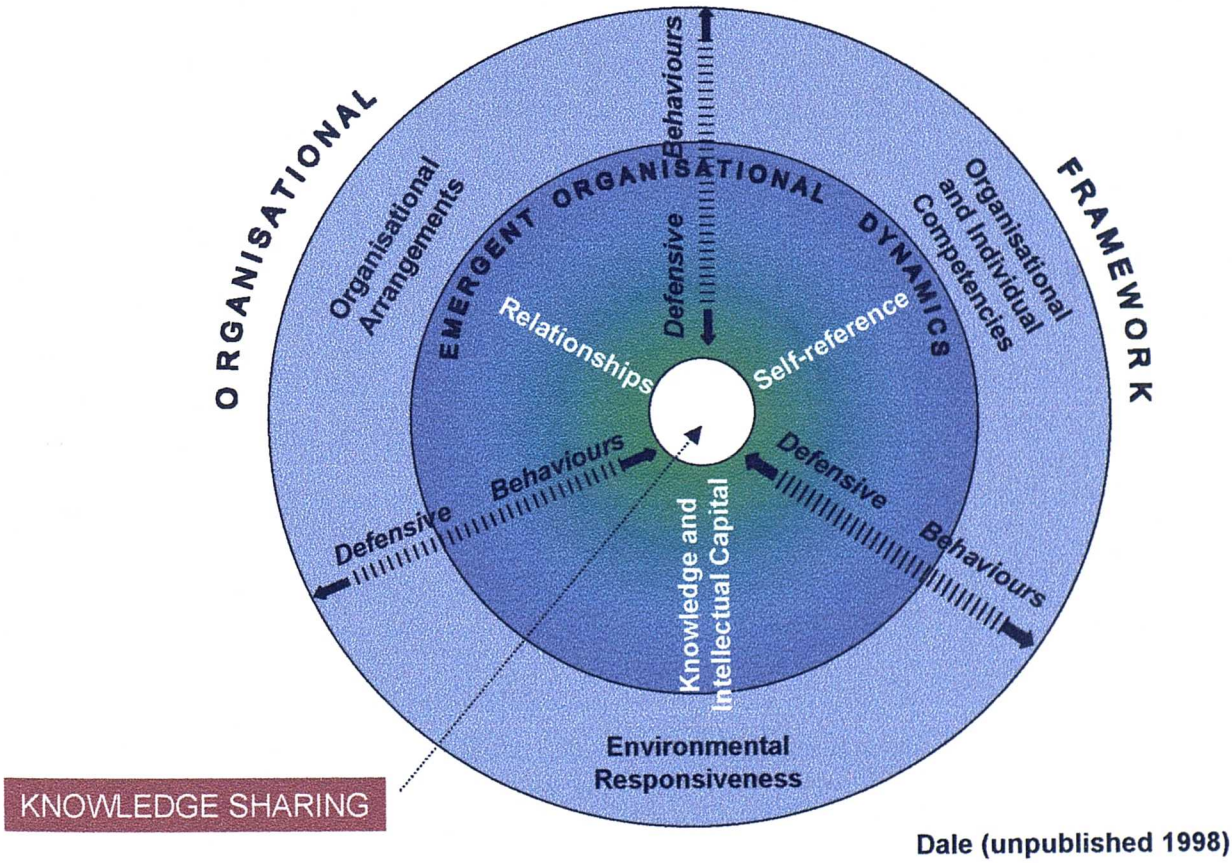
- There are pre-requisites to *organisational effectiveness* based on organisational *health* factors which form an ***organisational framework*** within which ***emergent organisational dynamics*** develop.

- The ***organisational framework*** requires:
  - An appropriate organisational form
  - Identification & development of personal and organisational competencies
  - Recognition of, and appropriate response to, environmental influences

- ***Emergent organisational dynamics*** require a focus on:
  - Development of a knowledge sharing culture and personal information and knowledge management skills
  - Development and maintenance of good relationships
  - Development of personal and organisational 'Self-Reference'
- ***Defensive behaviours (individual-organisational defensive routines)*** might continue acting as barriers to knowledge sharing and organisational effectiveness if personal experiences and frameworks of self-reference over-ride evolution of organisational frameworks, evolution of organisational dynamics and personal development initiated by organisations.

These factors are represented in the framework shown in figure 16.

Figure 16 **Model of organisational dimensions and defensive routines as barriers to knowledge and information sharing**



Dale (unpublished 1998)

Questions that arise are:

1. What makes people display defensive behaviours towards knowledge sharing?
2. What are the obstacles and barriers to knowledge sharing?
3. To what extent could these obstacles and barriers be overcome?

Theories of motivation

This section reviews the development of motivational theories, the psychological contract and the links with the advantages and disadvantages of organisational form, the psychological contract and associated barriers the sharing and use of knowledge as intellectual capital. Argyris' theory of defensive routines is introduced.

> "Unless people are motivated and encouraged and supported to give of their best, then you will have less work done and the system will be less efficient"
>
> **Dr Macara – Chair of BMA**
> **in HSJ 2 April 1998 p13**
> **Article by Crail M**

Motivation refers to "the sum of the forces that produce, direct, and maintain effort expended in particular behaviours" (Jewell and Siegall 1990). However, highly motivated people do not always produce effective organisations and well-structured organisations do not always produce highly motivated people. Theories developed by Herzberg (1966) and McClelland (1966) laid early foundations for understanding concepts of motivation which have been built on over the years by many theorists. Perhaps the most influential have been Expectancy Theory – Vroom, Porter and Lawler (1968), Balance Theory – Adams (1965) and Goal Setting Theory – Locke (1968). Together with Reinforcement Models, motivational

theory reinforces the need for organisations to ensure that they are structured appropriately, dynamically responsive to their environment (within and outside the organisation) and ensure the continual development of individuals so they become effective as individuals and team members.

Early motivational theory by McClelland suggested that individuals need, hierarchically, to satisfy physiological and safety, social and esteem needs before they become self-fulfilled and are fully motivated and effective. Only esteem and self-actualisation needs were seen as increasing work motivation – Herzberg suggested that *hygiene factors* formed the other needs identified by McClelland as they merely kept employees in an organisation.

Expectancy theory developed by Porter and Lawler (1968) was based on the premise that effort will result in desired outcome: i.e. it is expected to occur. Equity (balance) theory developed by Adams was based on the premise that people attempt to keep a balance between the effort they put into work and what they get out of it. Locke suggested that people set goals for themselves, and they are motivated to work toward these goals for themselves as achieving these goals is rewarding. McClelland proposed that people either have, or do not have a need for achievement but that this need can be developed. Other things being, equal people with a need for achievement will put more effort into work than people without this need will. Atkinson and Feather (1996) found that the need for achievement is balanced against a need to avoid failure. Reinforcement models are not so much a theory but more a set of principles that:

- People keep doing things that have rewarding outcomes
- People avoid doing things that have punishing outcomes

- People finally stop doing things that have neither rewarding nor punishing outcomes

The challenge with all theories of motivation is that you cannot see these forces at work, you can only see their results (Jewell and Siegall).

The Relationship between Organisational Forms and Motivation

Many researchers have extensively explored the influences of organisational structure on effectiveness. In particular, Mintzberg explored the influence on individual and team dynamics. He built upon the work of other theorists and proposed five organisational forms of which the 'adhocracy' form was the one he suggested was now prevalent in most organisations. This adhocracy form was later to be expanded into six forms each having advantages and disadvantages in terms of the potential way people dealt with each other and barriers that existed or developed as a result. These were detailed in figures 2, 3, 4 and 5.

Schein focused on motivation because he believed there had been too many misconceptions and myths about it. He believed that too many people attempted to infer motives from observed *organisational* behaviour. For example, good workers have been assumed to be highly motivated and poor workers lacking in ambition. However, it could be that the good worker has a good manager who develops, supports, encourages and rewards the *exploration* of innovation and creativity, and not just the achievement. In this way a poor manager may criticise and punish failed attempts at creativity and innovation, treating this as poor performance. This in turn becomes reinforced behaviour and the individual may withdraw, rebel and become sub-standard in the eyes of their manager.

Poor managers may not just be guilty of criticism, as ignoring people is as bad if not worse than being punished - at least when you are punished there is some manifestation of the manager's feelings.

The Psychological Contract

The first person to mention the psychological contract was Argyris (1960). Kotter described it as "An implicit contract between an individual and his organization which specifies what each expects to give and receive from each other in their relationship". Herriot had described the psychological contract as "the invisible glue which bonds individuals to the organisation over time. It incorporates the parties' beliefs, values, expectations and aspirations". The definition most often referred to is that made by Schein who described the psychological contract as "a set of unwritten reciprocal expectations between an individual employee and the organization".

Schein concluded that to achieve personal and organisational effectiveness there needed to be a *psychological contract* between the two parties that was characterised by:

1. The degree to which their *(the employee's)* expectations of what the organisation will provide them and what they owe the organisation in return matches the organisation's expectations of what it will get in return.

2. The nature of what is actually to be exchanged (assuming there is some agreement) – money in exchange for time at work; social need satisfaction and security in exchange for hard work and loyalty; opportunities for self-actualisation and challenging work in exchange for high productivity; high quality work and creative effort in the service of organisational goals; or various combinations of these and other things

Schein 1988 p99

It is the interaction of personal and organisational dynamics that shapes the relationship between the two – the *psychological contract*. The psychological dynamics cannot be seen if personal motivation or organisational dynamics are examined in isolation from each other (Schein 1988). The psychological contract is therefore dynamic in nature and changes over time. The psychological contract has been described as *elusive* (IPD 1996) as it was concerned with assumptions, expectations and promises. In the past the psychological contract has been strongly linked with perceptions of job security and with the changes to portfolio careers and more mobile career pathways it was considered important to assess not only perceptions of job security but also any significant links with components of the psychological contract.

The dynamic nature of the psychological contract is especially relevant when there are change in goals or organisational norms (culture, values and beliefs). A governing factor is the nature of these norms and the strength of affiliation that the employee and organisation feel towards these norms. Some norms will be felt to be essential (pivotal) and not negotiable, other norms may be desirable (peripheral) and give both employee and organisation some latitude for *negotiation*. Argyris described these essential personal norms as *governing values*. Schein characterised the acceptance or rejection of these pivotal and peripheral norms in a matrix (Figure 17).

Figure 17 Matrix of peripheral and pivotal norms

		Pivotal norms: *Accept*	Pivotal norms: *Reject*
Peripheral norms	***Accept***	Conformity	Subversive rebellion
	Reject	Create individualism	Open revolution

Schein 1988 p 100

Which norms are pivotal and which are peripheral would need negotiation and agreement for each situation but the generic model suggests that:

- Where pivotal and peripheral norms are accepted, the employee acts in a way perceived as *conformity* – a *company worker.*

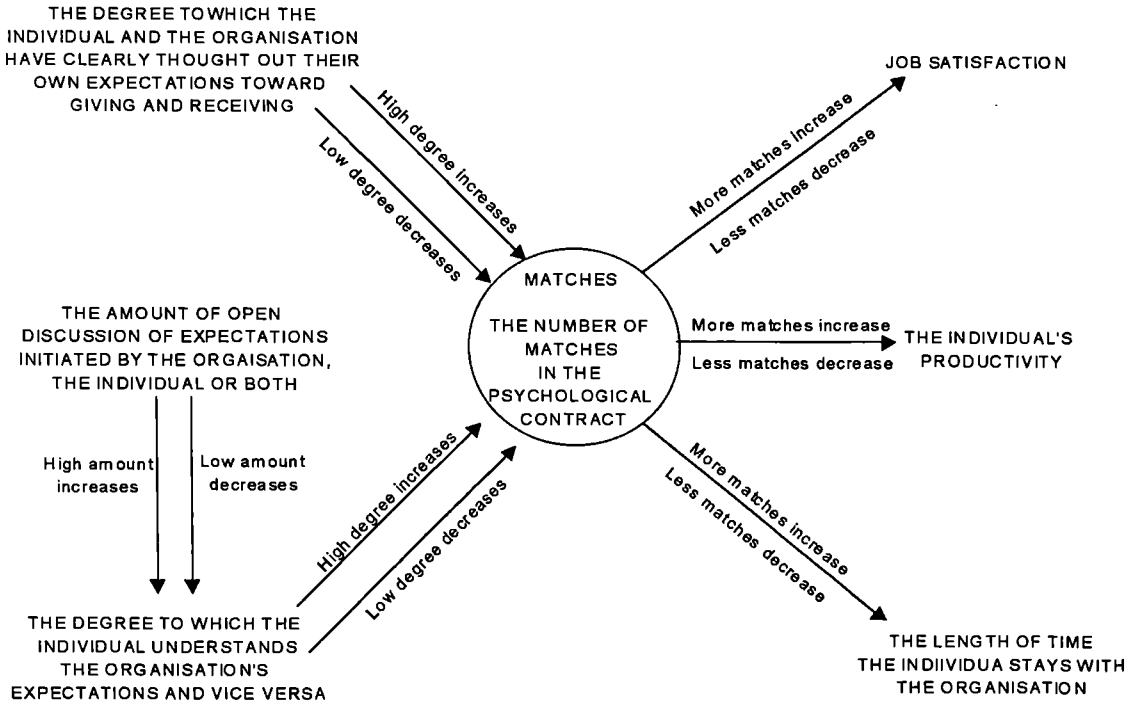
- Where pivotal and peripheral norms are both rejected by the individual there will probably be a manifestation in the form of *open revolution.* The open nature of this interaction is likely to result in the individual leaving the company either by choice or involuntarily!

- Where pivotal norms are accepted but peripheral norms are rejected the employee may display two characteristics that may complement each other or be opposed to each other. The employee may display individualism in a positive way and become creative. For an organisation that needs to innovate this is good news. However, if the organisation frowns on individualism for any reason, then this type of employee may be seen as having negative attributes and not being a *company worker*, being out of line and *non-conformist.*

- Rejecting pivotal norms but accepting peripheral norms may well result in personal dichotomy and manifest itself as *subversive rebellion*. The covert nature of this reaction may be the most damaging as it can be difficult to identify.

It would be expected that components of the psychological contract relate to elements of the organisational framework previously described. The health of, as well as changes in, elements the framework would be expected to impact on the psychological contract. Breaking, absence of, or damage to, the psychological contract would be expected to affect an employee's sense of commitment, sense of belonging to their organisation and their sense of well-being. Kotter (1972) described this effect diagrammatically (figure 18).

Figure 18 Kotter's mis-match model for the effect of the psychological contract



Kotter (1972) p95

The IPD described these interactions in terms of the model shown in table 12:

Table 12 A model of the psychological contract

Causes	Content	Consequences
Organisational culture	Fairness	Organisational citizenship
Human Resource Management policy		Organisational commitment
	Trust	
Experience		Motivation
Expectations		
Alternatives	The delivery of the deal	Satisfaction and well-being

IPD 1996 p 6

Fairness and trust are therefore identified as two components of the psychological contract but *delivery of the deal* needed stating in ways that respondents could readily identify with and respond to meaningfully.

Job security has been linked historically to the psychological contract. Employees might have reasonable expectations that they would be promoted as long as their performance and behaviour were satisfactory. The recent advent of portfolio careers and more mobile career pathways meant that this assumption would need testing as part of this research.

However, it might still seem reasonable to employees that they would be encouraged to learn and be creative, and that there would be opportunities to enhance their skills and knowledge as this would benefit their employer in respect of organisational effectiveness and achievement. Even if job security were no longer a feature of the modern organisation, it would still be an expectation that

employees would be treated with respect and their personal rights protected e.g. there would be a reasonable expectation that any downsizing would respect national and local laws, and agreements about periods of notice, redundancy etc.

Motivation theorists have made links between *meaningful work* and motivation. Whilst the IPD found that staff motivation was not a predictor of outcome, an employee might still expect their work to be meaningful.

As previously discussed, the pattern of work has changed in ways that promote empowerment of employees. This being so, one would expect to find employees experiencing increased numbers of self-managing teams, increased involvement of employees in decision making, and increased responsibility for individual employees. If the psychological contract were fully effective and organisational arrangements were appropriate and responsiveness then personal and organisational achievement should result, superior performance being recognised and appropriately rewarded.

Components of the psychological contract for the purposes of this research are summarised as employees perceiving that there is:

- involvement in decision making
- meaningful work
- personal responsibility
- an opportunity to be part of self-managing teams
- investment in training and skills development
- an atmosphere that encourage trust and mutual respect
- protection of personal rights
- recognition of, and reward for superior performance

Summary

Theories of motivation support the premise that if individuals feel insecure, perceive threats, foresee punishment or do not perceive reward or achievement as a result of their personal efforts, then they are likely to develop defensive behaviours to safeguard themselves. The interaction of organisational dynamics and personal motivation must be considered together. Organisational form is a determinant of the effect that the analytical elements of Kotter's model might have on the ability of an organisation to overcome defensive routines that people may develop in response to perceived threats.

The foregoing have fundamental effects on the psychological contract and its components which itself has a fundamental effect on employees, their propensity to perceive 'threats' and their propensity to become defensive.

Defensive Behaviours

This section builds on motivational theory, introduces the concept of defensive routines between individuals and between individuals and organisations. Professional and cultural tribalism is explored and links made to defensive routines, the *games* people play with each other and why we may lie and deceive or delude ourselves or others. A formal theory of defensive behaviour is stated and the terms defined.

Theory of Defensive Behaviours

Kotter's model uses the element of *Social System* to address issues that encompassed organisational values and norms as well as inter-personal relationships and the related issues of power, affiliation and trust.

Lomas (1993) highlighted the role that community norms played in determining clinical practice decisions when these norms had been built up over long periods of time. Scott and Jaffe saw defensiveness and resistance to change as showing that personal systems of self-defence were beginning to take over from rationality. Senge found that people often confuse loyalty to their job with loyalty to their own identities. Scott and Jaffe found that resistance arose in individuals because their security was threatened, the change threatened their sense of competence, they feared they would fail in new tasks or they were comfortable with the *status quo*.

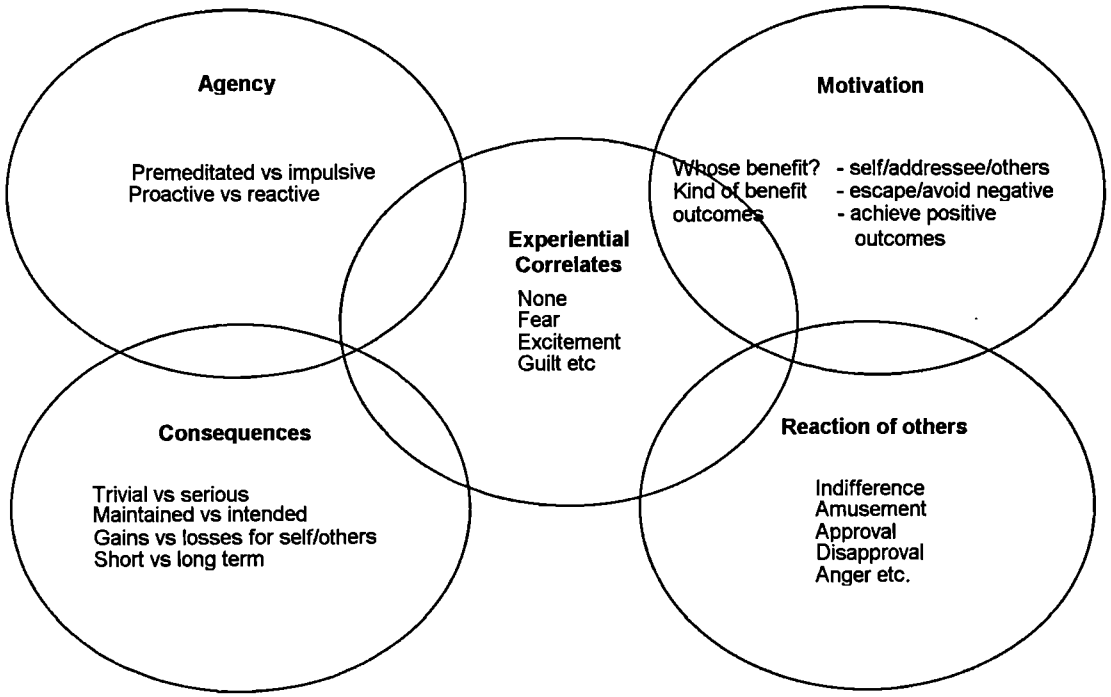
Scott and Jaffe made no link between resistance or personal values and beliefs nor did they make a link with potential conflict between professional and corporate loyalties. O'Brien *et al* identified that when the development of organisational cultural was under-emphasised, efforts were not directed at solving inter-departmental problems either because the organisation did not have the culture to sustain change or because employees effectively blocked implementation. O'Connor and Seymour, whilst researching neuro-linguistic programming, found that when individuals think they tend to 'favour one, perhaps two, representational systems regardless of what we are thinking about'. This supports the hypothesis that we subconsciously react in ways that consciously they might not choose.

Sub-cultures (*Tribes*) are often encouraged by professional education and training and Morris (1995) found that these sub-cultures cut across the dormant culture of the business, often providing opportunities for development, and sometimes unintentionally producing inertia, confusion and cynicism. This can manifest itself in *games* that tribes play with each other. Levitt and Wall (1996)

noted that when the government failed in 1991 to merge District Health Authorities with Family Health Service Authorities there was much internal strife and "FHSAs for their part made the most of the Government's primary care emphasis to enhance their reputation".

During the development of this research discussion took place with Professor Peter Robinson of the University of Bristol who has modelled individual-individual and individual-organisational interactions from the perspective of why individuals deceive, delude and tell lies (Robinson, 1996). His model has five dimensions and is shown in Figure19.

Figure 19 Model of individual-individual and individual-organisational interactions



Robinson (1996) makes reference to work done by Hopper and Bell who worked with a group of students and yielded six forms of deception (Table 12) - The words in italics are those grouped by students in the study.

Table 12 Six forms of deception

1. *Fictions* - words such as *exaggeration, myth* and *white lie*
2. *Playings* - amusements at least as far as intentions are concerned (e.g. *joke, hoax & tease)*
3. *Lies* - false verbal statements communicated with the intention to deceive (*lie, untruth, dishonesty, fib and cheating)*
4. *Crimes* - acts proscribed by law (*spy, forgery and disguise).*
5. *Masks* - activities that mask another person's view of the truth (e.g. *hypocrisy, two-faced & evasion).*
6. *Un-lies* - deception through implication (e.g. *distortion and misrepresentation*)

Failure to develop, or the breakdown of good relationships may result in tensions between people. Non-performing teams may try and blame one individual as a scapegoat thus 'taking their eye off the ball'. As Fritchie and Leary say "being right is not enough - attitudes are personal, behaviours belong to the organisation".

Blenkhorn (1995) found that make most managers felt uncomfortable with having their personal performance evaluated in certain ways. Blenkhorn called these *warm fuzzies* – *warm* he ascribed to corporate ideals to which few managers could take exception, and *fuzzies* he ascribed to those measurement issues which managers said would make them most uncomfortable with having their personal performance evaluated in these dimensions (see Table 13). These elements form constituents of organisational effectiveness and yet Blenkhorn's research shows that managers find discomfort in having their personal performance measured against them. This discomfort leads to a reluctance to discuss personal effectiveness in these areas and Argyris found that consequently defensive reasoning produces organisational defensive loops that lead to defensive cultures

and barriers to organisational effectiveness. These processes become self-fulfilling and self-sealing as they become *undiscussable* as described by Argyris (1985). Self-fulfilling is defined as "an expectation that leads to a certain pattern of behaviour whose consequences confirm the expectation".).

Table 13 'Warm-fuzzies'

Management Direction	The extent to which the objectives of an organisation, its component programmes or lines of business, and its employees, are clear, well integrated and understood and appropriately reflected in the organisation's plans, structure, delegations of authority and decision making processes
Relevance	The extent to which a line of business continues to make sense in regard to the needs of the public
Appropriateness	The extent to which efforts being made by the firm are logical in light of the specific objectives to be achieved
Achievement of intended results	The extent to which goals and objectives have been realised
Acceptance	The extent to which customers, for whom a line of business is designed, judge it to be satisfactory
Secondary impacts	The extent to which other significant consequences, either intended or unintended, and either positive or negative, have occurred
Productivity	An organisation's ability to adapt to changes in such factors as markets, competition, available funding or technology
Working environment	The extent to which the organisation provides an appropriate work atmosphere for its employees, provides appropriate opportunities foe development and achievement and promotes commitment, initiative and safety
Protection of assets	The extent to which important assets such as sources of supply, valuable property, key personnel, agreements, and important information are safeguarded
Monitoring & Reporting	The extent to which key matters pertaining to performance and organisational strength are identified, reported and carefully monitored

Individuals and groups of people may look at these issues and their general work in very different ways, each having their own language, values, histories,

sense of impatience, and rules for appropriate behaviour. This can be observed as a real or perceived inability to live in other people's worlds. Neuhauser found links to professionalism where different functions assume that others were aware of what they consider important. What one function thought was vital to success another function saw as inconsequential. Crow suggested that organisations could be thought of as a network of competing tribes, where power is distributed based on ability to control valued resources.

Morris found that successful organisations have been able to bring tribes together in durable confederations with the larger commitment to securing the success of the business as a whole. Handy (1995), and Osborne and Gaebler both proposed the concept of federalism and *twin citizenship*. This concept allows for individuals to be members of two groups simultaneously without conflicts of interest either professional or personal. An example would be an American from Texas who could be proud to be both a Texan and an American at the same time – as Handy says "being unique and yet being the same". Handy described individuals as being a member of one or more of four groups:

> **The club tribe** Handy described as being like a spider's web with the whole organisation at the centre with ever widening circles of influence and intimacy – the closer to the centre the more influence you have. However, it is the intimacy factor that is important, with the leader at the middle and those associated with the leader being members of that club. Those in the club find it an exciting place to work, sharing the same values and beliefs as the leader and other club members. The club can respond quickly to threats or new opportunities, since there is centralised power and good

communication, but as the success of the club relies on the strength of the leader, the loss of a strong leader can be devastating. This tribe works best when numbers are small (about 20), the 'right' people have been employed and the task requires this style of leadership e.g. the theatre, warfare, politics.

The role tribe Handy believed was best described as a traditional hierarchical tree – the boxes in the tree continue even if the person in that role should leave. The organisation sees itself as being a set of inter-linked roles. Such organisations usually abound with procedures and rules, they are managed rather than led, are secure and comfortable but often too predictable to be exciting. This tribe finds it hard to adjust to change or exceptions, finding difficulty in dealing with independence or initiative. This tribe works best when tasks are routine and stable e.g. banking, tax collection, public utilities.

The task tribe he described as being focused on a problem, project or task that a group of people has been brought together to complete. These groups can be disbanded, changed or re-formed as necessary and provide many people with the continuous stimulus they need to stay motivated. Such groups are seen by Handy as co-operative and yet the formation of a group does not in itself necessarily make everyone commit themselves fully or openly. For example, a finance professional may find conflict in achieving a task that goes against his/her professional standards by bending financial rules more than they feel comfortable. In other words

they are torn between being members of two tribes – club (financial) and task (the project in hand). They may additionally feel they have to report back to their professional, hierarchical leader for advice or guidance thus making them a member of a third, role tribe as well. Task teams offer the excitement of new challenges but with this comes the insecurity of employment as team members can be discarded at any time. This can make individuals protective of their professionalism, make them less inclined to share (valuable) information and perpetuate the team's work longer than necessary. These tribes work best when young, enthusiastic team members are testing their talents in the knowledge that new opportunities elsewhere are available when they wish to move on.

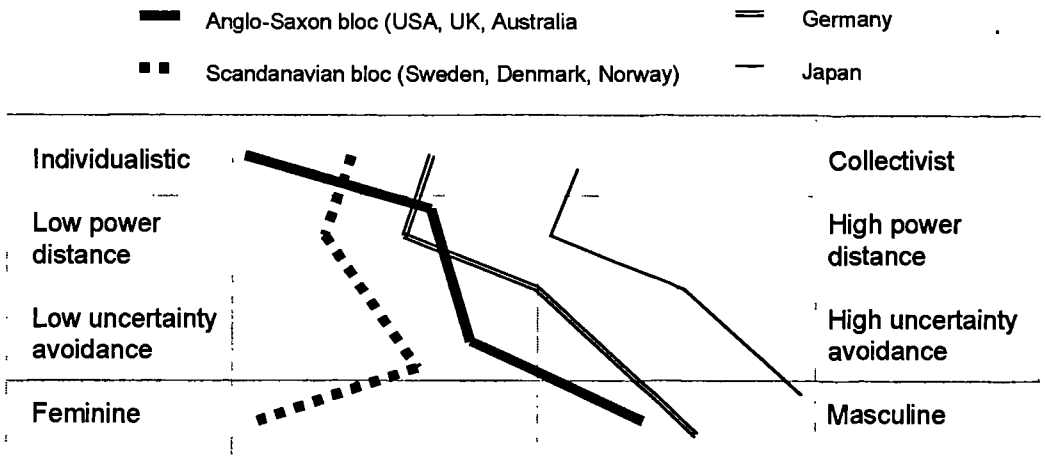
The person tribe was described by Handy as stars in a constellation – individual but recognisable because of they way they are arranged. The individual comes first and uses the organisation as a resource for them to use their individual talents. Doctors and barristers are good examples of this tribe at work. These tribes shy away from using the words *organisation or manager* preferring to use other words such as *practice,* and *chambers, bursar* and *senior partner* to describe their organisation and those at the top of the tree. In such tribes the professional is often the senior person rather than the *manager.* Members of *person tribes* cannot be commanded but have to be persuaded, cannot be managed but can be influenced or bargained with. Tribe members will not easily compromise their beliefs when working in teams and this can form significant barriers to knowledge sharing and team or organisational effectiveness as a result.

Goffee (1996) found that academic research on tribalism and cultural diversity had remained predominantly North American. Goffee described cultural diversity as "collective mental programming – deep assumptions not directly accessible, which may be reflected in values, attitudes and behaviours of individuals and groups". Goffee found Hofstede's model to be "influential". Based on a very large, world-wide survey Hofstede developed four dimensions within which human relationships could be understood in relation to work-related values:

- **Power Distance** — The extent to which the less powerful expect and accept that power is distributed unequally
- **Uncertainty avoidance** — The extent to which uncertainty or unknown situations are perceived as threatening
- **Individualism/ collectivism** — The extent to which individuals and families are expected to look after themselves
- **Masculinity/ femininity** — The extent to which *masculine* values (assertiveness, ambition, achievement) dominate as opposed to *feminine* values (relationships, quality of life, service).

Goffee examined the effects of international cultural differences that people had towards these values (Figure 20). This showed that, for example, those grouped as *Anglo-Saxon* (USA, UK, Australia) had moderately high preference for masculine values (assertiveness, ambition, achievement) whereas those in the Scandinavian block (Sweden, Denmark, Norway) showed a very high preference for feminine values (relationships, quality of life, service).

Figure 20 Inter-cultural differences toward work-related values



Goffee (1996)

Such differences suggest that research literature needs to be carefully considered to ensure that value, belief etc. frameworks are comparable. Goffee's work also gives a very useful profile of the general profile of those in the Anglo-Saxon group and also provides possible areas for future research of sub-cultural and professional workforce profiles within each group. It is believed that this would add to the understanding of *professional tribalism*.

Schofield (1998) saw the *feminine* values as being elements of the *soft* skills associated with people management. Schofield saw the need for executives to develop these skills for the 21st century as companies de-layered, people 'had to know more things' and especially how to work in cross-functional teams.

Hampden-Turner and Trompenaars found there to be twelve key, related value dimensions (arranged in six pairs) with associated management dilemmas:

1. Universalism vs Particularism

When no code, rule, or law seems to quite cover an exceptional case, should the most relevant rule be imposed however imperfectly, on that case, or should the case be considered in its unique merits, regardless of the rule?

2. Analysing vs Integrating

Are we more effective as managers when we analyse phenomena into parts, i.e. facts, items, tasks, numbers, units, points, specifics, or when we integrate and configure such details into whole patterns, relationships and wider contexts?

3. Individualism vs Communitarianism

Is it more important to focus upon the enhancement of each individual, his or her rights, motivations, rewards, capacities, attitudes or should more attention be paid to the advancement of the corporation as a community, which all its members are pledged to serve?

4. Inner-directed vs Outer-directed Orientation

Which are the more important guides to action, our inner-directed judgements, decisions, and commitments, or the signals, demands, and trends in the outside world to which we must adjust?

5. **Time as Sequence vs Time as Synchronisation**

   Is it more important to do things fast, in the shortest possible sequence of passing time, or to synchronise efforts so that completion is co-ordinated?

6. **Equality vs Hierarchy**

   Is it more important that we treat employees as equals so as to elicit from them the best they have to give, or to emphasise the judgement and authority of the hierarchy that is coaching and evaluating them?

These management dilemmas are likely to manifest themselves when issues within the psychological contract present themselves in workplace situations. If managers choose to maintain the psychological contract they may do so to the detriment of corporate vision, values, beliefs, attitudes etc. If they choose to be corporate as a priority then the psychological contract may suffer with consequent effects on individual.

Hunt (1992) also looked at international cross-cultural differences in goal orientation. Based on Maslow's *hierarchy of needs*, this gave a valuable insight into the way in which motivations differed and the comfort/discomfort that managers in different countries felt when faced with the same working issues (Table 14).

Table 14 **International cross-cultural differences in goal orientation**
(only the top three in each rank shown)

N= 5500 Managers	High mean ranking	Low mean ranking
Comfort Search for financial gain, avoidance of discomfort and stress	1. Spain 2. UK/US 3. France	1. Belgium 2. Sweden 3. Netherlands
Structure Avoidance of risk; search for clarity, order and structure	1. UK 2. France 3. Switzerland	1. Netherlands 2. US 3. Sweden
Relationships Avoidance of isolation; desire to belong to a team	1. Sweden 2. Netherlands 3. Germany/Spain	1. UK 2. US 3. Italy
Recognition Desire for achievements to be recognised	1. Italy 2. US 3. UK	1. Sweden 2. Netherlands 3. Spain
Power Desire to manage and control others	1. Germany 2. US 3. France	1. Spain 2. Sweden 3. Netherlands
Autonomy/creativity/ growth Search for freedom, independence, novelty, challenge, development	1. Sweden 2. US/UK 3. Netherlands	1. Spain 2. Italy 3. France

Hunt (1992)

What Hunt's figures show is that UK managers, generally, have:

- **the highest drive for avoiding risks** (and thus their tolerance of risk takers/taking would be low)
- **a low drive for belonging to a team** (and thus may be 'comfortable' as members of a professional/cultural tribe and find comfort in holding on to personal knowledge)
- **a high need for task achievement to be recognised** (and thus have high reward expectations from economic contracts)
- **a high need for independence, innovation, personal challenge and development** (and thus have high expectations from the psychological contract)

Tribalism usually results in the playing of management *games that* are manifestations of defensive routines. These may be mild and *fun* or quite serious and potentially destructive. To understand these games gives insight into the way in which relationships need managing, the value of knowledge and information, the relevance of partnerships and the importance of self-reference.

The Prisoner's Dilemma (named by Albert Tucker in an unpublished paper) is a relevant example that can be used as an illustration. The scenario is that two prisoners have been arrested for two different crimes that they know they are both guilty of committing. One crime is very minor and the other serious. Police will be able to prove that both were involved in both crimes if either admits guilt. The consequences of pleading innocence or guilt are made clear to each prisoner who is isolated from the other:

- Neither prisoner admitting guilt (co-operating) will result in both getting off
- Either prisoner pleading guilty (finking) will incriminate the other and.....
- The prisoner pleading guilty will have a very small sentence but his partner in crime will have a substantially heavier penalty
- Both admitting guilt will result in both receiving a moderate sentence

The prisoners have had the opportunity to talk to each other and 'get their story straight' before their interview with the police. This can have various outcomes and depends upon the strength of the promises - if promises are not binding, then although the two prisoners might agree not to fink, they would fink anyway when the time came to choose actions. Sentences for the prisoners' co-operation/finking are shown below in figure 21 (prisoner 1 sentence in column 1).

Figure 21 **Model of prisoners' dilemma**

		Prisoner 2	
		Co-operate	**Fink**
Prisoner 1	**Co-operate**	Free/Free	6 years/ 3 months
	Fink	3 months/ 6 years	2 years

This is similar to the Hawk/Dove game described by Rasmusen (1989) and Shubick (1982) that relates to the financial trading approach taken by each player. If each player chooses to be a dove then moderate rewards are gained by each. The rewards are greater if one player chooses to be a hawk but then the other gains nothing. However, if both choose to be hawks then both lose. Only choosing to be dove/dove results in a win/win scenario. All their scenarios result in lose/lose or win/lose with consequential probability that the loser will try and be a hawk the next time if they perceive that they need to win to save face, get their own back or recoup their loses (either financial or reputation).

Although inherently a non-co-operative game, the prisoner's dilemma can be modelled as co-operative by allowing the prisoners to communicate and make binding agreements. Co-operative games often allow players to split the gains from co-operation by making *side-payments* – transfers between themselves that change the prescribed pay-offs. Co-operative game theory generally incorporates commitments and side-payments via the solution concept, which can become very elaborate. For the NHS this is a co-operative game in which players can make

binding commitments (as opposed to a non-co-operative game in which they cannot).

McKay (1994) found for the North American healthcare system that co-operative game theory was automatic and frequently appealing to Pareto with regard to optimality, fairness and equity. McKay found that mediation and communication were both important in the absence of a clear focal point and that if players could not communicate, mediation might be able to help by suggesting an equilibrium. Handy (1994) believed that "loyalty goes first to one's team or project, then to one's own profession or discipline and only third to the organisation. If these are not the expectations of others – peers or line managers – then conflict, both personal and managerial, is inevitable and defensive routines a significant likelihood". Butler (1998) expected the Common's select health committee to address issues of tribalism "which affects NHS occupations" as part of its review of the chronic recruitment and retention problems in the NHS.

Argyris introduced the concept of *individual-individual* and *individual-organisational defensive routines* in 1985. Our reasoning is based on personal values, beliefs and cultures. Argyris found that these acted as barriers to organisational effectiveness when personal values, beliefs and cultures did not align with those of the organisation as a whole or with individual parts of it. In practice we therefore have two types of reasoning – productive and defensive. Oakley and Greaves found a similar defensive reaction when individuals perceived, for example, that the founding principles of the NHS were at risk.

Argyris could not find any systematic discussion or advice in the literature on how to engage defensive routines or how to prevent them. The research done by

Argyris concluded that defensive routines were probably the most important cause of failure in the implementation of sound strategy regardless of the approach used.

Argyris introduced the concept of issues that were *undiscussable* that are similar to Blenkhorn's *warm fuzzies*. Researchers have identified these issues as ones which must be clear, unambiguous, widely shared and owned, yet Blenkhorn's research also suggests that these may be *undiscussable*.

Argyris proposed several models based on his research. The first of his models is based on three elements of an individual's *master programme*:

1. the espoused theory individuals develop in the form of *if-then* propositions that define for that individual, what effective action should be taken *in that context*. e.g. when trying to help individuals to share knowledge, minimise actions that may make them defensive. These are our beliefs, attitudes and values.
2. operating assumptions that define effective action *regardless* of context e.g. don't trust people with power.
3. the *theory-in-use* – what people *actually* do when they take action.

Argyris exemplifies the principle of defensive routines as:

> If Y acts insensitively and punitively [premise], then [given a tacit theory of human defences] X, as the recipient of Y's action, will probably act defensively [conclusion].
>
> X's defences now become a premise for further reasoning about their future action *(when interacting with Y or perhaps other people)*

Argyris in Vroom and Deci p461

Individuals may, or may not, be aware of the differences between their espoused values and their actions. Argyris argued that whilst individuals often have "fundamental, systematic mismatches" between espoused theories and their actions, "individuals develop designs to keep them unaware of the mismatch" in order to *save face* when there are issues that are embarrassing or challenging. Argyris argues that this *ignorance* may be programmed into us.

Argyris developed Model I which dealt with observed behaviours of individuals with other individuals, and with organisations for which they worked or with whom they had contact. Individuals showed inconsistencies between their espoused and actual values and behaviours that became self-reinforcing. Through testing Argyris found the model held true in 99% of the 2000 cases he tested in North America, South America, Europe, Africa and the Far East. He found that whilst espoused theories varied widely, there was almost no variance in theories-in-use. Argyris summarised this as each of us wanting to:

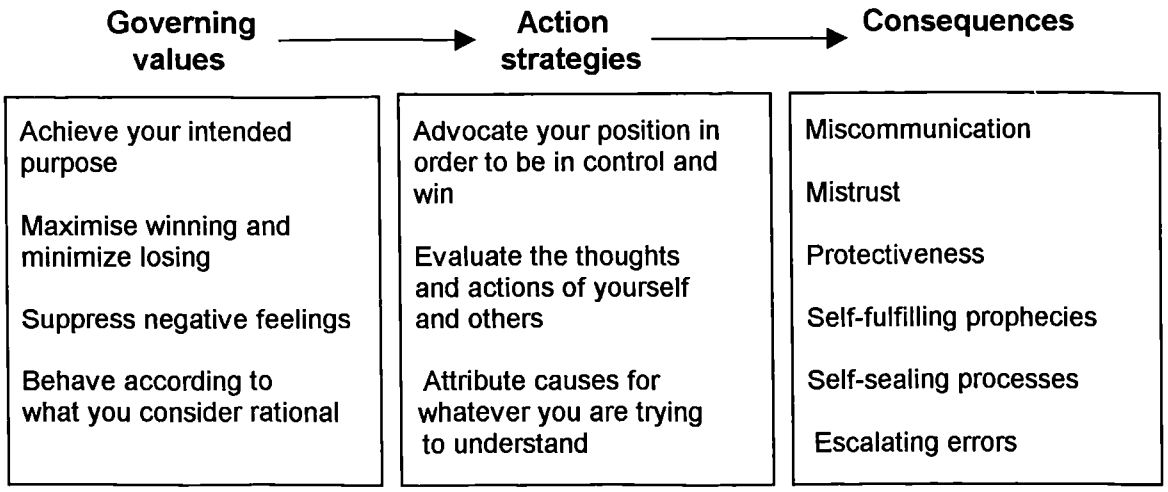
- Achieve our intended purpose
- Maximise winning and minimise losing
- Suppress negative feelings
- Behave according to what each of us considers rational

In order to achieve this, Argyris found that the *theories-in-use* that people use (i.e. what they actually do) to achieve these needs are:

- Advocate their own position
- Evaluate their thoughts and actions against those of others
- Attribute causes for whatever they were trying to understand

Each of thus performs in ways that satisfy our governing values by seeking a minimum, acceptable level of control, seeking to win or seeking to bring about any other desired result. These Model I theories-in-use are summarised in Figure 22.

Figure 22 Model I: Theories-in-use

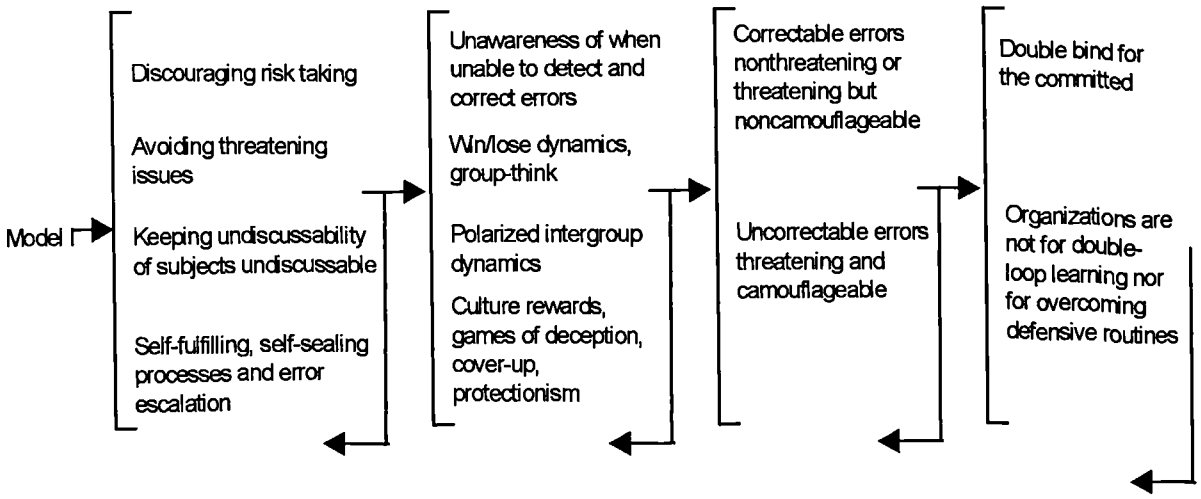


Argyris (1985)

However, Model I inhibits enquiry of governing values by others and as a consequence Argyris found that there was a likelihood of defensiveness, misunderstandings, and that the process would become self-fulfilling and self-sealing.

If it is true that most people use Model I, then Argyris claimed the consequences of this were the creation of organisational behavioural worlds that were consistent with, and protected the use of Model I. The organisational world Argyris described by his Model O-I, characterised by there being only limited learning in place. This is summarised in Figure 23.

Figure 23 ModelO-I



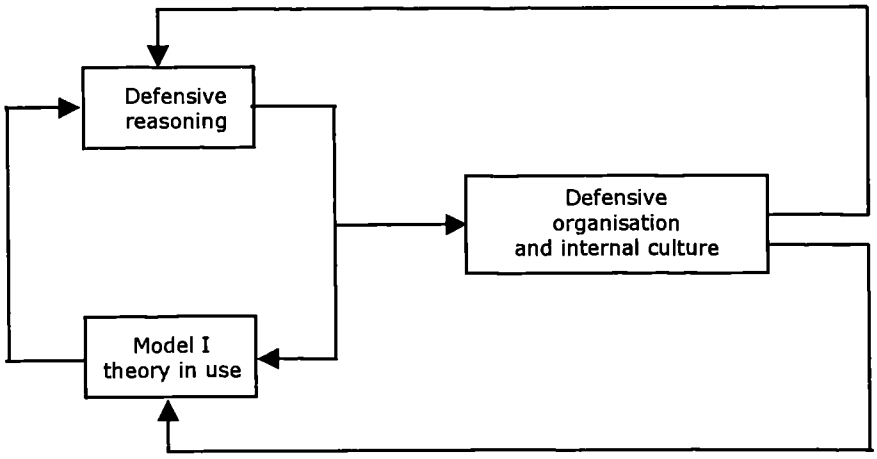
Argyris (1985)

The context or environment significantly influences how individuals think about effective action and as a result how they design and implement their thoughts. The theory is that individuals develop personal reasoning (*self-reference*) using their own value systems and *soft* information that they find compelling. Personal experiences make individuals want to win rather than not lose, and also to save face. Defence of these behaviours at work is reinforced by these and manifest themselves as the *consequences* in Model I.

Rather than individuals becoming defensive against the organisation, Argyris found that where inter-group dynamics were competitive rather than co-operative, mistrust replaced trust and informed dissent replaced blind deliverance. Coalition groups (tribes) arose as a result. Argyris found that this happened even though people did not realise that they are being defensive.

Figure 24 shows defensive reasoning coupled with models I and O-I, and how it can produce *organisational defensive loops* that lead to defensive organisations and cultures that become barriers to knowledge sharing and organisational effectiveness.

Figure 24 Model of defensive reasoning



Argyris (1985)

In these conditions policy and structural changes alone are unlikely to lead to double loop learning (Argyris). For changes to occur individuals need to change their theory-in-use through learning and change their personal O-I system. Changes need to be implemented at top management levels and be seen to have changed with new leaning systems and new actions demonstrated.

An organisational defensive routine is therefore any action, policy or practice that prevents organisational participants from experiencing embarrassment or threat whilst also preventing them from discovering the cause of the embarrassment or threat.

Organisational defensive routines are caused by circular, self-sealing processes in which individual's Model I theories-in-use produce individual

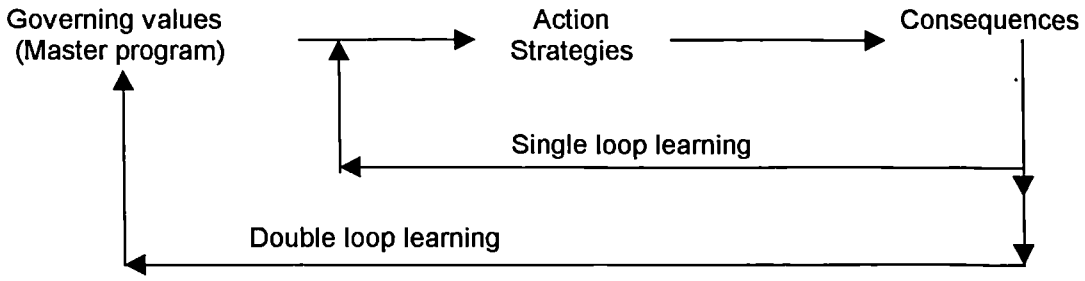
strategies of bypass and cover-up that result in organisational bypass and cover-up. These in turn reinforce individual's theories-in-use.

Argyris argued that this inter-dependence meant that both individual *and* organisational defensive routines had to be overcome in order for either to change. If only one side changed there might be some short-term benefits but this was unlikely to be maintained.

Individual's sense of competence, self-confidence and self-esteem are highly dependent upon their Model I theories-in-use and organisational defensive routines. Argyris claimed that this dependence "practically guarantees" that even when individuals act in ways to try and produce double-loop learning, the consequences will be "skilfully counter-productive" because Model I theories-in-use will not allow Model I governing values to be changes. Individual's theories-in-use thus become so internalised that they become taken for granted. Argyris described humans as *skilfully incompetent* (*skilful* behaviour being defined as *that which appears effortless and is produced automatically*).

Individuals learn from these experiences in ways that Argyris described as *single loop* or *double loop learning.* Single-loop learning occurs when individuals examine the consequences of an action they have taken and without considering any changes necessary in their master programme (i.e. they are not learning), proceed to develop another action plan. Double-loop learning occurs when individuals critically examine the outcome and consequences of their actions, interpret the reaction of others against their master programme, and learning from the experiences make any changes necessary to their master programme. This is summarised in figure 25.

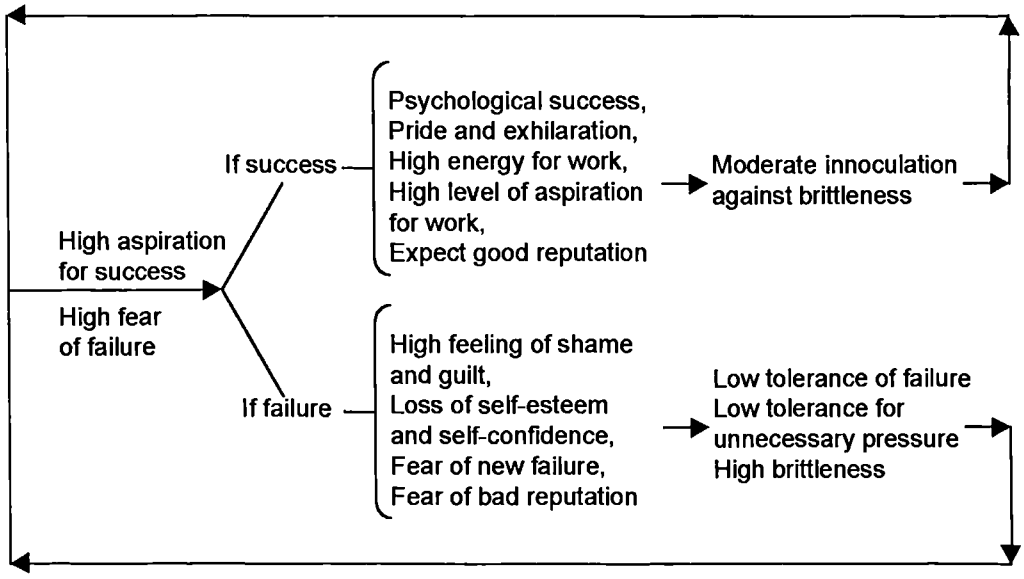
Figure 25 Single- and double-loop learning



Argyris (1985)

The interrelationship of Model I and the double-loop learning framework result in the paradox that double-loop learning could become both productive and counter-productive. Argyris described two possible scenarios for the input-process-outcome model based on an individual's high aspiration for success or their high fear of failure. These are shown in figure 26.

Figure 26 Double-loop learning – the psychology of success-brittleness syndrome



Argyris (1985)

The *brittleness* described here suggests a susceptibility to *breakage* rather than a totally predictable outcome. Argyris appears not to recognise the potential of

a third possible scenario to *if success/if failure* in that individuals may receive no feedback. However, in such circumstances the individuals will interpret whatever feedback they may get (real or imagined) and use their own master programme to interpret circumstances and incidents as success or failure and this will be real to them. The stress levels for individuals in such circumstances are likely to be considerably higher than for those who really know the truth. Argyris' findings about individuals' governing values accord with many classical models of rational human and organisational behaviours:

- An individual's actual behaviour (theories-in-use) is usually to seek to *win*
- The consequences are frequently mistrust, miscommunication, protectiveness etc
- Individuals may not know whether feedback they receive is genuine, or they may be given negative feedback when others feel the need to exert their personal power or authority in order to win
- This turns the individual's attention away from their governing variables and towards choosing an action strategy to safeguard themselves
- The consequences are that people escalate the errors in appropriate action, become defensive and focus on their self-protection i.e. 'save face'

Argyris suggested that one needed to go beyond beliefs, values and attitudes (i.e. beyond espoused theories) to collect relatively directly observable data from which to infer the theories-in-use.

To overcome potential defensive routines Argyris suggested that people needed to be educated in a new model of theory-in-use that he called Model II.

Argyris believed that in order to develop Model II, individuals had to develop their own information and own it, receive feedback positively and receive feedback in ways that encourage the individual to act *appropriately*. Model II is characterised by:

- governing values being based on valid knowledge and information, and informed choice
- differing values, beliefs and cultures being known and understood
- action strategies clearly displaying how those that prepared it reached their conclusions
- 'errors' being detected and corrected as part of a learning organisation
- there being trust and respect

Argyris also suggested that people may need help to develop the necessary skills and develop the necessary organisational features. For example, skills to be candid and invite candour from others, cultures that have norms of trust and risk-taking, organisational policies that demonstrate the new values and skills.

Personal motivation is explained through motivational theories. There are close links to the way in which organisations are structured and they ways in which they work. There are advantages and disadvantages of any organisational arrangements (organisational *form*) and associated barriers to the sharing and use of knowledge.

In their survey of 1,361 managers, the Institute of Management (1998) found that 60% of those surveyed had been affected by organisational change with most of the respondents citing the change as being aimed at driving down costs and increasing competitiveness. The study showed that two thirds of those surveyed

believed that restructuring had had a massively negative affect on employee loyalty, morale, motivation and perceptions of security with the most severe effects being in public limited companies and public sector organisations.

Perceptions of impact varied greatly between respondents. Chairmen, Chief Executives and Directors tended to believe that loyalty, morale and motivation had all improved as a result of restructuring. However, an "overwhelming majority" of senior managers disagreed with this optimistic assessment, with the views of junior management becoming progressively more negative. Wall (1999) found that middle management was "the most uncomfortable job in the managerial hierarchy....dumped on from above and reviled by those from below".

Macintosh (1999) reported that managers and GPs had warned that further "wholesale reorganisation" and job losses could follow if dozens of PCGs decided to move to Trust status in 1999. Macintosh quotes Cathy Hamlyn, Associate Director of the NHS Confederation as saying that the effect of structural change on managers' jobs was a concern for PCG staff and for community trusts which will be directly affected by the move to Primary Care Teams (PCTs). Macintosh also quotes Mike Sobanja, Chief Officer of the NHS Primary Care Group Alliance as saying that there was more danger to managers' jobs from mergers than from moving up the levels toward trust status.

Defensive routines are therefore likely to continue if:

1. individuals are embedded only with Model I
2. individuals are embedded in an I-O learning system and...
3. there are issues that are individually or organisationally threatening

It is these theories that are to be tested in this research.

Summary

Few people look with neutrality upon any proposal that will affect them personally. They will either see the proposal as an opportunity or a threat dependant upon whether they see themselves as having weaknesses or strengths that will enable them to 'win'. Whilst efforts can be made to overcome defensive routines, Argyris found personal opportunity or threat to be the over-riding motivation to be overtly or covertly supportive or defensive towards proposals which individuals found threatening to their values, culture or beliefs they might have and that were deeply held.

Individual values, culture and beliefs (personal standards) need to be identified, legitimised and aligned with those of other individuals, with other professionals (these are professional standards) and with the organisation with which they work (these are organisational standards). Individuals need to have the confidence to make their personal and professional standards known without fear of being excluded, criticised or punished. 'Win/win' situations should be the natural expectation, reinforced by observable behaviours which themselves are rewarded. Innovation and managed risks should be rewarded and not punished and individuals should feel comfortable with having their personal performance assessed by others apart from their usual line/professional manager.

CONCLUSION

The NHS could be viewed as a *service organisation* whose effectiveness is assessed by the extent to which it meets its operational and strategic objectives. There is local interpretation and implementation of action but all broad objectives are set within the context of national Planning & Priority Guidelines. Politicians and

their civil servants set and assess these broad objectives. The degree of subsequent achievement through local implementation and the associated degree of success are assessed, for example, by the extent to which local people perceive their local NHS is providing services that meet their expectations. This can lead to competing claims where, for example, there is a national imperative to keep within budget whilst patients perceive that treatment should be available when it is needed, without delay and regardless of cost. Achievement is therefore assessed dichotomously by stakeholders who often hold very different sets of values and beliefs by which *effectiveness* is judged.

Kotter's model for analysis of organisational dynamics has been used as a robust tool for analysing health authority organisational dynamics. It has been identified that the human elements in most organisations will probably result in barriers to full co-ordination of effort because of functional and professional differences in values, cultures and beliefs unless there are particularly strong or influential reasons which override these differences. The way that organisations are structured has been shown to have a strong influence on working arrangements that can facilitate or form barriers to knowledge sharing.

One overriding influence can be the extent to which cultural and professional values and beliefs differ from those who hold the purse strings. For example, clinicians rely on knowledge sharing to benefit their patients. Clinical failures may result in their professional organisations taking punitive action that could result in loss of registration and consequent loss of career. The motivation is thus to minimise the threat of punishment and maximise benefits to patients (and consequently themselves). This motivation is usually sufficient to override any potential defensive behaviour.

It has been determined that organisations can be established to satisfy just a short-term goal or be established to satisfy both short and long-term goals. It has been identified that there is a basic organisational framework that exists as a pre-requisite to longer-term survival, effectiveness, growth, development and response to a rapidly changing environment. Organisational *health* can therefore be assessed by determining the degree of conformance to good practice in the organisational framework identified through the literature search as necessary to overcome barriers to effective working in general and knowledge sharing in particular.

Once *good health* within the organisational framework provides a safe, secure environment in which individuals can work and develop, organisations can then focus on specific aspects of their business in order to become effective in the longer term. Knowledge and information, relationships, and self-reference have been identified as the emergent organisational dynamics which organisations need to develop as new ways of working evolve.

Individuals need to improve personal competencies generally, and management of relationships in particular. This is increasingly necessary as people work on various time-limited project groups and simultaneously work corporately, functionally and geographically. Organisations need to identify those organisational competencies and skills required both permanently and for specific projects or other time-limited tasks. The result of not doing this is likely to be mismatches between expectations, low morale, high staff turnover, non-achievement of objectives, not having effective individuals, teams or organisations and barriers to knowledge sharing being present as a result.

The management of knowledge, corporate and individual, has been identified as a key element in overcoming barriers to the sharing of knowledge and intellectual capital as organisations become increasingly information and knowledge reliant.

The development of the psychological contract and identification by individuals of their intellectual capital will be major factors in maintaining personal motivation and consequently facilitating the sharing and use of knowledge.

People either see progress or change as an opportunity or a threat dependant upon whether they see themselves as having weaknesses or strengths that will enable them to *win*. Argyris suggested that personal defensiveness might be overcome where:

- Individual values, culture and beliefs (personal standards) have been identified, legitimised and aligned with other individuals, with other professionals (professional standards) and with the organisation of which they are part.
- Individuals have the confidence to make their personal and professional standards known without fear of being excluded, criticised or punished.
- *Win/win* situations are the natural expectation, reinforced by observable behaviours which themselves are rewarded.
- Innovation and managed risks are rewarded and not punished.

People also need to be confident that their own expectations of employment are matched with those of their employer. This goes beyond the economic contract (hours, rate of pay etc.) to reflect:

- social need satisfaction
- security in exchange for hard work and loyalty
- opportunities for self-actualisation
- challenging work in exchange for high productivity
- high quality work and creative effort in the service of organisational goals
- trust and respect

The psychological contract encompasses both the economic and personal requirements as pre-requisites to knowledge sharing behaviours being observable and becoming part of organisational culture. Schein had concluded that even though it remained unwritten, the psychological contract was a powerful determinate of behaviour in organisations. These factors can be represented in the framework shown in figure 27.

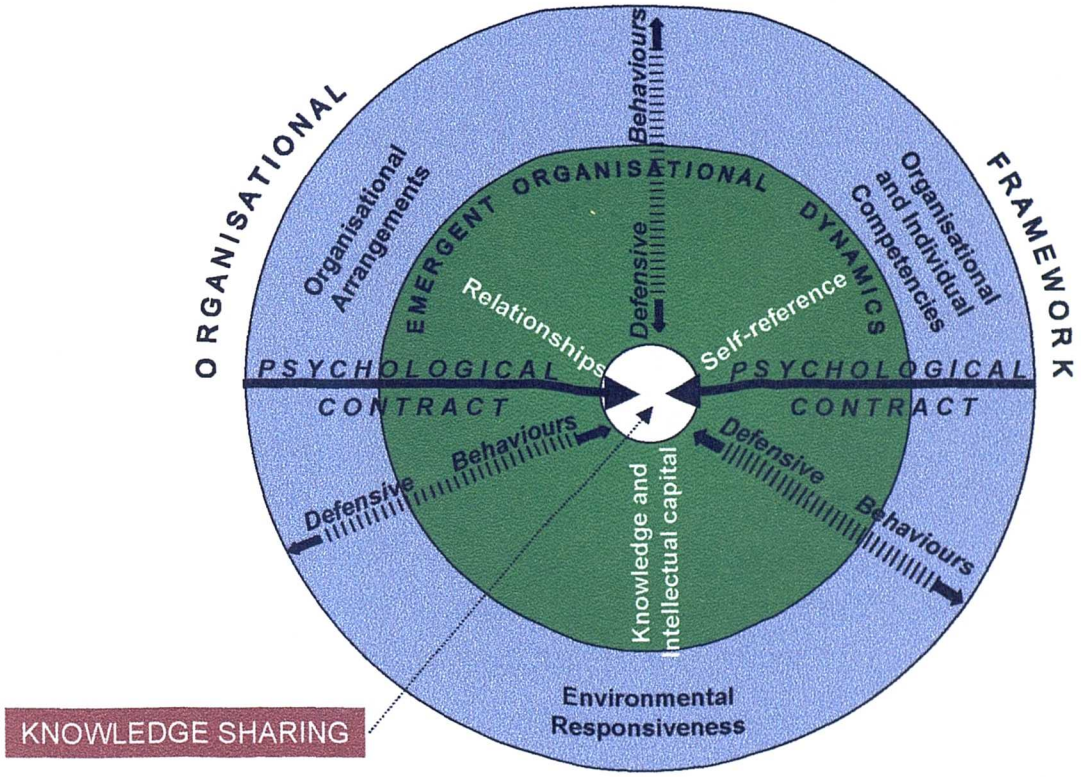
The research question is:

What makes people become defensive towards knowledge sharing and what is the role of the psychological contract in this process?

As a result of the literature review a questionnaire was developed that collected employees' views on critical issues. Employee perceptions and their observations were sought as directly observable data from which to infer the theories-in-use of those individuals and also those with whom they interact. Most importantly, views were sought on four particular outcomes:

- how often had respondents experienced people keeping knowledge and information to themselves?
- how often, over the last twelve months, had respondents kept valuable information and knowledge to themselves rather than share it?
- how often had respondents observed others seeking to win at the cost of someone else losing?
- how often had respondents sought to win at the cost of someone else losing?

Figure 27 **Model of organisational dynamics, the psychological contract and defensive routines as barriers to knowledge and information sharing**



Dale (unpublished 1998)

Data from the questionnaire was to be analysed to determine the extent to which these outcomes correlated with respondents' views on other critical issues and the extent to which:

- ***organisational frameworks*** had:
  - appropriate organisational form(s)
  - identified and developed personal and organisational competencies
  - developed appropriately in response to environmental influences

- ***emergent organisational dynamics*** were recognised and there was focus on:
  - development of a knowledge sharing culture, personal information and knowledge management skills
  - development and maintenance of good relationships
  - development of personal and organisational 'Self-Reference'

- ***the psychological contract*** was present and not damaged or broken

- ***defensive routines*** had been overcome by the psychological contract or remained as barriers to knowledge and information sharing

The null hypothesis would be that there is no significant association between employment or personal threats that employees perceived at work whether these be related to components of the psychological contract, or to other key factors identified as forming part of the theoretical concept.

The alternate hypothesis is that there are significant associations, implying that employees feeling under threat, or perceiving that their psychological contract has been violated, will display defensive behaviours in general and that these create barriers towards knowledge sharing.

CHAPTER 3
METHODOLOGY

This section details the development of the questionnaire, reviews research methodologies and draws conclusions about the appropriate methodologies and research techniques applicable to this research including ethical issues. The method of data collection is outlined and a copy of the questionnaire referenced.

Introduction

A healthy organisational framework has been identified as a pre-cursor to the longer-term survival and effectiveness of an organisation. For longer-term survival and effectiveness, emergent organisational dynamics have been identified as key elements of organisational health for knowledge sharing to be optimised.

To overcome defensive behaviour Argyris suggested that one needed to go beyond espoused theories of beliefs, values and attitudes and collect relatively directly observable data from which to infer his theories-in-use. The constituent elements identified during the development of the questionnaire used in this research are believed to satisfy Argyris' requirement for relatively observable data from which it could be inferred to what extent his theories-in-use are evident. Their relationship and association with elements of the psychological contract provided the basis for developing the questionnaire to empirically test the extent to which the psychological contract overcame the defensive routines which Argyris described, and the associated barriers to knowledge sharing and use.

Development of the questionnaire

This section summarises the issues for which relatively observable data needs collecting and the development of relevant questions to elicit the necessary responses from which it could be inferred to what extent Argyris' theories-in-use were evident.

The literature review identified that for defensive routines to knowledge sharing to be overcome an organisation needed to ensure that:

- ***organisational frameworks*** had:
  - appropriate organisational form(s)
  - identified and developed personal and organisational competencies
  - developed appropriately in response to environmental influences

- ***emergent organisational dynamics*** had been recognised and there was a focus on:
  - development of a knowledge sharing culture, personal information and knowledge management skills
  - development and maintenance of good relationships
  - development of personal and organisational 'Self-Reference'

- ***the psychological contract*** was present and not damaged or broken

The specific issues identified as being in need of testing empirically were that:

For Organisational Frameworks:

- ***formal organisational arrangements***
  - Organisational arrangements were predominantly organic/network in nature with the minimum of functional arrangements and/or arrangements that failed to integrate geographic teams.
  - Management decisions were made, and felt by employees to be made, at appropriate levels of managerial responsibility.
  - The power-base structure was not significantly different from that which might reasonably be expected.
  - The organisation achieved what it set out to achieve.

- ***external environment***
  - adequate attention was paid to obtaining the views of service users.
  - the organisation had a positive and active approach to change
  - the number of objectives that satisfy local needs were maximised
  - stakeholders had confidence in the organisation (for the NHS this includes regional offices, local trusts, health authorities, GPs, social services, politicians, media and general public).

- ***employees and other tangible assets***
  - employees believed top managers knew what the organisation needs to do to be effective
  - the necessary skills and knowledge necessary to do the job adequately had been identified by the organisation

- job-related skills were at high levels
- job-related knowledge was at high levels
- there were adequate opportunities to develop job-related skills and knowledge
- employees were motivated

For Emergent Organisational Dynamics:

- ***Knowledge and information***
  - Corporate knowledge was not scattered
  - Staff turnover was not high
  - Organic structures were in place rather than hierarchical structures
  - Strategic plans for information management and technology were clear
  - Relationships with providers were good
  - There was co-ordination of, and focus on, training and development
  - There was networking and learning from other organisations
  - There was awareness of, and commitment to, information at Board level

- **Relationships**
  - employees know who their stakeholders are
  - relationships with stakeholders were good
  - values, beliefs and views of stakeholders were known and understood
  - values, beliefs and views of stakeholders were shared wherever possible
  - success was recognised within the organisation
  - failure was not apparent to those outside the organisation

- ***Self-reference***
  - Individual, professional and organisational values, culture and beliefs were aligned
  - Individuals had the required personal competencies
  - Organisations knew the competencies they required
  - Personal relationships were excellent
  - Individuals understood the purpose and goals of the organisation and teams of which they were part
  - Individuals felt secure and motivated

For Personal Standards:

- Individuals should be open about any conflict they might have between their personal standards and those of any team of which they are part
- Espoused theory should be that individuals do not intentionally seek to win at the cost of someone else losing
- Theory-in-use should be that others are not observed seeking to win at the cost of someone else losing
- Individuals should feel encouraged to be innovative
- Organisational reaction to innovation that fails should be supportive and learning
- Components of the psychological contract should be present and not have been damaged or broken over recent times

Questions were drafted that addressed these specific issues. In this way the extent to which respondents agreed or disagreed with each question could be assessed.

The style of questions was based on the need to:

- differentiate *yes/no* responses
- determine variances in agreement/disagreement to attitude statements
- order statements and scores based on individual opinion or belief
- allow respondents to easily select responses from a range of options including those of 'not known' and 'no response'

These questions were initially piloted with a cohort of managers from a top-level management programme at the King's Fund. This cohort formed a learning set comprised of a health authority Chief Executive, an acute Trust Chief Executive, two Directors of Nursing, a Director of Human Resources in an acute trust and a Director of Operations in a community trust.

The general response was positive with the acute Trust Chief Executive confirming that this research was very topical and a request to share the outcome with him. Specific comments were not many and highlighted a few issues of ambiguity, a few issues of clarity (the need to define descriptions) and one case of questioning the relevance of one (complex) issue being addressed.

In parallel the first version of the questionnaire was shared with the two supervisors of this research and further revisions were made as a result of comments from a statistician and researcher at the Unit of Health Care Epidemiology, University of Oxford. The organisational development manager at

the first health authority finally reviewed the questionnaire with her colleagues, following which final amendments were made.

Scoring and rating protocols had been developed at the same time as the questionnaire. Responses from the pilot studies were analysed and as a result several amendments were made. These were mostly a repeat of incorrectly assigned Likert scale values (0 to 4 having been incorrectly applied in the first instance rather than the conventional 1 to 5 that was eventually used for the questionnaire). The sample size was too small to confidently conclude anything significant from responses to questionnaires but the intention of using radar diagrams to display and compare results could be tested. This was done with encouraging results.

Research methodology

This section summarises the types of research used and appropriate research tools. These tools were critically appraised to ensure that the limitations of the selected tools were fully understood. The subject of the research was subsequently considered and the process of development and testing of the research tools explained.

Consideration of method

Blaxter, Hughes and Tight (1996) divided research techniques for the purposes of appraising research tools into three divisions - *research families, research approaches* and *research techniques*. Each division was itself subdivided into appropriate categories (table 15).

Table 15 Research techniques

Research families	• Qualitative or quantitative • Deskwork or fieldwork
Research approaches	• Action research • Case studies • Experiments • Surveys
Research techniques	• Documents • Interviews • Observations • Questionnaires

Blaxter, Hughes and Tight p59

Research families

Qualitative or qualitative?

Best and Khan (1989) summarised these two parts of the research family as:

> "Quantitative research consists of those studies in which the data concerned can be analysed in terms of numbers... Its results are more readily analysed and interpreted...Research can also be qualitative, that is, it can describe events, persons and so forth scientifically without the use of numerical data."

Best and Khan pp89-90

Both types are valid and are not mutually exclusive but quantitative research was used for this research as the approach required was to collect facts and study the relationships of one set of facts to another (Bell, 1996) rather than use qualitative research that is more concerned with understanding people's perceptions of the world (Blaxter, Hughes and Tight,). Although a quantitative approach was selected as the primary research method, qualitative approaches would be used where appropriate.

Deskwork or fieldwork?

Deskwork is "literally...those things which can be done while sitting at a desk" whereas fieldwork requires "going out to collect research data" (Blaxter, Hughes and Tight). However, the distinction between fieldwork and deskwork is usually blurred, since no matter how much a fieldworker may spend away from a desk, at some stage it will be inevitable that deskwork is required. Similarly, the production of a questionnaire or survey can be done at a desk but inevitably this will be need to be developed or need testing in the field in order to ensure its relevance and validity. Whilst it may be important for some areas of research in order to plan the approach and manage personal time, it was not considered necessary for this research to make any distinction.

Research approaches

Action research

Action research is a popular technique for attempting to achieve improvements by auditing processes and critically analysing events (Bowling). Action research has been described as:

> "Essentially an on-the-spot procedure designed to deal with a concrete problem in an immediate situation. This means that the step-by-step process is constantly monitored (ideally, that is) over varying periods of time and by a variety of mechanisms (questionnaires, diaries, interviews and case studies, for example) so that the ensuing feedback may be translated into modifications, adjustments, directional changes, redefinitions, as necessary, so as to bring about lasting benefit to the ongoing process itself."
>
> **Cohen and Mannion(1989)**

Hart and Bond (1995) used seven criteria to describe action research:

- it is educative
- it deals with individuals as members of social groups
- it is problem-focused, context-specific and future orientated
- it involves a change intervention
- it aims at improvement and involvement
- it involves a cyclic process in which research, action and evaluation are inter-linked
- it is founded on a research relationship in which those involved are participants in the change process

Bell pointed out that that an important feature of action research was that the task was not finished when the project ended - participants should follow on to review, evaluate and improve practice. Action research, therefore, appeals to people who identify problems during the course of their work, see merit in investigating these problems with a view to improving practice and as a result embark upon formal processes of research. Bell also point out that action research was not a method or technique but an approach to research in which the basic principles were those of practicality and problem solving.

Because of the nature of action research there is considerable emphasis on fieldwork as opposed to deskwork. Action research is also predominantly quantitative in approach rather than qualitative. For these reasons action research was the approach used for this research.

Case study

Case studies predominantly focus on a single example, event or incident although multiple focus may, at times, be appropriate (Blaxter, Hughes and Tight). Case studies offer the opportunity to investigate one aspect of a problem in some depth. Although mostly time-limited, some case studies may extend over several years. Case studies may mix many different methods of research but usually focus on small numbers of cases.

The great strength of the case study approach is that it allows the researcher to concentrate on a specific instance or situation and to identify, or attempt to identify, the various interactive processes at work (Bell) which may remain hidden in larger studies. They are free-standing exercises and may precede surveys and be used to identify key issues for further investigation (Bowling).

Case studies are therefore selective and there may be difficulty in cross-checking findings and generalising from findings is not usually possible (Bell). Blaxter, Hughes and Tight also warned against undertaking case study works in the researcher's place of work for the same reasons. There were links with action research but these should not be seen as generic.

Case study is a useful tool in developing action research and will be used for this purpose in this research when appropriate.

Surveys

Greenfield (1996) described a survey as:

> "a procedure in which information is collected systematically about a set of cases (such as people, organisations, objects). The cases (or sample units) are selected from a defined population and the aim is to construct a data set from which estimates can be made and conclusions reached about the population."
>
> **p115**

Bell put this more simply:

> "the aim of a survey is to obtain information which can be analysed and patterns extracted and comparisons made'. stated that 'qualitative surveys use explicit, standardised and objective methods of sampling, data collection and data analysis'.
>
> **p10**

Surveys, like nearly all research methods, have problems associated with them. Frequently conducted by questionnaire, the most marked problem with surveys is that unless the sample size is considerable there are risks that the sample surveyed may not be representative of the population as a whole. This means that in advance of a survey the characteristics of the potential survey group need assessing to determine that potential dimensions of analysis will contain sample sizes that would ensure statistically significant results.

Another problem can be that whilst answers to *who, what, where, when* and *how* can usually be readily ascertained, the answer to *why* can often be elusive as causal relationships can rarely be proven by survey alone (Bell). However, as a fact finding process to inform a theoretical framework it is an excellent tool and its use was planned for this research.

Research Techniques

Interviews

Interviews can be an effective research method but they rely on the interviewer being skilled in interview techniques in order to effectively probe responses and investigate motives and feelings. Interviews can also be time consuming and long-winded (Blaxter, Hughes and Tight). However, in similar ways to surveys it can produce richness to, for example, questionnaires by putting flesh on the bones (Bell). Wise and Aron (1972) likened interviewing to going

fishing and Cohen (1976) found that like fishing "interviewing is an activity requiring careful preparation, much patience, and considerable practice if the eventual reward is to be a worthwhile catch".

Interviews are, by definition, conducted face-to-face. This may take place with the interviewer and respondent together in the same room or this can be done using remote, electronic means – the telephone or other electronic communications.

Interviews are a useful way of developing questionnaires and testing various aspects of research and interviews were used in this way rather than as the primary research method.

CONCLUSION

Research families

Quantitative methods would be the primary research family member although some elements of qualitative research were anticipated. **Fieldwork** would be used primarily with the inevitability of deskwork to produce the analysis and final thesis.

Research approaches

Action research would be the primary approach with **case studies** used where appropriate.

Research techniques

Surveys would be used in the form of **questionnaires** as the primary research technique. **Interviews** would be used to develop the questionnaires and **documents** used as supporting research material.

Questionnaire design

Structured questionnaires use structured pre-formulated questions, tests and/or scales to ensure that respondents each answer sets of standardised questions which focus on the topic of research. Questions and answer can be pre-coded and analysed using fairly straightforward techniques. Because these surveys are often undertaken in the absence of the interviewer, the questions need to be well prepared and pre-tested to ensure they are eliciting the type of response expected and that analysis gives valid and potentially significant results.

Unstructured questions are usually of a *free style* type, are often exploratory in nature and used for in-depth interviewing where the interviewer can probe in increasing depth, those answers from the respondent which the interviewer considers will give him/her the insight being sought. The unstructured nature of the interview also allows the interviewer to ask questions out of sequence, or indeed add questions that become relevant as the interview proceeds.

The strength of structured questionnaires is the very structure they present. Questions (appropriately developed and tested) and answers can be pre-coded and answers subsequently coded in ways that allow replication of the survey in statistically valid ways. Data collection is considerably eased and respondents can find the *tick box* approach one that encourages them to complete questionnaires in the knowledge that they do not have to think too much and the completion time is more or less known at the outset. They can allow them to plan the time they give to complete the questionnaire.

A disadvantage of structured questionnaires is that the development process may not have identified all relevant questions and respondents may not feel that their personal response can be accommodated in the limited options presented to

them. This may force them to give a response that they would usually not give or force them to give *no response* or declare *not known*. Care must also be taken to ensure words or phrases used in the questionnaire are as clear as possible as ambiguity can give the same outcome.

Care must also be taken in structured questionnaires to ensure information about attitudes and behaviours are carefully framed. Questions about socially acceptable behaviour may prompt socially acceptable answers rather than honest answers. The researcher must be alert to this potential bias when developing questions.

Whilst focusing on the substantive content of their research, researchers often overlook the data that either allow analysis by, for example, the various organisations from which survey details were obtained, the sub-groups of these organisations (such as professional or functional groupings) and by categories such as gender and age (Greenfield).

Survey documents of this type are therefore designed to obtain:

- Answers to substantive questions focusing on the topic of research
- Answers to questions designed to provide means of classifying cases into sub-groups that will be used in analysis (such as profession, functional group)
- Information carried over from the sampling frame (such as organisation) or recorded for observation (such as gender, age group)

based on categories by Greenfield p119-120

Key aims in the design of questionnaires

(with acknowledgement to Greenfield p119-200)

- ensure that questions do not lead respondents to answering particular questions in particular ways when the respondent may not have strong or clear views of their own (such as "would you agree that ....)
- use simple grammar and avoid complex/lengthy questions such that the respondent loses track of the actual question being asked.
- ensure that questions lead the respondent in a natural sequence and avoid the respondent wasting time by having to read unnecessary questions. i.e. do not have 'nested' questions that lead the respondent to answer various questions only for the respondent to find in the last question that this section did not apply to them.
- use simple language (that used by the tabloid press is suggested by Greenfield)
- avoid slang, abbreviations or fashionable words
- do not ask two questions in one (e.g. "are you male and over 30 years of age")
- make it easy for respondents to answer by the use of tick boxes
- do not use double negatives

and for postal/self-completion surveys:

- gain agreement of participating organisations before distributing the questionnaire. *Cold selling* is hard work!
- ensure there is at least an introductory letter and preferably have someone local to the organisation being surveyed act as your local

agent. Ideally take the time to personally visit the site, make yourself known to the respondents, explain the purpose of your research and survey and answer any questions they may have.

- Make the questionnaire as attractive as possible either in its design or by the potential benefit the respondent would gain by, for example, offering to share the outcome of the research at a later date. This will encourage completion of the questionnaire.
- instructions for completion of the questionnaire should be clear, unambiguous and give clear directions what to do with the completed questionnaire.
- Make the return of the completed questionnaires as simple as possible

Ethical issues

Blaxter, Hughes and Tight summarised ethical issues under four headings: Confidentiality, Anonymity, Legality and Professionalism. Following this good practice:

Confidentiality

Ground rules were established with the participating organisations about how feedback (if asked for) would be given. Agreement was reached that the names of individuals would not be revealed if, for example, there were critical comments about top management. This ensured that expectations were aligned, and that opportunities for further work with that organisation in the future were not marred.

It was stressed to all respondents that any confidential comments they may make would not be revealed to a third party.

Anonymity

The rules of anonymity were made clear to respondents and adhered to. General questionnaire design, even when collecting biographical data, was structured in ways whereby anonymity could be assured.

Legality

It was unlikely to be an issue in this area of research but it was ensured that the questionnaire did not encourage respondents to contravene any national or organisational codes or rules of morality, ethics or general probity.

Professionalism

Rules of professional conduct were incorporated where necessary. No one was forced or coerced into completing a questionnaire against their will. This was agreed with the local agent and only reasonable encouragement to respond was given.

Physical layout of questionnaire

The questionnaire was produced with printing made clear and ensuring that questions were easy to understand. Extensive use of capital letters was avoided as they have the effect of *dazzling* (Bowling p242). Confidentiality was stressed at the outset of the questionnaire.

Respondents were led through the questionnaire so that questions naturally flowed from one to the next.

Questions were uniquely identified by codes for section, number etc. and had been identified by the researcher as open (requiring the respondent to enter words of their own choice), closed (requiring the respondent to choose from a selection of options offered to them) or dichotomous (requiring selection from a 'yes/no' offering).

Because of the inherent difficulties of analysing open responses, and the need for completion to be as quick possible to complete, it was decided to use closed and dichotomous questions only in the questionnaire developed for this research. The aim was to develop a repeatable tool for analysis that encouraged completion of questionnaires.

Respondents were given a full choice of responses including *no response* and *not known*. These are different responses and allowance was made for the respondent to make this differentiation.

Where options for response include banding (e.g. age) they were made mutually exclusive such as 29-30, 31 to 39 and not 20-30, 30-40 such that a person aged 30 has two options in which to respond.

Where respondents were, for example, asked to state their position in the organisation, each person might have their own interpretation and express it in different ways. Position may mean *job title* to one person, *senior manager* to another and *third-in-line* to another. To make analysis easier discrete categories were created that covered all interpretations. In each category. respondents were offered a range of options (prompts) from which they could select their response rather than allowing them a free-form response. The option of *other – please state* still appeared.

Questions that have socially acceptable answers may elicit socially acceptable answers. Similarly may tend to answer positively to questions that are worded positively. Respondents may become conditioned or *stereotyped* to answer questions by ticking responses that are always on the right (or left) side of the page unless care is taken to alternate the usual response by deliberately putting that tick box on the opposite side of the page and making the respondent think (i.e. reversing the scale).

Questions could have been single items, appear in batteries or as scales:

Single items could have the drawback of encouraging respondents to give socially acceptable answers to dichotomous questions whereas the use of scales can to some extent overcome this. Interviewer bias could have had an effect but as this questionnaire will not be face-to-face this can be ignored other than in the wording used to construct the questions in the first place.

Batteries are groups of single-item questions that relate to the same variable of interest. Each item is analysed and presented individually, not summed together.

Scales were used as these offered respondents a choice from a series of responses relating to a single item. The responses could then be weighted if desired or necessary. Responses ranged between two extremes at either end of the scale with a neutral response between the two extremes. The wording of the descriptions on these scales needed to give the respondent the feel that each extreme limit was

equidistant from the mid-point. Various scales were available ranging from lines with opposite definitions at each end of the line to fixed-step scales with definitions for each step. These are described in more detail below.

Likert Scales

Likert scales are the most commonly used means of measuring responses on categorial scales especially for health status and health related surveys (Bowling) and their use was planned for this research. These are usually based on five or seven point scales with intervals that incrementally described options for individual response e.g. 'very mild', 'mild', 'moderate', 'well', 'severe', 'very severe', and are frequently used with dichotomous 'yes/no' response formats (Bowling 1997). A variation on the Likert scale is the Visual Analogue Scale (VAS) which presents the respondent with a line at each end of which are dichotomous descriptions. The respondent is asked to mark the line at the position that best fits their response between the two extremes. Categorial scales are generally considered to be easier to administer, analyse and interpret (Bowling) and Likert scales were therefore chosen for this questionnaire.

Responses were assigned values from 1 to 5 (on a five point scale) assigning '1' to the response that is deemed to be the least desirable as an answer to the question being asked. Responses by all respondents could then be statistically tested for significance and confidence levels. This is a strength of using Likert scales.

A weakness of the Likert method is that each respondent's response can only have meaning relative to the responses to that question. Another

weakness can be that a mid-score becomes ambiguous in that the respondent could have wanted to express *not known* or wanted to indicate that they had *no opinion*. To overcome this weakness these additional two responses were offered to respondents.

The use of descriptors on the Likert scale was used as this has been found to be useful as respondents can have different views of where to mark a linear scale for *well*. However, individuals do have their own frame of reference within which *well* lies and this varies from person to person. Only by obtaining the correct number of people in the survey could valid and statistically significant results be potentially obtained.

When using scale values care was taken to ensure that respondents did not become bored with being presented with the same format so their use was interspersed with dichotomous questions, rankings and questions that relied on responses other than in a Likert format.

The Survey

The Management Team of the first health authority addressed ethical and confidentiality issues on 4 August 1998 and agreed to the survey being done. Each questionnaire given to members of staff included an introductory letter that stressed the confidential nature of responses (Annex A). The final version of the questionnaire is attached (Annex B).

Distribution of the questionnaire took place in January 1999 and was arranged through the Personnel Manager of the health authority. Progress chasing took place within the health authority.

Organisational change in the first health authority resulted in a poor response (11 completed questionnaires returned out of 100 distributed. Agreement was secured to distribute additional questionnaires in the second health authority where 30 completed questionnaires were returned out of 50 distributed during March 1999.

Correlations

Pearson correlation is calculated from scores whereas Spearman correlation is calculated from the rank of scores. MacRae (1998b) summarises the differences between the two types of correlation as:

- Spearman correlation is less affected than Pearson correlation by outliers because they use ranked scores
- Pearson correlation uses more of the information in the scores if interval scale measurement has been achieved
- Pearson correlation is preferable where there are measurements on at least an interval scale *and* there are no outliers

The questionnaire developed for this research potentially included outlying responses. Rank scores were used in the questionnaire rather than interval scores. For these reasons, Spearman correlation was used in analysing responses. This agrees with the view expressed by MacRae that in practice "you are likely to use Spearman correlation more often than Pearson".

Spearman's correlation is usually referred to as Spearman's Rho, often shortened to r_s. *This shortened form, or symbol,* (r_s) *is used extensively in the chapters on results and analysis.*

Limitations of the research and confounding factors

In developing this research there have been several limitations and potentially confounding factors:

- **It was possible that the low level of response from the first health authority could have elicited responses from a non-representative sample of the overall population.** Evaluation through Mann Whitney test did not reveal any significant differences in response between the first health authority and the second health authority. It is feasible that the sample from the second health authority was also unrepresentative of the population in the health authority but with a 14% sample in the second health authority (n=30/220), this is considered unlikely.

- **The research took place over a period of political change and subsequently there were threats to job security in health authorities that may otherwise not have been present.** However, the NHS Executive has for many years been seeking to make economies and there has been a constant threat to job security for many in the NHS.

- **The research focuses on two health authorities.** The health authority that was initially to be the focus of this research was a typical 'middle England' health authority. However, validation of the research findings by applying the research tool to another health authority was seen as adding validity and providing a benchmarking capability. To this end the co-operation of another health authority in the south east of England was secured.

- **The research was undertaken at a 'point in time' and may not give representative findings.** The health authorities concerned were faced with similar challenges to all other health authorities in England. There is therefore reason to believe that conclusions drawn from this research are broadly representative of health authorities at this time.

- **The research was developed for health authorities rather than the NHS in general or other organisations in the public/private sectors.** The underlying rationale for the research and subsequent questionnaire is generic. The research was tailored for health authorities as much as it would need tailoring for any other organisation. The critical elements relating to the presence/absence of the psychological contract would be common to any subsequent use of the analytical tool used.

- **Respondents gave socially acceptable answers in response to questions.** If all respondents had given socially acceptable answers then little variance would have been evident. However, this was not the general case. The only socially acceptable set of responses was given in response to self-assessment questions about outcomes. Argyris proposed that espoused theories did not match theories-in-use. Identifying this as a difference in response to questions about self-perception and observation of others did reveal a difference and thus accorded with Argyris' theories. In this instance socially acceptable answers were those that were sought.

- **Sample sizes and population sizes for clinicians and those at CEO/director level were both small.** It was recognised that this could give a potential for bias in responses for each group and for the organisations. The relatively high response rate for those at CEO/Director level (n=9/12) gives reasonable confidence that there is no individual bias for those in this group although organisational bias could still be possible. Further application of the questionnaire in other health authorities would be useful to assess any bias.

CHAPTER FOUR

RESULTS

This section summarises the pre- and post-survey reviews of the questionnaire. Reviews are also made of response categories and appropriate groupings made where appropriate. Components from factor analysis are identified.

Data homogeneity is assessed. Inter-group correlations are analysed. Together with the outcome of a Mann-Whitney analysis, correlations and significant variances are used to inform the process of analysing responses.

The theoretical construct is re-visited and an assessment made of how closely this matches the outcome of factor analysis. Components of the psychological contract are assessed for links with outcomes, factor analysis, staff motivation and job security.

Introduction

150 questionnaires were distributed of which 41 were returned - 11 out of 100 returned form one health authority, and 30 out of 50 returned from a second health authority. The questionnaire had been assessed prior to the survey to determine which questions would provide:

1. data for grouping respondents
2. outcomes reported by respondents
3. behaviours reported by respondents
4. predictors of outcomes and behaviour

Post-hoc the questions would be re-assessed to determine whether these groupings were appropriate. Initial groupings are summarised in Table 16.

Table 16 Pre-screening of questionnaires

Question	Outcome/Behaviour, Predictors or Group
Bio data 1-5	Group
Bio data 6	Predictor
A1	Predictor
A2	Check
A3, A4, A5	Predictors
B1	Predictor
B2	Behaviour/Predictor
B3	Check
B4	Predictor
C1 - C4	Predictors
D1 - D8	Predictors
D9, D10	Behaviour/Outcome
E1, E2, E3	Predictors
E4, E5	Predictors
F1- F7	Predictors
G1, G2	Behaviour
G3, G4	Behaviour/Outcomes
G5	Behaviour/Predictor
G6	Predictor

Questionnaire categories

An initial review of the questionnaires was undertaken to establish groupings that could be made in order to maintain sample sizes, and also ensure validity of correlations and other statistical analyses undertaken.

Organisational structure

Question A1 was designed to elicit respondents' views on the extent to which their organisation was functional or organic. The first response category related to the perceived degree of functionality and all other responses related to different organic forms. Whilst the specific organic forms were available for analysis it was appropriate to group all non-functional responses into a single variable which characterised the respondents' perceptions of the degree to which their organisation was non-functional i.e. organic. Other responses were left ungrouped.

Environmental influences

Responses to questions B1, B2 and B3 were left ungrouped. Question B4 was designed to elicit respondents' perceptions of the levels of confidence that various stakeholders had in the respondents' organisations. Whilst the specific responses were available for analysis it was also appropriate to group responses into a single variable which characterised the respondents' perceptions of the degree to which their organisation held the overall confidence of stakeholders.

Information and knowledge

All responses were left ungrouped.

Relationships

Questions C1, C2 and C3 were designed to elicit respondents' perceptions of the state of relationships between the respondent's organisation and the stakeholders identified for question B. Whilst the specific responses were

available for analysis, it was also appropriate to group responses into single variables that characterised the respondents' perceptions of:

- the degree to which their organisation had good relationships with stakeholders (C1)
- the degree to which stakeholders understood the values, beliefs and views of the respondents' organisations (C2)
- the degree to which stakeholders shared the values, beliefs and views of the respondents' organisations (C3).

The other two responses were left ungrouped.

Self reference

All responses were left ungrouped.

Personal standards

Question G6 was designed to elicit respondents' perceptions of changes in their organisations over the previous 12-18 months. Whilst the specific responses were available for analysis it was also appropriate to group responses into a single variable which characterised the respondents' overall perceptions of the degree to which they had experienced these changes. Other responses were left ungrouped.

Post-survey review of questionnaire

In the following, Spearman correlation is referred to as Spearman's Rho, shortened to r_s.

Biographical data

Age

Frequency distributions from the questionnaires from the first and second health authorities (HA1 and HA2 respectively) are shown in Table 17. Four respondents were age 30 or less and one respondent was under 21 years of age. These respondents were grouped together into an age group of 30 or under. There was just one respondent whose age was over sixty and this respondent was combined with those aged 51-60 to from a new group of those aged over 50. The frequency distribution of the new age groupings is shown in Table 17.

Table17 Frequency of age distributions (ungrouped)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20 and under	1	2.4	2.4	2.4
	21-30	4	9.8	9.8	12.2
	31-40	10	24.4	24.4	36.6
	41 - 50	14	34.1	34.1	70.7
	51 and over	12	29.3	29.3	100.0
	Total	41	100.0	100.0	

Table18 Frequency of age distributions (grouped)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	30 and under	5	12.2	12.2	12.2
	31-40	10	24.4	24.4	36.6
	41-50	14	34.1	34.1	70.7
	51 and over	12	29.3	29.3	100.0
	Total	41	100.0	100.0	

These revised age groups have been used in all the following analyses.

Line relationships

Frequency distributions are shown in Table 19. From the literature review differences in response were expected, and sought, between those of Director level and above, and those below this level. For this reason groups 1 and 2 were combined (Table 20).

Table 19 Frequency distributions – line relationships (ungrouped)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	CEO/Director	9	22.0	22.0	22.0
	3rd in line	14	34.1	34.1	56.1
	4th in line	14	34.1	34.1	90.2
	5th in line	4	9.8	9.8	100.0
	Total	41	100.0	100.0	

Table 20 Frequency distributions – line relationships (grouped)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	CEO	2	4.9	4.9	4.9
	Director	7	17.1	17.1	22.0
	3rd in line	14	34.1	34.1	56.1
	4th in line	14	34.1	34.1	90.2
	5th in line	4	9.8	9.8	100.0
	Total	41	100.0	100.0	

These revised line relationship groups are those used henceforth in any analysis.

Profession

Frequency distributions are shown in Table 21. From the literature review differences in response were expected, and sought, between those of clinical and non-clinical professions. For this reason, the groupings were made as shown in Table 22. Groupings were made on the basis shown below:

Clinical: Medical/dental, pharmacist, nursing, Professions Allied to Medicine

Non-clinical: Information management, commissioning, administration, finance, IT, primary care development, clerical, general management, primary care support, planning/strategy, secretarial .

Table 21 Frequency distributions – professions (ungrouped)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Medical/dental	7	17.1	17.1	17.1
	Pharmacist	1	2.4	2.4	19.5
	Information management	4	9.8	9.8	29.3
	Administration	5	12.2	12.2	41.5
	Nursing	5	12.2	12.2	53.7
	Finance	4	9.8	9.8	63.4
	Clerical	1	2.4	2.4	65.9
	PAMs	2	4.9	4.9	70.7
	General management	7	17.1	17.1	87.8
	Primary care support	1	2.4	2.4	90.2
	Planning/strategy	2	4.9	4.9	95.1
	Secretarial	1	2.4	2.4	97.6
	Health promotion	1	2.4	2.4	100.0
	Total	41	100.0	100.0	

Table 22 Frequency distributions – professions (grouped)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Clinical	15	36.6	36.6	36.6
	Non-clinical	26	63.4	63.4	100.0
	Total	41	100.0	100.0	

Function

Frequency distributions are shown in Table 23. From the literature review differences in response were expected, and sought, between clinical and non-clinical professions. As differences were also expected, and sought between managerial and administrative/clerical employees, the non-clinical group was sub-divided. For these reasons the groupings were made as shown in Table 24. The groupings were made on the basis shown below:

Clinical: Public health, nursing, pharmacy, Professions Allied to Medicine

Managerial: Finance, information management, commissioning, IT, planning/strategy, general management, primary care support, primary care development

Administrative: and clerical Administration, clerical pool, secretarial pool

Additionally, two respondents classified themselves as in functions of *executive team* support and *human resources*. These were both allocated to the *managerial* group.

Table 23 Frequency distributions – Function (ungrouped)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Public health	17	41.5	41.5	41.5
	Finance	4	9.8	9.8	51.2
	Information management	1	2.4	2.4	53.7
	Commissioning	6	14.6	14.6	68.3
	Administration	1	2.4	2.4	70.7
	Nursing	1	2.4	2.4	73.2
	Planning/strategy	3	7.3	7.3	80.5
	Pharmacy	3	7.3	7.3	87.8
	General management	1	2.4	2.4	90.2
	Primary care development	2	4.9	4.9	95.1
	Executive team	1	2.4	2.4	97.6
	HR	1	2.4	2.4	100.0
	Total	41	100.0	100.0	

Table 24 Frequency distributions – Function (grouped)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Clinical	20	48.8	48.8	48.8
	Managerial	17	41.5	41.5	90.2
	Admin & clerical	4	9.8	9.8	100.0
	Total	41	100.0	100.0	

Experience of change

Whilst individual items of change were available for analysis, it was also considered useful to group respondents by the number of changes experienced. There were 11 change categories and to group respondents the responses were split into those who reported experiencing less than 5 changes, those who reported experiencing more than 6, and those who reported experiencing about half (5 or 6 experiences of change over the last 12 months). From the frequency distributions these groupings were made and are shown in Table 25.

Table 25 Number of changes experienced

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	<5	12	29.3	29.3	29.3
	5 - 6	18	43.9	43.9	73.2
	>6	11	26.8	26.8	100.0
	Total	41	100.0	100.0	

Homogeneity of data

Data was screened to establish whether any of the data sets were not homogeneous. A Mann-Whitney test was used as a distribution-free test for two groups of unmatched scores to establish if there were any significant differences between groups. The results are shown in table 26.

Table 26 Outcome of Mann Whitney test

	Questionnaire section							
	Bio data	**A**	**B**	**C**	**D**	**E**	**F**	**G**
Health Authorities	1	x	x	x	x	x	x	2
Above/below Director level	x	x	3	x	x	4	x	5
Clinical/non-clinical	x	x	x	x	6	7	8	9

The Mann-Whitney test highlighted the following questions as having differing responses by groups which warranted further investigation:

1 How many work changes have you experienced over the last 12 months?

2 How has the number of managers changed over the last 12-18 months?

3 What is the organisational reaction to change?

4 To what extent is success recognised within your organisation?

5 To what extent have you sought to 'win' at the cost of others 'losing'?

6 Is intellectual capital yours?

7 Is there now more meaningful work compared with 12-18 months ago?

8 How good are relationships with your organisation's stakeholders?

9 How has the number of managers changed over the last 12-18 months?

The differing responses were analysed through frequency, mean, standard deviation and variance.

Health Authorities

1 How many changes have you experienced over the last 12 months?

Responses from HA1 showed a mean of 6.36 (σ =2.54). Responses from HA2 showed a mean of 5.21 (σ =4.24). A striking difference in responses was found when considering the percentage of responses when grouped. These are shown in Table 27.

Table 27 Number of changes experienced over the last 12 months (max 11)

	Less than 5	5 or 6	More than 6
HA1	31.0%	51.7%	17.1%
HA2	27.3%	27.3%	45.5%

Twice as many respondents in HA1 reported experiencing 5 or 6 changes over the previous 12 months compared with HA2. Nearly three times as many respondents in HA2 reported 7 or more changes compared with HA1.

2 How has the number of managers changed over the last 12-18 months?

Responses by those in the HA1 group showed a mean of 3.24 (σ =0.69). Responses of those in the HA2 group showed a mean of 2.36 (σ =0.81).

The variations did not reach a level of significance but the difference in mean scores warranted further investigation later on.

CEO/director and below Director

3 What is the organisational reaction to change?

Responses of those at Director level or above showed a mean of 3.89 (σ =0.60). Responses of those below Director level showed a mean of 3.19 (σ =0.97).

This shows that whilst those below Director level did not share the optimism of the organisations reaction to change, the variation did not reach a level of significance. The difference in mean scores are investigated later.

4 To what extent is success recognised within your organisation?

Responses of those at Director level or above showed a mean of 3.38 (σ =0.92). Responses of those below Director level showed a mean of 2.53 (σ =0.90).

This shows that whilst those below Director level did not share the positive belief by Chief Executives and Directors, the variation did not reach a level of significance. However, the difference in mean scores warranted further investigation.

5 To what extent have you sought to *win* at the cost of others *losing*?

Responses of those at Director level or above showed a mean of 2.44 (σ =0.88). Responses of those below Director level showed a mean of 1.72 (σ =0.59).

Those below Director reported that they were less likely to seek to win at the cost of someone else losing than are those at Director level or above. The variation did not reach a level of significance but the difference in mean scores warranted further investigation.

Clinical/Non-clinical

6 Is intellectual capital yours?

Responses of those in the clinical group had a mean of 0.00. i.e. none of the 14 respondents believed that intellectual capital was theirs. Responses of those in the non-clinical group had a mean of 0.24 (σ =0.44). i.e. 1 in every 4 non-clinical respondents believed that intellectual capital belonged to them.

The variations did not reach a level of significance but the difference in mean scores warranted further investigation.

7 Is there now more meaningful work than 12-18 months ago?

Responses by those in the clinical group showed a mean of 2.54 (σ =0.88). Responses of those in the non-clinical group showed a mean of 3.15 (σ =0.67).

The variations did not reach a level of significance but the difference in mean scores warranted further investigation.

8 What are relationships of your organisation like with others?

Responses by those in the clinical group showed a mean of 2.25 (σ =1.08). Responses of those in the non-clinical group showed a mean of 2.86 (σ =0.49)

The clinical group displayed a significant variance. Those in the clinical group appeared to display a slightly more pessimistic view of relationships with stakeholders than the non-clinical group.

9 Has the number of managers changed over the last 12-18 months?

Responses by those in the clinical group showed a mean of 2.71 (σ =0.83). Responses of those in the non-clinical group showed a mean of 3.15 (σ =0.78).

The variations did not reach a level of significance but those in the clinical group perceived a reduction in the number of managers over the last 12-18 months whereas non-clinical respondents perceived an increase over the same period.

Outcomes

The proposed outcomes against which correlations were to be made were divided into two groups. The first group comprised those outcomes that would reflect any win/lose stance taken by respondents and the propensity of respondents to keep knowledge secret. The second group comprised those

outcomes that would indicate the existence of psychological contracts and whether these were being upheld or not.

Win/lose and knowledge sharing outcomes

- The extent to which respondents observed others seeking to win at the cost of someone else losing (question G3)
- The extent to which respondents sought to win rather than lose (question G4)
- The frequency with which respondents experienced people keeping knowledge and information to themselves (question D9)
- The frequency with which respondents had kept valuable information and knowledge to themselves rather than share it (question D10)

Primary analysis was undertaken to determine whether there was any correlation between these four outcomes (Table 28).

Table 28 Correlations between outcomes

			knowledge kept secret - self	knowledge kept secret - others	seeing others win/lose	you win/lose
Spearman's rho	knowledge kept secret - self	Correlation Coefficient	1.000	.282	.370*	.250
		Sig. (2-tailed)	.	.074	.019	.130
		N	41	41	40	38
	knowledge kept secret - others	Correlation Coefficient	.282	1.000	.469**	.037
		Sig. (2-tailed)	.074	.	.002	.824
		N	41	41	40	38
	seeing others win/lose	Correlation Coefficient	.370*	.469**	1.000	.492**
		Sig. (2-tailed)	.019	.002	.	.002
		N	40	40	40	38
	you win/lose	Correlation Coefficient	.250	.037	.492**	1.000
		Sig. (2-tailed)	.130	.824	.002	.
		N	38	38	38	38

*. Correlation is significant at the .05 level (2-tailed).

**. Correlation is significant at the .01 level (2-tailed).

The null hypotheses would be that there was no correlation between any of these four variables. In actuality, correlations were found whereby when respondents *see others seeking to win rather than lose* they :

1. *seek to win rather than lose* ($p=0.002$, $r_s=0.5$, $n=38$)
2. *experience people keeping knowledge and information to themselves* ($p=0.002$, $r_s=0.46$, $n=40$)
3. *keep valuable information and knowledge to themselves rather than sharing it* ($p=0.019$, $r_s=0.37$, $n=40$)

The correlations for 1 and 2 above are at levels of significance and predictability that make it reasonable to reject two null hypotheses and use the alternate hypotheses that:

A. When an individual sees others keeping valuable information and knowledge to themselves rather than sharing it, that individual perceives that those others are seeking to win rather than lose

B. When an individual sees others seeking to win rather than lose, that individual will themselves then seek to win rather than lose

The correlation for 3 above is weaker and at a level of significance that does not immediately suggest that the null or alternate hypotheses can be discarded or adopted.

One might also have expected to see correlations between *individuals keeping valuable information and knowledge to themselves rather than sharing it, others keeping valuable information and knowledge to themselves rather than sharing it* and *individuals seeking to win rather than lose.*

However, part of the theory that Argyris developed includes the concept of *self-deceit* whereby individuals do not recognise these negative attributes in themselves. This would also fit with the tendency of people to give socially desirable answers. In addition, it is feasible that individuals are convincing

themselves that it is others rather than themselves that are to blame for these failures. The absence of correlation could be viewed as support for these three hypotheses. However, whilst these conclusions appear valid for a general population, it needed to be tested whether the expected differences between CEO/directors and other employees, and between clinical and non-clinical employees existed. It also needed to be tested whether the remaining significant correlation (3 above) became more significant for these sub-groups.

CEO/director and sub-director split (Tables 29 and 30)

Table 29 Correlations between outcomes - CEO/director level (n=9)

			knowledge kept secret - self	knowledge kept secret - others	seeing others win/lose	you win/lose
Spearman's rho	knowledge kept secret - self	Correlation Coefficient	1.000	-.109	.050	.340
		Sig. (2-tailed)	.	.780	.898	.371
		N	9	9	9	9
	knowledge kept secret - others	Correlation Coefficient	-.109	1.000	.736*	-.424
		Sig. (2-tailed)	.780	.	.024	.256
		N	9	9	9	9
	seeing others win/lose	Correlation Coefficient	.050	.736*	1.000	.112
		Sig. (2-tailed)	.898	.024	.	.775
		N	9	9	9	9
	you win/lose	Correlation Coefficient	.340	-.424	.112	1.000
		Sig. (2-tailed)	.371	.256	.775	.
		N	9	9	9	9

*. Correlation is significant at the .05 level (2-tailed).

Table 30 Correlations between outcomes - below CEO/director (n=32)

			knowledge kept secret - self	knowledge kept secret - others	seeing others win/lose	you win/lose
Spearman's rho	knowledge kept secret - self	Correlation Coefficient	1.000	.405*	.403*	.088
		Sig. (2-tailed)	.	.021	.025	.651
		N	32	32	31	29
	knowledge kept secret - others	Correlation Coefficient	.405*	1.000	.444*	.210
		Sig. (2-tailed)	.021	.	.012	.273
		N	32	32	31	29
	seeing others win/lose	Correlation Coefficient	.403*	.444*	1.000	.574**
		Sig. (2-tailed)	.025	.012	.	.001
		N	31	31	31	29
	you win/lose	Correlation Coefficient	.088	.210	.574**	1.000
		Sig. (2-tailed)	.651	.273	.001	.
		N	29	29	29	29

*. Correlation is significant at the .05 level (2-tailed).

**. Correlation is significant at the .01 level (2-tailed).

Below CEO/director level correlations where significant for the same categories as for the respondents in the overall group with the predictability of these relationships generally being close to useful. There was a positive correlation, albeit weak, between *seeing others keeping valuable information and knowledge to themselves rather than sharing it* and these group members *keeping valuable information and knowledge to themselves rather than sharing it* ($p=0.021$, $r_s=0.405$, $n=32$). Perhaps most importantly, there was a positive correlation with a useful level of predictability between *seeing others seeking to win rather than lose* and *individuals keeping valuable information and knowledge to themselves rather than sharing it* ($p=0.001$, $r_s= 0.574$, $n=29$)

At CEO/director level there was a significant positive correlation for *seeing others seeking to win rather than lose* and *others keeping valuable information and knowledge to themselves rather than sharing it.* This correlation is not unexpected and is supported by a good level of predictability ($p=0.024$, $r_s=0.736$, $n=9$).

Even though the number of respondents in the CEO/director category is small ($n=9$), what appears predictable with a good level of certainty, is that the perceptions of those at Board level and those below Board level are different. Those people at Board level have reached a false consensus - <u>not</u> having perceived that difficulties and suspicions exist, whereas those below Board level perceived suspicion and that power games were taking place.

There is a marked difference in the perceived behaviour and actions between those at Board level and those below when *others are seen to be seeking to win rather than lose*. The reaction of individuals below Board appears to be that they themselves *seek to win rather than lose* whereas those at Board level do not.

Clinical/non-clinical split (Tables 31 and 32)

Table 31 Correlations between outcomes – clinical group (n=15)

			knowledge kept secret - self	knowledge kept secret - others	seeing others win/lose	you win/lose
Spearman's rho	knowledge kept secret - self	Correlation Coefficient	1.000	.254	.060	.380
		Sig. (2-tailed)	.	.361	.838	.200
		N	15	15	14	13
	knowledge kept secret - others	Correlation Coefficient	.254	1.000	.448	-.121
		Sig. (2-tailed)	.361	.	.108	.695
		N	15	15	14	13
	seeing others win/lose	Correlation Coefficient	.060	.448	1.000	.252
		Sig. (2-tailed)	.838	.108	.	.406
		N	14	14	14	13
	you win/lose	Correlation Coefficient	.380	-.121	.252	1.000
		Sig. (2-tailed)	.200	.695	.406	.
		N	13	13	13	13

Table 32 Correlations between outcomes - non-clinical group (n=26)

			knowledge kept secret - self	knowledge kept secret - others	seeing others win/lose	you win/lose
Spearman's rho	knowledge kept secret - self	Correlation Coefficient	1.000	.294	.534**	.179
		Sig. (2-tailed)	.	.144	.005	.392
		N	26	26	26	25
	knowledge kept secret - others	Correlation Coefficient	.294	1.000	.455*	.052
		Sig. (2-tailed)	.144	.	.020	.804
		N	26	26	26	25
	seeing others win/lose	Correlation Coefficient	.534**	.455*	1.000	.625**
		Sig. (2-tailed)	.005	.020	.	.001
		N	26	26	26	25
	you win/lose	Correlation Coefficient	.179	.052	.625**	1.000
		Sig. (2-tailed)	.392	.804	.001	.
		N	25	25	25	25

**. Correlation is significant at the .01 level (2-tailed).

*. Correlation is significant at the .05 level (2-tailed).

Similarly, the responses from the non-clinical group match the responses and levels of significance of the overall group whereas the clinical group's perceptions showed no correlations at all. This again suggests that clinicians did not perceive that difficulties, suspicions and aberrant behaviour were taking place whereas non-clinicians did. For the non-clinical group the levels of predictability are all between *useful* and *good*.

The size of these group was sufficient for a conclusions to be drawn, at least as working principles, that there were significant differences in perception between individuals in these clinical and non-clinical groups, and that the

usefulness of these correlations to make predications was mostly between *useful* and *good*.

Espoused theories and theories-in-use

If the theories proposed by Argyris were to hold true for those organisations surveyed, responses to questions on *outcomes* would need to demonstrate this. Espoused theories would relate to questions on whether respondents sought to win at the cost of someone else losing, and whether they kept knowledge to themselves. The espoused theories would be that we don't seek to win at the cost of someone else losing and that we don't keep knowledge to ourselves. Theories-in-use would be tested by using respondents as observers of the extent to which they believed they observed people seeking to win at the cost of someone else losing, and whether others keeping knowledge to themselves was reported. Mean rankings of responses to these questions, broken down by sub-group, are shown in tables 33 and 34.

Table 33 Mean ranking of *espoused theory* outcomes by sub-group

n =	15	26	9	32	41
	Clinicians	Non-clinicians	CEO/directors	Below CEO/director level	Overall
Keeping knowledge secret to yourself	1.33	1.8	1.67	1.44	1.49
You seeking to win, at cost of someone else losing	1.69	2.00	1.72	2.44	1.89

Table 34 Mean ranking of *Theories-in-use* outcomes by sub-group

n =	15	26	9	32	41
	Clinicians	Non-clinicians	CEO/directors	Below CEO/director level	Overall
See others keeping knowledge secret to yourself	2.40	2.54	2.44	2.50	2.49
See other people seeking to win at the cost of someone else losing	2.93	2.96	3.33	2.84	2.95

The survey reveals that overall the mean rank of *theory-in-use* outcomes are one scale rank higher than *espoused theory* outcomes. This finding is in line with the theory Argyris put forward that espoused theories (what we say we do) and theories-in-use (what we actually do) are different.

The differences in response by sub-group reveal three interesting results:

- Those at CEO/director level are much more likely than anyone else to report seeing other people seeking to win at the cost of someone else losing.
- Those at CEO/director level are more likely than anyone else to themselves seek to win at the cost of someone else losing.
- Clinicians appear less likely than other people to seek to win if they observe other people seeking to win, although they are just as likely to keep knowledge to themselves.

These findings imply that those at CEO/director need to develop a greater understanding of others they work with, in order to reduce the suspicion that those at CEO/director level appear to have. This would require more openness and more clarity of how decisions are arrived at, as well as more clarity about the value and

belief systems behind views that are expressed, if this normally self-sealing process was to be overcome.

It was thus concluded that the use of these measures of outcome was valid for the purpose of testing the hypothesis of this research. It was also concluded that responses analysed by line relationship and clinical/non-clinical groupings varied at levels of significance that required any subsequent analysis to be undertaken in the ways described above.

BIOGRAPHICAL DATA

Biographical data was correlated with responses to all questions to determine whether there where correlations with correlation coefficients at levels whereby their use as predictors would be of value.

From the literature review it was forecast that there would be no correlations by age, gender, line relationship, profession or function and this turned out to be the case in practice.

The only correlation that resulted was between the number of changes and the standards that individuals worked to when their personal and team standards were in conflict. The correlation was approaching levels of confident predictability ($p<.01$, $r_s=0.454$, $n=36$). In such situations this predicts that the more standards are in conflict, the more people are likely to work to their personal standards rather than those of the team of which they were part.

Neither of these response elements correlated with any other responses to questions in the overall questionnaire.

QUESTION RESPONSES

Correlations were established for responses to questions in each section that related to:

- Organisational arrangements (section A)
- Environmental responsiveness (section B)
- Competencies (section C)
- Information and knowledge (section D)
- Relationships (section E)
- Self-reference (section F)
- Personal standards (section G)

As differences in response were expected and sought between those of director level and above, and those below director level, all correlations were split on this basis as well as being correlated as a single group of respondents.

In the following, references to 'sub-groups' refer to HA, Clinical/non-clinical and above/below CEO/Director level splits unless stated otherwise.

ORGANISATIONAL ARRANGEMENTS

Elements identified from the literature review were:

- Organisational arrangements should be predominantly organic/network in nature with the minimum of functional arrangements and/or arrangements that fail to integrate geographic teams
- The power-base structure should not be significantly different from that which might reasonably be expected
- Management decisions should be made, and felt by employees to be made, at appropriate levels of managerial responsibility
- The organisation should achieve what it set out to achieve

Organisational arrangements predominantly organic/network in nature with the minimum of functional arrangements and/or arrangements that fail to integrate geographic teams (Table34)

Respondents' perceptions were that organisational arrangements were predominantly organic in nature (mean=57%, n=41). There was no significant difference in response from any sub-groups although significance was approached (probability = 94.2%) for those at CEO/director level who had a more optimistic view that their organisations were now organic in nature.

Table 35 Frequency distribution – organic organisational structure

Percentage organic		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	10.0	3	7.3	9.7	9.7
	15.5	1	2.4	3.2	12.9
	20.0	1	2.4	3.2	16.1
	30.0	3	7.3	9.7	25.8
	40.0	1	2.4	3.2	29.0
	50.0	5	12.2	16.1	45.2
	60.0	3	7.3	9.7	54.8
	66.0	1	2.4	3.2	58.1
	70.0	3	7.3	9.7	67.7
	75.0	2	4.9	6.5	74.2
	80.0	4	9.8	12.9	87.1
	100.0	4	9.8	12.9	100.0
	Total	31	75.6	100.0	
Missing	System	10	24.4		
Total		41	100.0		

The power-base structure should not be significantly different from that which might reasonably be expected (Table 36)

Respondents' perceptions of the power-base structure were not significantly different from that which might reasonably be expected. Although respondents did not perceive there to be a clear power-base structure at the 'top-of-the-shop' with the Chief Executive, NHS Executive and National Politicians all jockeying for position, there was broad agreement of the hierarchy of power.

Table 36 Perceptions of power base

	Primary rank	Secondary rank	Supplementary ranks
Chief Executive	1st 53%	2nd 19%	
National politicians	1st 31%	7th 11%	
NHS Executive	2nd 37%	1st 24%	
Regional Office	3rd 31%	2nd 28%	
Directors	4th 25%	3rd 22%	
Senior Managers	5th 24%	6th 12%	
GPs	6th 31%	7th 16%	
Public	7th 22%	6th 19%	10th 16% 11th 22%
Local politicians	8th 24%	7th 12%	
Media	9th 20%	8th 17%	
Social Services	9th 16%	10th 16%	7th 16% 5th 16%

The organisation should achieve what it set out to achieve. (Table 37)

Overall, respondents reported that their organisations achieved about 70% of what they said they would achieve. However, there was significant variance with 39.5% (n=15/41) of respondents reporting that their organisation achieved 60% or less of what it set out to achieve. Respondents' perceptions here were later found to have important relationships with other criteria.

Further analysis showed that, although not statistically significant:

- Non-clinical respondents gave a more optimistic response
- CEO and Directors had a more optimistic response
- HA2 had a more optimistic response

Table 37 Frequency distribution – organisational achievement

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	<50%	7	17.1	18.4	18.4
	51% - 60%	8	19.5	21.1	39.5
	61% - 70%	4	9.8	10.5	50.0
	71% - 80%	11	26.8	28.9	78.9
	81% - 90%	8	19.5	21.1	100.0
	Total	38	92.7	100.0	
Missing	System	3	7.3		
Total		41	100.0		

Management decisions should be made, and felt by employees to be made, at appropriate levels of managerial responsibility. (Tables38 and 39)

Overall, more respondents (n=22/41) reported that decision levels were *too high* than *appropriate* (n=18/41). 47.5% of respondents (n=19/41) reported the frequency of decisions being made *too high* to be either *frequently* or *all the time*. No respondents felt that decisions were being made at levels that were *too low*.

Table 38 Frequency distribution – decision level

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Appropriate	18	43.9	45.0	45.0
	Too high	22	53.7	55.0	100.0
	Total	40	97.6	100.0	
Missing	System	1	2.4		
Total		41	100.0		

Table 39 Frequency distribution – frequency of decisions made too high

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	1	2.4	2.5	2.5
	Occasionally	16	39.0	40.0	42.5
	Frequently	13	31.7	32.5	75.0
	Often	6	14.6	15.0	90.0
	All the time	4	9.8	10.0	100.0
	Total	40	97.6	100.0	
Missing	System	1	2.4		
Total		41	100.0		

The reported frequency of decisions being made *too high* was very slightly less than *frequently* but there was significant variance with 42.5% (n=17/41) of respondents believing that decisions were made at levels that were too high only *occasionally* or *never* and 32.5% (n=13/40) of respondents believing decisions were *frequently* made at levels that were *too high*. 25% (n=10/40) of respondents believed that such decisions were made at levels that were too high either *often* or *all the time*.

Those below Director level reported more occasions of *too high - too often* than Director level and above. This shows a marked difference in perception.

Most respondents at CEO/director level reported their belief that decision-making occurred *too high* only *occasionally* whereas the most of those below CEO/director level reported that this happened *frequently, often* or *all the time.* This implies that those at and below CEO/director level have a mismatch of perception about the frequency at which decisions are made at levels that are *too high.*

ENVIRONMENTAL RESPONSIVENESS

Elements identified from the literature review were:

- adequate attention should be paid to obtaining the views of service users.
- the organisation should have a dynamic and active approach to change
- the number of objectives that satisfy local needs should be maximised
- stakeholders should have confidence in the organisation (for the NHS this includes regional offices, local trusts, health authorities, GPs, social services, politicians, media and general public).

Adequate attention should be paid to obtaining the views of service users. (Table 40)

Overall, respondents believed that the effort put into obtaining views of the public was just more than *barely adequate.* There was significant variance with 41.5% (n=17/41) of respondents believing that the attention paid was *inadequate* or *barely adequate* and 17% (n=7/41) of respondents believing that the attention

paid was *very adequate* or *more than adequate*. Although not of significant variance, further analysis showed that:

- those below CEO/director level believed that less attention was paid to getting public views than those at CEO/director level
- HA1believed that less attention was paid to getting public views than HA2

Table 40 Frequency distribution – attention paid to obtaining users' views

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Inadequate	8	19.5	19.5	19.5
	Barely adequate	9	22.0	22.0	41.5
	Adequate	17	41.5	41.5	82.9
	Very adequate	6	14.6	14.6	97.6
	More than adequate	1	2.4	2.4	100.0
	Total	41	100.0	100.0	

The organisation should have a proactive approach to change (Table 41)

A mean score of 3.34 suggests that when faced with pressures for change, those organisations surveyed generally had a reaction of *accepting* change, with 31.7% (n=13/41) saying their organisation was *quick to accept* change. There was significant variance in the above/below Director split where those at CEO/director level had no negative beliefs in their organisations' reactions to change.

Table 41 Frequency distribution – organisational reaction to change

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Resists change	2	4.9	4.9	4.9
	Reluctantly accepts	3	7.3	7.3	12.2
	Accepts	19	46.3	46.3	58.5
	Quick to accept	13	31.7	31.7	90.2
	Pioneers change	4	9.8	9.8	100.0
	Total	41	100.0	100.0	

The number of objectives that satisfy local needs should be maximised (Table 42)

The question asked sought responses about the influence that various stakeholders had on setting strategic and financial plans. The clear priority setters were Central Government (mean=1.08) with corporate (internal to organisation) priorities coming a long second (mean=2.41). Locality teams/geographic teams/primary care groups came third (mean=2.97), with the influence of local politicians/councillors coming fourth (mean=3.64).

Table 42 Frequency distribution – influence on strategic planning and annual objectives

	Rank
Central Government (i.e. through NHS Executive plans/priorities	**1.1**
Corporate (internal to organisation) priorities	**2.4**
Locality teams/geographic teams/primary care groups	**3.0**
Local politicians/councillors	**3.4**

Stakeholders should have confidence in the organisation. (Table 43) *(for the NHS this includes regional offices, local trusts, health authorities, GPs, social services, politicians, media and general public).*

Overall, respondents reported the confidence of stakeholders as being slightly less than moderate with a mean of 2.87. There was no significant difference in response from any sub-groups.

Table 43 Frequency distribution – stakeholder confidence

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Low	7	17.1	18.4	18.4
	Low/moderate	7	17.1	18.4	36.8
	Moderate	15	36.6	39.5	76.3
	Moderate/high	7	17.1	18.4	94.7
	High	2	4.9	5.3	100.0
	Total	38	92.7	100.0	
Missing	System	3	7.3		
Total		41	100.0		

COMPETENCIES

The literature review identified that the presence of competencies could be assessed by determining whether:

- the skills and knowledge necessary to do the job adequately have been identified by the organisation
- job-related skills are at high levels
- job-related knowledge is at high levels
- there are adequate opportunities to develop job-related skills and knowledge
- employees are motivated

The skills and knowledge necessary to do the job adequately have been identified by the organisation and are at high levels

This was tested by asking respondents whether they believed that:

- job-related knowledge of employees was at high levels
- job-related skills of employees were at high levels

The job-related knowledge of employees should be at high levels. (Table 44)

Respondents reported overall that employee job-related knowledge was slightly more than *adequate* (mean=3.29). However, 34% (n=14/41) of respondents believed that employee job-related knowledge was *very adequate* or *more than adequate*. There was no significant difference in response from any sub-groups.

Table 44 Frequency distribution – knowledge levels

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Barely adequate	5	12.2	12.2	12.2
	Adequate	22	53.7	53.7	65.9
	Very adequate	11	26.8	26.8	92.7
	More than adequate	3	7.3	7.3	100.0
	Total	41	100.0	100.0	

The job-related skills of employees should be at high levels. (Table 45)

Respondents reported overall that employee job-related skills were slightly more than 'adequate' (mean=3.32). 34% (n=14/41) of respondents believed that employee job-related skills were *very adequate* or *more than adequate*. There was no significant difference in response from any sub-groups.

Table 45 Frequency distribution – skill levels

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Barely adequate	3	7.3	7.3	7.3
	Adequate	24	58.5	58.5	65.9
	Very adequate	12	29.3	29.3	95.1
	More than adequate	2	4.9	4.9	100.0
	Total	41	100.0	100.0	

There should be adequate opportunities for employees to develop job-related skills and knowledge. (Table 46)

Overall, respondents believed there was *some* opportunity for employees to develop job-related skills and knowledge (mean=3.10). 32.5% (n=13/40) of respondents believed there was *quite a bit* of opportunity. 22.5% (n=9/41) of respondents believed there to be *very little* opportunity for employees to develop job-related skills and knowledge. There was no significant difference in response from any sub-groups.

Table 46 Frequency distribution – opportunities to develop knowledge and skills

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very little	9	22.0	22.5	22.5
	Some	18	43.9	45.0	67.5
	Quite a bit	13	31.7	32.5	100.0
	Total	40	97.6	100.0	
Missing	System	1	2.4		
Total		41	100.0		

Employees should feel motivated. (Table 47)

The opinion of respondents overall was that most employees were quite motivated. However, there was significant variance with 29% (n=12/41) of respondents believing that most employees *were not very motivated* or *de-motivated*, and 32% (n=13/41) of respondents expressing the view that most employees were *fairly motivated* or *very motivated*. Further analysis showed that, although not quite at a level of significance, those at CEO/director level believed their organisation was more motivated than those below this level reported. This applied across both health authorities and across the clinical/non-clinical splits. There was no significant difference in response from any other sub-groups.

Table 47 Frequency distribution – employee motivation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	De-motivated	4	9.8	9.8	9.8
	Not very motivated	8	19.5	19.5	29.3
	Quite motivated	16	39.0	39.0	68.3
	Fairly motivated	8	19.5	19.5	87.8
	Very motivated	5	12.2	12.2	100.0
	Total	41	100.0	100.0	

INFORMATION AND KNOWLEDGE

Elements identified from the literature review were:

- Corporate knowledge should not be scattered
- Organic structures should be in place rather than hierarchical structures
- Information/IT strategic plans should be clear
- Relationships with providers should be good
- There should be co-ordination of and focus on training & development
- There should be networking and learning from other organisations
- There should be awareness of and commitment to information at Board level

Corporate knowledge should not be scattered (Table 48)

This was tested by asking respondents the extent to which they believed information professionals were integrated with other teams. Overall, respondents had a tendency to believe that information professionals were not integrated with other teams (mean=0.34).

Table 48 Frequency distribution – are information professionals integrated with other teams?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	27	65.9	65.9	65.9
	Yes	14	34.1	34.1	100.0
	Total	41	100.0	100.0	

Organic structures should be in place rather than hierarchical structures

This was addressed as an element of Organisational Structures

Information/IT strategic plans should be clear (Table 49)

Most respondents reported that information/IT strategic plans were clear (mean=0.63)

Table 49 Frequency distribution – are information/IT strategic plans clear?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	15	36.6	37.5	37.5
	Yes	25	61.0	62.5	100.0
	Total	40	97.6	100.0	
Missing	System	1	2.4		
Total		41	100.0		

Relationships with providers should be good

This was addressed as an element of Environment Influences

There should be co-ordination of and focus on IT/information training & development (Table 50)

A majority of respondents believed there were good opportunities for training and development in IT and the use of information (mean=0.64).

Table 50 Frequency distribution – Focus on IT/information training and development?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	15	36.6	37.5	37.5
	Yes	25	61.0	62.5	100.0
	Total	40	97.6	100.0	
Missing	System	1	2.4		
Total		41	100.0		

There should be networking and learning from other organisations (Table 51)

There was a split response to the question about information links with other organisations, with a mean of 0.51. There was no significant difference in response from any sub-groups.

Table 51 Frequency distribution – networks to learn from other organisations?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	19	46.3	48.7	48.7
	Yes	20	48.8	51.3	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

There should be awareness of, and commitment to information at Board level (Table 52)

67.6% or respondents (n=25) reported a commitment at Board level.

Table 52 Frequency distribution – commitment to information at Board level?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	12	29.3	32.4	32.4
	Yes	25	61.0	67.6	100.0
	Total	37	90.2	100.0	
Missing	System	4	9.8		
Total		41	100.0		

Information should support performance and review processes (Table 53)

A mean of 2.77 indicates that overall, most respondents believe that information supports performance and review processes more than *in parts* but less than *quite well*. 23% (n=9/39) of respondents reported that information supported performance and review processes *mostly* or *completely*.

Table 53 Frequency distribution – information supports review process?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not at all	2	4.9	5.1	5.1
	In parts	16	39.0	41.0	46.2
	Quite well	12	29.3	30.8	76.9
	Mostly	7	17.1	17.9	94.9
	Completely	2	4.9	5.1	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

People should share valuable information and knowledge. (Tables 54 and 55)

56% (n=23/41) of respondents reported that they *never* or only *sometimes* saw others keeping valuable information and knowledge to themselves. 44% (n=19/41) of respondents reported that they saw this happen *frequently, most of the time* or *all the time*.

56% (n=23/41) of respondents reported that they *never* kept knowledge to themselves with 41% (n=17/41) of respondents reporting that they *sometimes* kept knowledge to themselves. One respondent reported keeping knowledge to themselves *most of the time*. Reports of keeping knowledge to oneself occurred mostly from those below CEO/director level.

Table 54 Frequency distribution – seeing others keeping knowledge to themselves

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	2	4.9	4.9	4.9
	Some of the time	21	51.2	51.2	56.1
	Frequently	15	36.6	36.6	92.7
	Most of the time	2	4.9	4.9	97.6
	All the time	1	2.4	2.4	100.0
	Total	41	100.0	100.0	

Table 55 Frequency distribution – keeping knowledge to yourself

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	23	56.1	56.1	56.1
	Sometimes	17	41.5	41.5	97.6
	Most of the time	1	2.4	2.4	100.0
	Total	41	100.0	100.0	

RELATIONSHIPS

The literature review showed that organisations need to ensure that:

- their relationships with stakeholders are good
- organisational values, beliefs and views are understood by stakeholders
- organisational values, beliefs and views are shared by stakeholders wherever possible
- success is recognised within the organisation
- failure is not apparent to those outside the organisation

Relationships with stakeholders should be good.

This was addressed in the section on Relationships

Organisational values, beliefs and views should be known and understood by stakeholders (Table 56)

Responses from sub-categories in this question were averaged to derive each respondent's mean rank of their assessment of stakeholders' knowledge and understanding of respondent's organisational values, beliefs and views. Mean ranks can therefore appear in table 49 as increments between the response categories of 1, 2, 3, 4 or 5.

The mean of 2.8 suggests that overall, respondents believe organisational values, beliefs and views are only *slightly or moderately* understood by stakeholders. There was no significant difference in response from any sub-groups.

Table 56 Frequency distribution – the extent to which stakeholders know and understand organisational values, beliefs and views

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.33	1	2.4	3.1	3.1
	1.44	1	2.4	3.1	6.3
	2.00	1	2.4	3.1	9.4
	2.11	1	2.4	3.1	12.5
	2.22	1	2.4	3.1	15.6
	2.33	2	4.9	6.3	21.9
	2.44	5	12.2	15.6	37.5
	2.56	3	7.3	9.4	46.9
	2.67	2	4.9	6.3	53.1
	2.78	1	2.4	3.1	56.3
	2.89	2	4.9	6.3	62.5
	3.22	3	7.3	9.4	71.9
	3.33	4	9.8	12.5	84.4
	3.56	3	7.3	9.4	93.8
	3.67	1	2.4	3.1	96.9
	4.89	1	2.4	3.1	100.0
	Total	32	78.0	100.0	
Missing	System	9	22.0		
Total		41	100.0		

1 = Not at all 2 = Slightly 3 = Quite a bit 4 = Mostly 5 = Entirely

Organisational values, beliefs and views should be shared by stakeholders wherever possible (Table 57)

Responses from sub-categories in this question were averaged to derive each respondent's mean rank of their assessment of the extent to which stakeholders share the respondent's organisational values, beliefs and views. Mean ranks can therefore appear in table 49 as increments between the response categories of 1, 2, 3, 4 or 5.

The mean of 2.7 suggests that overall, respondents believe organisational values, beliefs and views are only *slightly* or *moderately* shared by stakeholders. There was no significant difference in response from any sub-groups.

Table 57 **Frequency distribution – the extent to which stakeholders share organisational values, beliefs and views**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.56	1	2.4	3.2	3.2
	1.78	3	7.3	9.7	12.9
	1.89	1	2.4	3.2	16.1
	2.00	1	2.4	3.2	19.4
	2.22	1	2.4	3.2	22.6
	2.33	2	4.9	6.5	29.0
	2.44	2	4.9	6.5	35.5
	2.56	4	9.8	12.9	48.4
	2.78	1	2.4	3.2	51.6
	3.00	5	12.2	16.1	67.7
	3.11	1	2.4	3.2	71.0
	3.22	2	4.9	6.5	77.4
	3.33	3	7.3	9.7	87.1
	3.44	1	2.4	3.2	90.3
	3.56	1	2.4	3.2	93.5
	4.00	2	4.9	6.5	100.0
	Total	31	75.6	100.0	
Missing	System	10	24.4		
Total		41	100.0		

1 = Not at all 2 = Slightly 3 = Quite a bit 4 = Mostly 5 = Entirely

Success should be recognised within the organisation (Table 58)

The mean of 2.71shows that respondents overall believed that key people in their organisations did not recognised success frequently but did so more than occasionally. However, nearly half the respondents (n=18/38) believed that organisational success was only recognised by key people within the organisation occasionally or *never.* Those at CEO/director level or above had a significantly more frequent view that success was being recognised than those below CEO/director level.

Table 58 Frequency distribution – frequency with which success is recognised by key people in organisation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	3	7.3	7.9	7.9
	Occasionally	15	36.6	39.5	47.4
	Frequently	10	24.4	26.3	73.7
	Often	10	24.4	26.3	100.0
	Total	38	92.7	100.0	
Missing	System	3	7.3		
Total		41	100.0		

Failure should not be evident to those outside the organisation (Table 59)

Respondents believed that organisational failure was visible to key people outside the organisation slightly more than *occasionally* (mean=2.41). 69% of respondents (n=25/36) said that this happened only *occasionally* or *never*. 31% (n=11/36) said failures were evident outside the organisation *frequently, often* or *all the time.*

Table 59 Frequency distribution – failure visible outside organisation?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	1	2.4	2.8	2.8
	Occasionally	24	58.5	66.7	69.4
	Frequently	7	17.1	19.4	88.9
	Often	3	7.3	8.3	97.2
	All the time	1	2.4	2.8	100.0
	Total	36	87.8	100.0	
Missing	System	5	12.2		
Total		41	100.0		

SELF-REFERENCE

Elements identified from the literature review were:

- Individual, professional and organisational values, culture and beliefs need to be aligned
- Individuals should have the required personal competencies

- Organisations should know the competencies they require
- Personal relationships should be excellent
- Individuals should understand the purpose and goals of the organisation and teams of which they are part
- Individuals should feel secure and motivated

Individual, professional and organisational values, culture and beliefs (standards) need to be aligned.

This was addressed by the following questions:

How closely do your personal standards match those of the organisation you work for? (Table 60)

Respondents believed that the match was at least *quite a bit* but not *mostly.* (mean=3.23). There was no significant difference in response from any sub-groups.

Table 60 Frequency distribution – extent to which personal standards match your organisation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not at all	1	2.4	2.5	2.5
	Slightly	8	19.5	20.0	22.5
	Quite a bit	12	29.3	30.0	52.5
	Mostly	19	46.3	47.5	100.0
	Total	40	97.6	100.0	
Missing	System	1	2.4		
Total		41	100.0		

How strongly do your personal standards match those of the function/profession you work in? (Table 61)

Respondents believed that the match was more than *quite a bit* and approaching *mostly.* (mean=3.78). Clinicians expressed views that were

statistically significant from non-clinicians. Clinicians believed their standards more closely matched the function/profession with which they worked.

Table 61 **Frequency distribution – extent to which personal standards match function you work in**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Slightly	4	9.8	9.8	9.8
	Quite a bit	6	14.6	14.6	24.4
	Mostly	26	63.4	63.4	87.8
	Entirely	5	12.2	12.2	100.0
	Total	41	100.0	100.0	

Do others you work with have standards that differ from your own?(Table 62)

66% of respondents (n=27/41) said that others they worked with had standards that differ from their own. There was no significant difference in response from any sub-groups.

Table 62 **Frequency distribution – do others have different standards to yours?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	14	34.1	34.1	34.1
	Yes	27	65.9	65.9	100.0
	Total	41	100.0	100.0	

Do you know what the standards are of others you work with? (Table 63)

80.5% of respondents (n=33/41) said that they knew the standards of others they worked with. There was no significant difference in response from any sub-groups.

Table 63 **Frequency distribution – do you know standards of others you work with?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	8	19.5	19.5	19.5
	Yes	33	80.5	80.5	100.0
	Total	41	100.0	100.0	

Are people you work with aware of your personal/professional standards? (Table 64)

80.6% of respondents (n=29/36) said that others they worked with were aware of their personal/professional standards.

Table 64 Frequency distribution – are people aware of your personal/professional standards?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	7	17.1	19.4	19.4
	Yes	29	70.7	80.6	100.0
	Total	36	87.8	100.0	
Missing	System	5	12.2		
Total		41	100.0		

Individuals should have the required personal competencies.

Organisations should know the competencies they require.

These issues were addressed in the section on Competencies.

Personal relationships should be excellent.

This issue was addressed in the section on Relationships.

Individuals should understand the purpose and goals of the organisation (Table 65)

A mean of 3.34 suggests that overall, respondents believe that what the organisation is seeking to achieve is understood by slightly more than half the employees but not a majority. There was no significant difference in response from any sub-groups.

Table 65 Frequency distribution – number of employees understanding what the organisation is seeking to achieve

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	A minority of employees	7	17.1	17.1	17.1
	About half the employees	15	36.6	36.6	53.7
	A majority of employees	17	41.5	41.5	95.1
	Nearly all employees	2	4.9	4.9	100.0
	Total	41	100.0	100.0	

Individuals should feel secure and motivated. (Table 66)

Self-assessment of job security revealed that overall, respondents felt slightly less than neutral with a leaning towards feeling *insecure* (mean=2.93). There was no significant difference in response from any sub-groups.

Table 66 Frequency distribution – perceptions of job security

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very insecure	3	7.3	7.3	7.3
	Quite insecure	14	34.1	34.1	41.5
	Neutral	11	26.8	26.8	68.3
	Quite secure	9	22.0	22.0	90.2
	Very secure	4	9.8	9.8	100.0
	Total	41	100.0	100.0	

Staff motivation was addressed in the section on Competencies

PERSONAL STANDARDS

The literature review showed that employees should have:

- social needs satisfied
- job security in exchange for hard work and loyalty
- opportunities for self-actualisation
- challenging work in exchange for high productivity
- opportunities to provide high quality work and creative effort in the service of organisational goals

These issues were addressed by the following battery of questions:

If you are working in a team where <u>your</u> standards are in conflict with those of other team members what do you do? (Table 67)

58.5% of respondents expressed the opinion that they would *<u>openly</u> disagree and <u>openly</u> work to their own standards*. There was no significant difference in response from any sub-groups.

Table 67 Frequency distribution – conflict resolution of standards

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Quietly disagree and work to team standards	3	7.3	7.7	7.7
	Openly disagree and openly work to your own standards	24	58.5	61.5	69.2
	Quietly disagree and quietly work to your own standards	3	7.3	7.7	76.9
	Openly voice your disagreement but work to team standards	3	7.3	7.7	84.6
	Openly voice your disagreement but quietly work to your own standard	6	14.6	15.4	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

If standards are in conflict do you work primarily to team (multidisciplinary) standards or to your personal standards? (Table 68)

57% (n=21/37) of respondents said they would work to team (multidisciplinary) standards primarily with 43% (n=16/37) of respondents said they would primarily work to personal standards. There was no significant difference in response from any sub-groups.

Table 68 Frequency distribution – priority standards

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Team standards	21	51.2	56.8	56.8
	Personal standards	16	39.0	43.2	100.0
	Total	37	90.2	100.0	
Missing	System	4	9.8		
Total		41	100.0		

During the course of your work, how often during your work do you observe others seeking to *win* at the cost of someone else *losing*? (Table 69)

The mean (2.95) response was that respondents observed this happening *sometimes* with 20% (n=8/40) seeing this happen *often*. There was no significant difference in response from any sub-groups.

Table 69 Frequency distribution – others seeking to *win* at cost of someone else *losing*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	1	2.4	2.5	2.5
	Seldom	8	19.5	20.0	22.5
	Sometimes	23	56.1	57.5	80.0
	Often	8	19.5	20.0	100.0
	Total	40	97.6	100.0	
Missing	System	1	2.4		
Total		41	100.0		

During the course of your work, how often do you seek to *win* at the cost of someone else *losing*? (Table 70)

The mean (1.89) response was that respondents did this less than *seldom*. There was a significant difference in the response of those below Director level who were less likely to seek to *win* than those at Director level or above.

Table 70 Frequency distribution – personally seeking to *win* at cost of someone else *losing*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	11	26.8	28.9	28.9
	Seldom	21	51.2	55.3	84.2
	Sometimes	5	12.2	13.2	97.4
	Often	1	2.4	2.6	100.0
	Total	38	92.7	100.0	
Missing	System	3	7.3		
Total		41	100.0		

If innovation does not succeed what is the general reaction of senior managers? (Table set 71)

Respondents said the reactions were:

Well done for trying	33.3%
What could we learn for next time?	51.3%
We ought not to be the first to try new things	5.1%
Lets forget about it	10.3%
Whose fault was it?	30.8%
I don't feel encouraged to be innovative	15.4%

Table set 71 Frequency distribution – organisational reaction to unsuccessful innovation

Well done for trying

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	26	63.4	66.7	66.7
	Yes	13	31.7	33.3	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

What could we learn for next time?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	19	46.3	48.7	48.7
	Yes	20	48.8	51.3	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

Let's forget about it

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	35	85.4	89.7	89.7
	Yes	4	9.8	10.3	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

Let others try first next time

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	37	90.2	94.9	94.9
	Yes	2	4.9	5.1	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

Not encouraged to be innovative

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	33	80.5	84.6	84.6
	Yes	6	14.6	15.4	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

Whose fault was it?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	27	65.9	69.2	69.2
	Yes	12	29.3	30.8	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

There was no significant difference in response from any sub-groups.

Changes over the previous 12-18 months:

Employee involvement in decision making (Table 72)

Respondents reported overall that this had remained *much the same* (mean=2.88) although 25% (n=10/40) reported that this had become *less or much less*. There was no significant difference in response from any sub-groups.

Table 72 Frequency distribution – employee involvement in decision making

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Much less	2	4.9	5.0	5.0
	Less	8	19.5	20.0	25.0
	Much the same	23	56.1	57.5	82.5
	More	7	17.1	17.5	100.0
	Total	40	97.6	100.0	
Missing	System	1	2.4		
Total		41	100.0		

Emphasis on meaningful work (Table 73)

Respondents reported overall that this had remained *much the same'*(mean=2.95) although 23% (n=9/39) reported that this had become *less* or *much less*. Respondents in the clinical group showed a significant difference in their belief that meaningful work was now less.

Table 73 Frequency distribution – emphasis on meaningful work

		Frequency	Percent	Valid Percent	Cumulative Percent
	Much less	2	4.9	5.1	5.1
	Less	7	17.1	17.9	23.1
	About the same	21	51.2	53.8	76.9
	More	9	22.0	23.1	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

Responsibility for individual employees (Table 74)

Respondents reported overall that this had remained *much the same* (mean=2.97) although 19% (n=7/37) reported that this had become *less* or *much less* and 19% reported that this had become *more.* There was no significant difference in response from any sub-groups.

Table 74 Frequency distribution – responsibility for individual employees

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Much less	1	2.4	2.7	2.7
	Less	6	14.6	16.2	18.9
	About the same	23	56.1	62.2	81.1
	More	7	17.1	18.9	100.0
	Total	37	90.2	100.0	
Missing	System	4	9.8		
Total		41	100.0		

The number of managers (Table 75)

Respondents reported overall that this had remained *much the same* (mean=3.00). There was no significant difference in response from any sub-groups. HA2 showed a significant variance when reporting that there were now *more* managers than 12-18 months ago.

Table 75 Frequency distribution – the number of managers

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Much less	3	7.3	7.5	7.5
	Less	4	9.8	10.0	17.5
	About the same	23	56.1	57.5	75.0
	More	10	24.4	25.0	100.0
	Total	40	97.6	100.0	
Missing	System	1	2.4		
Total		41	100.0		

The number of self-managing teams (Table 76)

Respondents reported overall that this had remained *much the same'* (mean=2.92). There was no significant difference in response from any sub-groups.

Table 76 Frequency distribution – the number of self-managing teams

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Much less	2	4.9	5.1	5.1
	Less	4	9.8	10.3	15.4
	About the same	28	68.3	71.8	87.2
	More	5	12.2	12.8	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

Investment in training/skills development (Table 77)

Respondents reported overall that this had remained *much the same* (mean=2.85). There was no significant difference in response from any sub-groups.

Table 77 Frequency distribution – investment in training/skills development

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Much less	3	7.3	7.7	7.7
	Less	6	14.6	15.4	23.1
	About the same	24	58.5	61.5	84.6
	More	6	14.6	15.4	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

An atmosphere that encourages trust/mutual respect (Table 78)

Respondents reported a slight worsening *of atmospheres that encourage trust/mutual respect* (mean=2.54). 35% (n=14/40) of respondents reported that this was now *less* and 12.5% (n=5/40) reported that this was now *much less*. There was no significant difference in response from any sub-groups.

Table 78 Frequency distribution – an atmosphere that encourages trust/mutual respect

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Much less	5	12.2	12.5	12.5
	Less	14	34.1	35.0	47.5
	Much the same	16	39.0	40.0	87.5
	More	5	12.2	12.5	100.0
	Total	40	97.6	100.0	
Missing	System	1	2.4		
Total		41	100.0		

Protection of personal rights (Table 79)

Respondents reported overall that this had remained *much the same'* (mean=2.85). 24% (n=9/38) of respondents reported that this was now *less* and 13% (n=5/38) reported that this was now *much less*. There was no significant difference in response from any sub-groups.

Table 79 Frequency distribution – protection of personal rights

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Much less	5	12.2	13.2	13.2
	Less	9	22.0	23.7	36.8
	Much the same	21	51.2	55.3	92.1
	More	3	7.3	7.9	100.0
	Total	38	92.7	100.0	
Missing	System	3	7.3		
Total		41	100.0		

Encouragement to learn and be creative (Table 80)

Respondents reported that this was slightly less but overall had remained *much the same* (mean=2.80). 22.5% (n=9/40) of respondents reported that this was now *less or much less* than 12-18 months ago. There was no significant difference in response from any sub-groups.

Table 80 Frequency distribution – encouragement to learn and be creative

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Much less	3	7.3	7.5	7.5
	Less	6	14.6	15.0	22.5
	Much the same	27	65.9	67.5	90.0
	More	4	9.8	10.0	100.0
	Total	40	97.6	100.0	
Missing	System	1	2.4		
Total		41	100.0		

Recognition and reward for superior performance (Table 81)

Respondents reported that this was now slightly less (mean=2.63). 32.5% (n=13/40) of respondents reported that this was now *less* or *much less* than 12-18 months ago. There was no significant difference in response from any sub-groups.

Table 81 Frequency distribution – recognition and reward for superior performance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Much less	4	9.8	10.0	10.0
	Less	9	22.0	22.5	32.5
	Much the same	25	61.0	62.5	95.0
	More	2	4.9	5.0	100.0
	Total	40	97.6	100.0	
Missing	System	1	2.4		
Total		41	100.0		

Size of managerial groups (Table 82)

Respondents reported that this remained *much the same* (mean=2.87). 23% (n=9/39) of respondents reported that the size of managerial groups was now *smaller or much smaller* than 12-18 months ago. There was no significant difference in response from any sub-groups.

Table 82 Frequency distribution – size of managerial groups

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Much smaller	2	4.9	5.1	5.1
	Smaller	7	17.1	17.9	23.1
	Much the same	25	61.0	64.1	87.2
	Larger	4	9.8	10.3	97.4
	Much larger	1	2.4	2.6	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

The need for staff with specialist skills (Table 83)

Respondents reported that this was slightly more (mean=3.38). 36% (n=14/39) of respondents expressed the view that there was *more* need, and 10% (n=4/39) reported the need was now *much more* than 12-18 months ago. There was no significant difference in response from any sub-groups.

Table 83 Frequency distribution – size of managerial groups

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Much less	1	2.4	2.6	2.6
	Less	5	12.2	12.8	15.4
	Much the same	15	36.6	38.5	53.8
	More	14	34.1	35.9	89.7
	Much more	4	9.8	10.3	100.0
	Total	39	95.1	100.0	
Missing	System	2	4.9		
Total		41	100.0		

Factor analysis and the theoretical construct

To test the validity of the theoretical construct developed for this research, factor analysis was used to identify themes and clusters that might support the theoretical constructs used in this research (table 84). The factor analysis identified components in each of the framework categories and leads to the conclusion that the theoretical construct is valid. The relationship of components was then explored to determine if there were significant correlations with levels of probability that linked these components. Such links would further support the theoretical construct. Three components (shown bracketed) were at levels of confidence where their inclusion in the matrix was valid but their use as predictors was borderline.

A Cronbach alpha test was undertaken on these components to assess internal reliability. The outcome score of 0.72 suggested that components identified through factor analysis had internal consistency and internal reliability.

Table 84 Factor analysis components

Component	Component parts	Component part rank *	Extract **
Organisational structure	♦ Perceptions of organisational achievement	1	.792
	♦ Decision level	1	-.690
	♦ Frequency of decisions made too high	1	-.724
Environmental influences	♦ Organisational reaction to change	2	-.684
	♦ The confidence of stakeholders in the organisation	1	.801
Competencies	♦ Knowledge of employees	1	.754
	♦ (Skills of employees)	1	.640
Information and knowledge	♦ Board commitment to information	1	.700
	♦ Information supports performance review	1	.695
	♦ Keeping personal knowledge to oneself	3	.721
	♦ (Information staff integrated with other teams)	1	.649
Relationships	♦ Organisational values shared by stakeholders	1	.708
	♦ Organisational values understood by stakeholders	1	.712
	♦ (Relationships with stakeholders)	1	.646
Self-reference	♦ Employees understand what the organisation is seeking to achieve	1	.771
Personal standards	♦ Encouragement to learn and be creative	2	.675
	♦ An atmosphere that encourages trust/mutual respect	2	.812
	♦ Investment in training/skills development	2	.679
	♦ Personal rights protected	2	.780
	♦ Not encouraged to be innovative	1	-.735
	♦ Seeing others seeking to 'win' at cost of someone else 'losing'	1	-.776

* **Component ranks** identify those component parts that have contributed towards the overall ranking of variance *at that level*. Those component parts ranked at 1 have a higher relative importance in the factor analysis than those ranked at 2 or 3 respectively. Only those rankings that constitute the major proportion of factor analysis are used in factor analysis. In this analysis ranks 1, 2 and 3 accounted for 23%, 12% and 9% of variances respectively. Collectively they accounted for 44% of all variances in response.

** **Extract** values of 0.7 and above are used to identify major components of factor analysis. The extract value shows the proportion of that component part used to form the overall factor analysis. E.g. an extract of 0.792 shows that 79.2% of that component was used to form that factor analysis at rank level 1. A *negative* extract indicates a negative relationship of the component part to which it relates.

Inter-group Factor Analysis component correlations (Table set 85)

Organisational structure

Perceived organisational achievement

	Correlation coefficient	Significance (2 –tailed)	N
Decision level	-.507	.001	37
Frequency of decision make too high	-.618	<.001	38
Skills of employees	.597	<.001	38
Knowledge of employees	.619	<.001	38
Skills and knowledge development opportunities	.539	<.001	38
Board commitment to information	.518	.001	36
Information support to performance review	.603	<.001	37
Organisational values understood by stakeholders	.542	.001	32
What organisation is seeking to achieve is understood	.547	.001	38

Decision levels

	Correlation coefficient	Significance (2 –tailed)	N
% organisational achievement	-.507	.001	37
Frequency of decisions made too high	.707	<.001	39
Organisational success recognised outside organisation	-.545	<.001	38
Seeing people seeking to win at cost of others losing	.589	<.001	39
Information support to performance review	.528	.001	38

Frequency of decisions made too high

	Correlation coefficient	Significance (2 –tailed)	N
% organisational achievement	-.618	<.001	38
Decisions levels	.707	<.001	39
Knowledge of employees	-.571	<.000	40
Organisational success recognised outside organisation	-.623	<.001	37
Seeing people seeking to win at cost of others losing	.510	.001	40
Opportunities to develop skills and knowledge	-.564	<.001	40
Staff motivation	-.601	<.001	40
Information support to performance review	-.606	<.001	39
Organisational mission understood	-.543	<.001	40

Environmental influences

The confidence of stakeholders in the organisation

	Correlation coefficient	Significance (2 –tailed)	N .
Organisational values shared by stakeholders	-557	.001	31
Organisational mission understood	.521	.001	38

Organisational reaction to change

	Correlation coefficient	Significance (2 –tailed)	N
Learning links to other organisations	.498	.001	39

Competencies

Employee knowledge

	Correlation coefficient	Significance (2 –tailed)	N
% organisational achievement	.619	<.001	38
Frequency of decisions too high	-.571	<.001	40
Skills of employees	.789	<.001	41
Information support to performance review	.517	.001	39
Organisational values understood by stakeholders	.571	.001	32
Staff motivation	.543	<.001	41
What organisation is seeking to achieve is understood	.508	.001	41

Information and knowledge

Board commitment to information

	Correlation coefficient	Significance (2 –tailed)	N
Blame culture when innovation fails	-.554	<.001	36
% organisational achievement	.518	.001	38

Information supports performance review

	Correlation coefficient	Significance (2 –tailed)	N
% organisational achievement	.603	<.001	37
Decision level	-.528	.001	38
Frequency of decision make too high	-.606	<.001	39
Knowledge of employees	.517	.001	39
Organisational success recognised outside organisation	.570	<.001	36
What organisation is seeking to achieve is understood	.573	<.001	39

Keeping personal knowledge to oneself

	Correlation coefficient	Significance (2 –tailed)	N
Blame culture when innovation fails	.515	.001	39
Intellectual capital your own property? (MW)	.521	.001	39

Relationships

Organisational values shared with stakeholders

	Correlation coefficient	Significance (2 –tailed)	N
Confidence of stakeholders in your organisation	.557	.001	31
Seeing people seeking to win at the cost of others losing	-.739	<.001	31
Organisational values understood by stakeholders	.737	<.001	30
What organisation is seeking to achieve is understood	.682	<.001	31
Job security	.552	.001	31
Superior performance rewarded	.499	.004	31
Involved in decision making	.574	.001	31
Learning encouraged	.560	.001	31
Training investment	.521	.003	31

Organisational values understood by stakeholders

	Correlation coefficient	Significance (2 –tailed)	N
% organisational achievement	.542	.001	32
Knowledge of employees	.571	.001	32
Seeing people seeking to win at the cost of others losing	-.529	.002	32
Relationships with stakeholders	.732	<.001	32
Organisational values shared with stakeholders	.737	<.001	30
What organisation is seeking to achieve is understood	.502	.003	32

Self-reference

What organisation is seeking to achieve is understood by employees

	Correlation coefficient	Significance (2 –tailed)	N
% organisational achievement	.547	<.001	38
Frequency of decision make too high	-.543	<.001	40
Skills of employees	.556	<.001	41
Knowledge of employees	.508	.001	41
Confidence of stakeholders in your organisation	.521	.001	38
Own standards match those of your organisation	.514	.001	40
Involved in decision making	.635	<.001	40
Opportunities to develop skills and knowledge	.529	<.001	40
Staff motivation	.518	.001	41
Seeing people seeking to win at the cost of others losing	-.538	<.001	40
Information support to performance review	.573	<.001	39
Organisational values shared with stakeholders	.682	<.001	31
Organisational values understood by stakeholders	.502	.003	32

Personal standards

Seeing others seeking to win at cost of someone else losing

	Correlation coefficient	Significance (2 –tailed)	N
Level of decision making	.589	<.001	39
Frequency decisions taken too high	.510	<.001	40
Organisational values shared by stakeholders	-.739	<.001	31
Organisational values understood by stakeholders	-.529	.002	32
What organisation is seeking to achieve is understood	-.538	<.001	40
You seek to win whilst others lose	.492	.002	38

Organisational reaction to change

Not encouraged to be innovative

	Correlation coefficient	Significance (2 –tailed)	N
Organisational values shared with stakeholders	.560	.001	31
Personal standards match those of organisation	.522	.001	39
Learning encouraged	-.588	<.001	39
The number of self-managing teams	-.555	<.001	38
Organisational success recognised outside organisation	.522	.001	37

Encouragement to learn and be creative

	Correlation coefficient	Significance (2 –tailed)	N
Organisational success recognised by key people inside the organisation	.522	.001	37
Opportunities for employees to develop skills and knowledge	.583	<.001	40
Discouragement from being innovative	-.588	<.001	39
Involved in decision-making	.504	.01	40
Investment in training/skills development	.618	<.001	39
The values, beliefs and views of the organisations are shared by stakeholders	.560	.001	31
Protection of personal rights	.581	.001	38
An atmosphere that encourages trust/mutual respect	.635	<.001	40
Personal standards match those of the organisation	.522	.001	39

An atmosphere that encourages trust/mutual respect

	Correlation coefficient	Significance (2 –tailed)	N
Organisational success recognised by key people inside the organisation	.548	<.001	37
Job security	.583	<.001	40
Encouragement to learn and be creative	.635	<.001	40
Investment in training/skills development	.692	<.001	39
Protection of personal rights	.839	<.001	38

Protection of personal rights

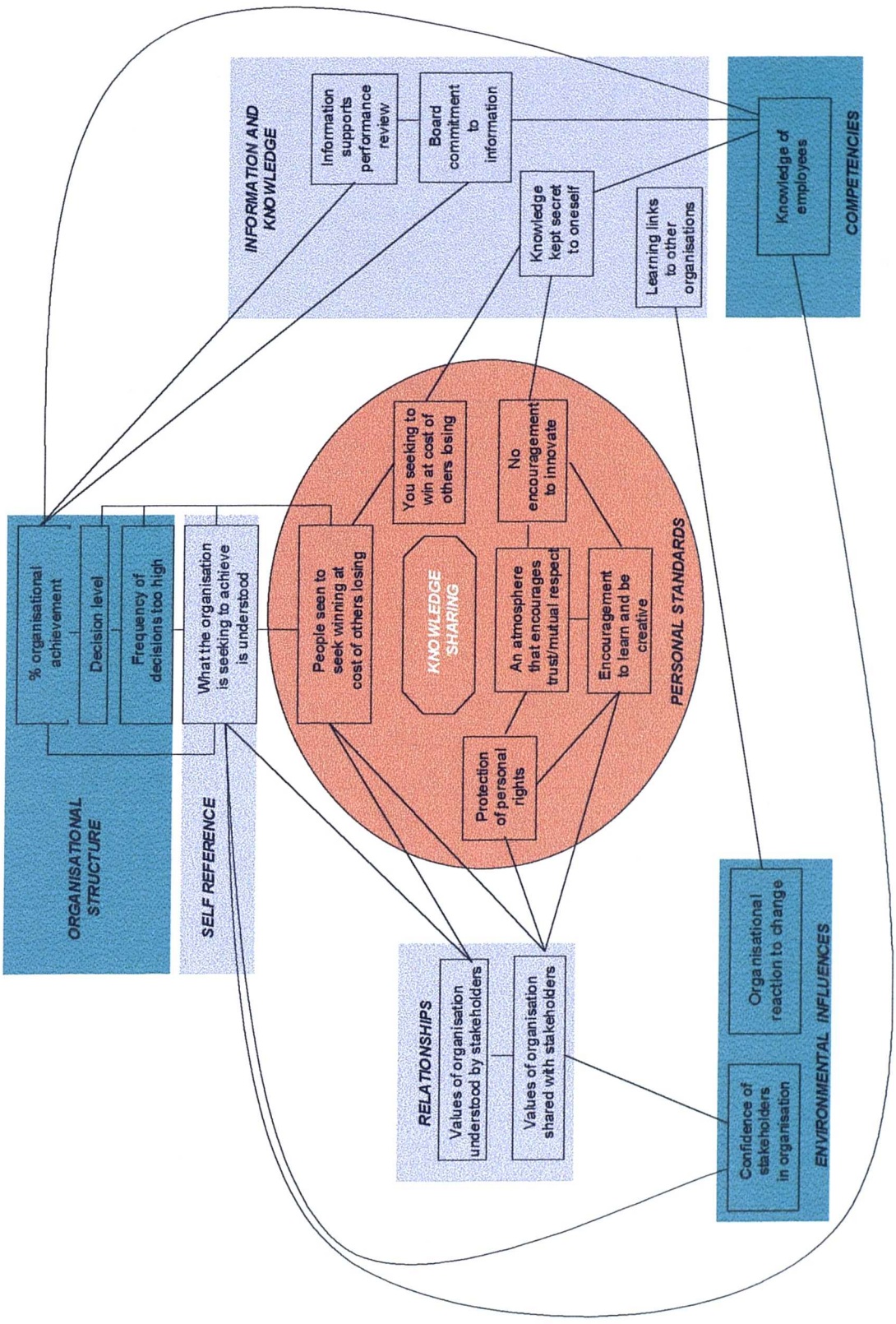
	Correlation coefficient	Significance (2 –tailed)	N
Job security	.618	<.001	38
Encouragement to learn and be creative	.510	.001	38
Investment in training/skills development	.692	<.001	39
An atmosphere that encourages trust/mutual respect	.839	<.001	38

Investment in training and skills development

	Correlation coefficient	Significance (2 –tailed)	N
Organisational values shared by stakeholders	.521	.001	31
Atmosphere that encourages trust and mutual respect	.692	<.001	39
Learning encouraged	.618	<.001	39
The number of self-managing teams	.494	.002	38
Personal rights protected	.593	<.001	38
Job security	.532	<.001	39

Components identified through factor analysis confirmed that the elements of the theoretical framework were valid. The negative correlations associated with the elements of *personal standards* will be explored in more depth later. The inter-relation of the factor analysis components is shown in Figure 28.

Figure 28 Correlation of factor analysis components aligned with theoretical construct



PSYCHOLOGICAL CONTRACT COMPONENTS

The components of the psychological contract are summarised below. Those issues shown **bold** were those identified as components from factor analysis.

- Employee involvement in decision making (question G6.1)
- An emphasis on meaningful work (question G6.2)
- Personal responsibility (question G6.3)
- The number of self-managing teams (question G6.5)
- Investment in training/skills development (question G6.6)
- **An atmosphere that encourages trust and mutual respect (question G6.7)**
- **Protection of personal rights (question G6.8)**
- **Encouragement to learn and be creative (question G6.9)**
- Recognition and reward for superior performance (question G6.10)

The correlations between components of the psychological contract and responses to other questions are summarised below. The null hypothesis would be that components of the psychological contract would not have significant relationships with elements of organisational dynamics.

Psychological Contract component correlations (Table set 86)

All response correlations are with Factor Analysis components unless annotated as 'not FAC'

Employee involvement in decision making (question G6.1)

	Correlation coefficient	Significance (2 –tailed)	N
Organisational values shared by stakeholders	.574	.001	31
What organisation is seeking to achieve is understood	.635	<.001	40
Encouragement to learn and be creative	.504	.001	40
Emphasis on meaningful work	.660	<.001	39

An emphasis on meaningful work (question G6.2)

	Correlation coefficient	Significance (2 –tailed)	N
Others aware of your standards (not FAC)	.549	.001	35
Supportive culture when innovation fails	.492	.002	38
Employee involvement in decision making	.660	<.001	39

Personal responsibility (question G6.3)

	Correlation coefficient	Significance (2 –tailed)	N
There were no correlations			

The number of self-managing teams (question G6.5)

	Correlation coefficient	Significance (2 –tailed)	N
Organic organisational structure (not FAC)	.521	.003	30
No encouragement to be innovative	-.555	<.001	38
Investment in training/skills development	.494	.002	38

Investment in training/skills development (question G6.6)

	Correlation coefficient	Significance (2 –tailed)	N
Job security (not FAC)	.532	<.001	39
Encouragement to learn and be creative	.618	<.001	39
The number of self-managing teams	.494	.002	38
An atmosphere that encourages trust/mutual respect	.692	<.001	39
Protection of personal rights	.593	<.001	38

An atmosphere that encourages trust and mutual respect (question G6.7)

	Correlation coefficient	Significance (2 –tailed)	N
Encouragement to learn and be creative	.635	<.001	40
Investment in training/skills development	.692	<.001	40
Protection of personal rights	.839	<.001	38
Job security (not FAC)	.583	<.001	40

Protection of personal rights (question G6.8)

	Correlation coefficient	Significance (2 –tailed)	N
Opportunities for employees to develop skills and knowledge	.583	<.001	40
Investment in training/skills development	.593	<.001	38
An atmosphere that encourages trust/mutual respect	.839	<.001	38
Job security (not FAC)	.618	<.001	38

Encouragement to learn and be creative (question G6.9)

	Correlation coefficient	Significance (2 –tailed)	N
Encouragement to learn and be creative	.581	<.001	38
The values, beliefs and views of the organisations are shared by stakeholders	.560	.001	31
Personal standards match those of the organisation	.522	.001	37
No encouragement to be innovative	-.588	.001	40
Involvement in decision making	.504	.001	40
Investment in training/skills development	.618	<.001	39
An atmosphere that encourages trust/mutual respect	.635	<.001	40
Personal rights protected	.581	<.001	38

Superior performance rewarded (question G6.10)

	Correlation coefficient	Significance (2 –tailed)	N
Organisational values shared by stakeholders	.499	.004	31
Job security (not FAC)	.608	<.001	40
Protection of personal rights	.510	.001	38

A Cronbach alpha test was applied to these elements to determine internal consistency and reliability. The score of 0.86 suggests very strongly that these elements are reliable in their application to determine responses to issues about components of the psychological contract.

The components of the psychological contract having significant correlations. The null hypothesis can therefore be rejected and the alternate hypothesis adopted. The alternate hypothesis being that components of the psychological contract do have significant impact on our behaviours, on our attitude to a number of organisational issues, and that organisational dynamics have a significant impact on our perception of whether the psychological contract is intact or has been broken.

Job security and staff motivation (Tables 87 and 88)

These elements are central to the concepts of defensive behaviours and the psychological contract. Significant correlations are summarised below:

Table 87 Correlations with job security

	Correlation coefficient	Significance (2 –tailed)	N
Organisational values shared by stakeholders	.552	.001	31
Superior performance rewarded	.608	<.001	40
Investment in skills/training development	.532	<.001	39
An atmosphere that encourages trust/mutual respect	.583	<.001	40
Personal rights protected	.618	<.001	38

Table 88 Correlations with staff motivation

	Correlation coefficient	Significance (2 –tailed)	N
Frequency that decisions are made 'too high'	-.601	<.001	40
Organisational success recognised by key people inside the organisation	.558	<.001	38
What the organisation is seeking to achieve is understood	.518	.001	41
Knowledge of employees	.543	<.001	41
Opportunities to develop skills/knowledge	.537	<.001	40

Interrelationships of the psychological contract components are shown diagrammatically in figure 30. The components of the psychological contract also have relationships with other specific issues such as job security and staff motivation, as well as the outcomes expressed as win/lose scenarios, observing others seeking to win at the cost of someone else losing, and personally seeking to win at the cost of someone else losing.

Those issues that correlated with elements in the psychological contract are also shown in figure 29. This shows the main pathways that link these elements. Figure 31 shows the psychological contract components component matrix common to all sub-groups. Detailed correlation component matrices are shown in figures 30, 31, 32 and 33 for clinical, non-clinical, CEO/director level and below CEO/director level respondents respectively. (The symbol ψ in the following figures denotes a component of the psychological contract.)

Figure 29 **Interrelation of psychological contract components, outcomes, factor analysis components, job security and staff motivation**

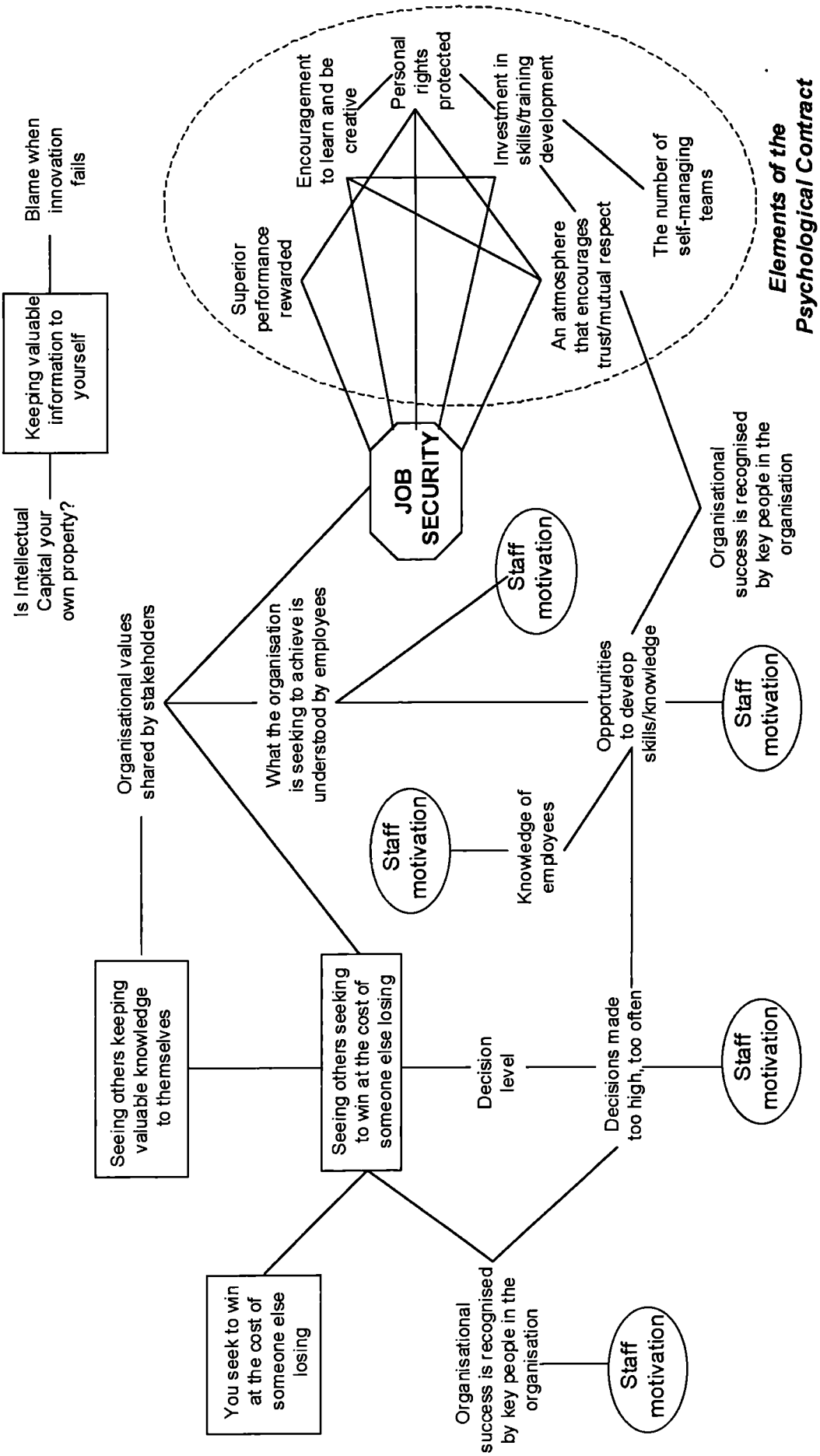
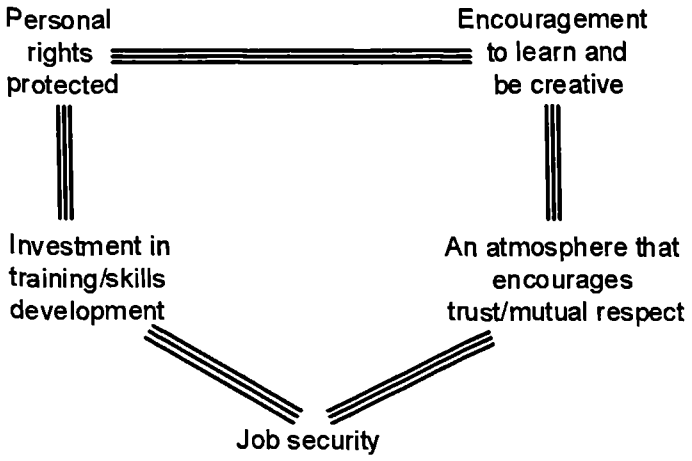


Figure 30 Generic components of correlation matrices



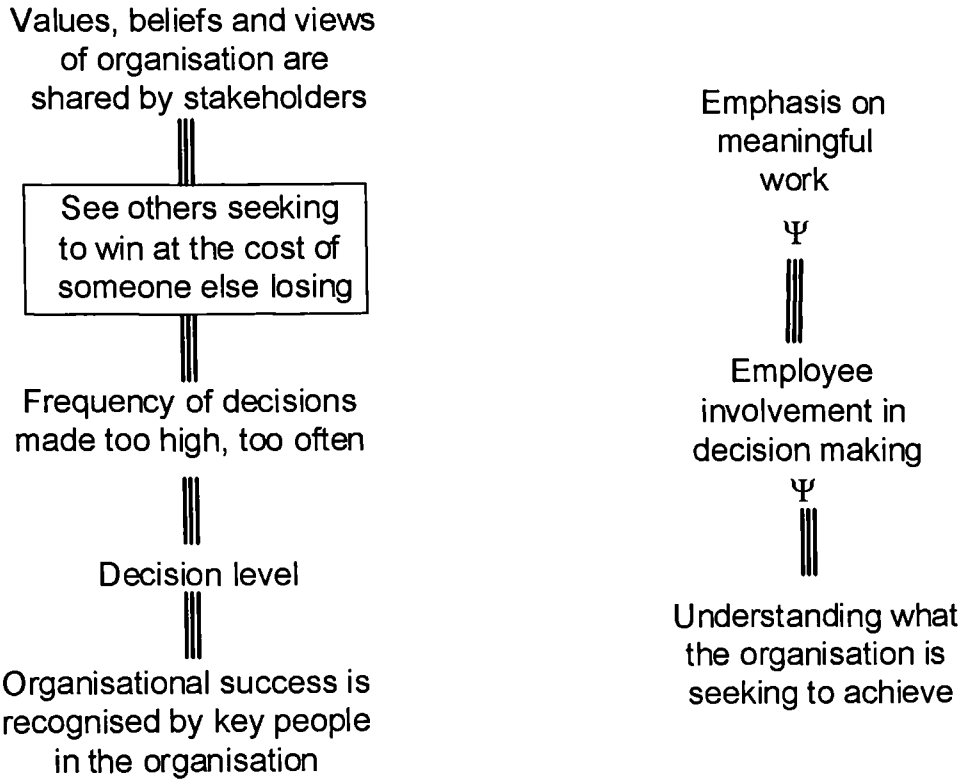


Figure 31 Clinical respondents correlation matrix

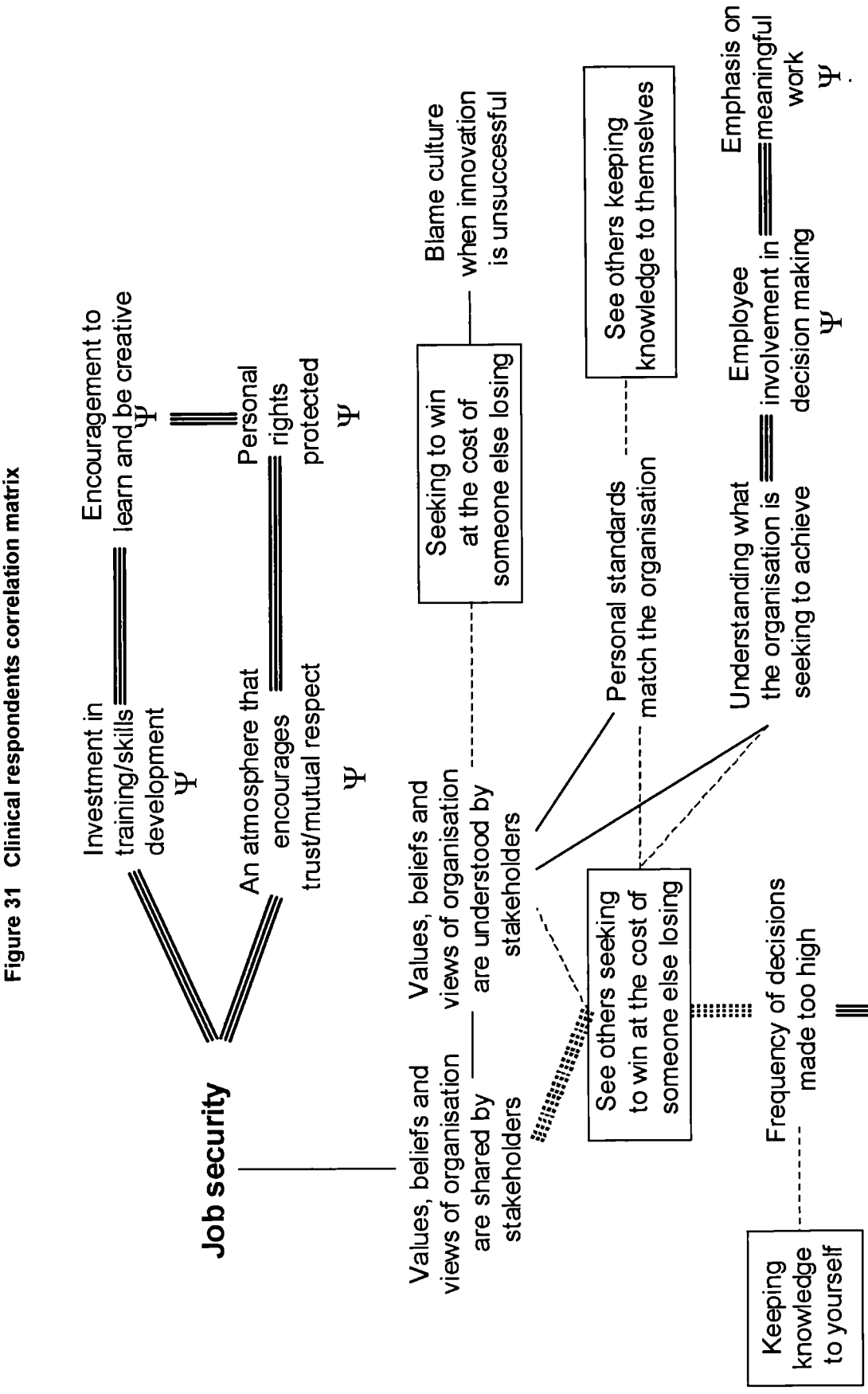


Figure 32 Non-clinical respondents' correlation matrix

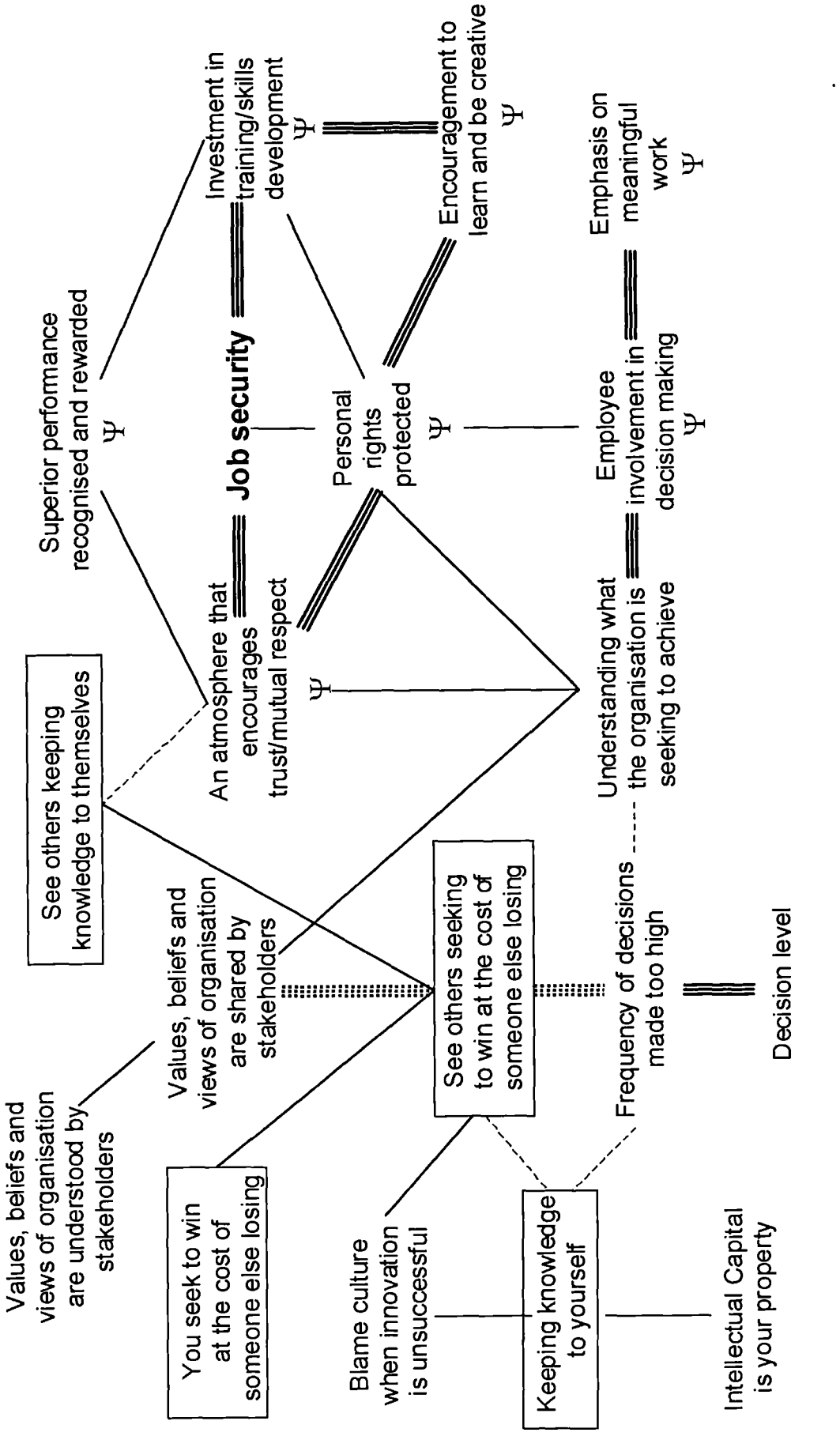


Figure 33 CEO/director respondents' correlation matrix

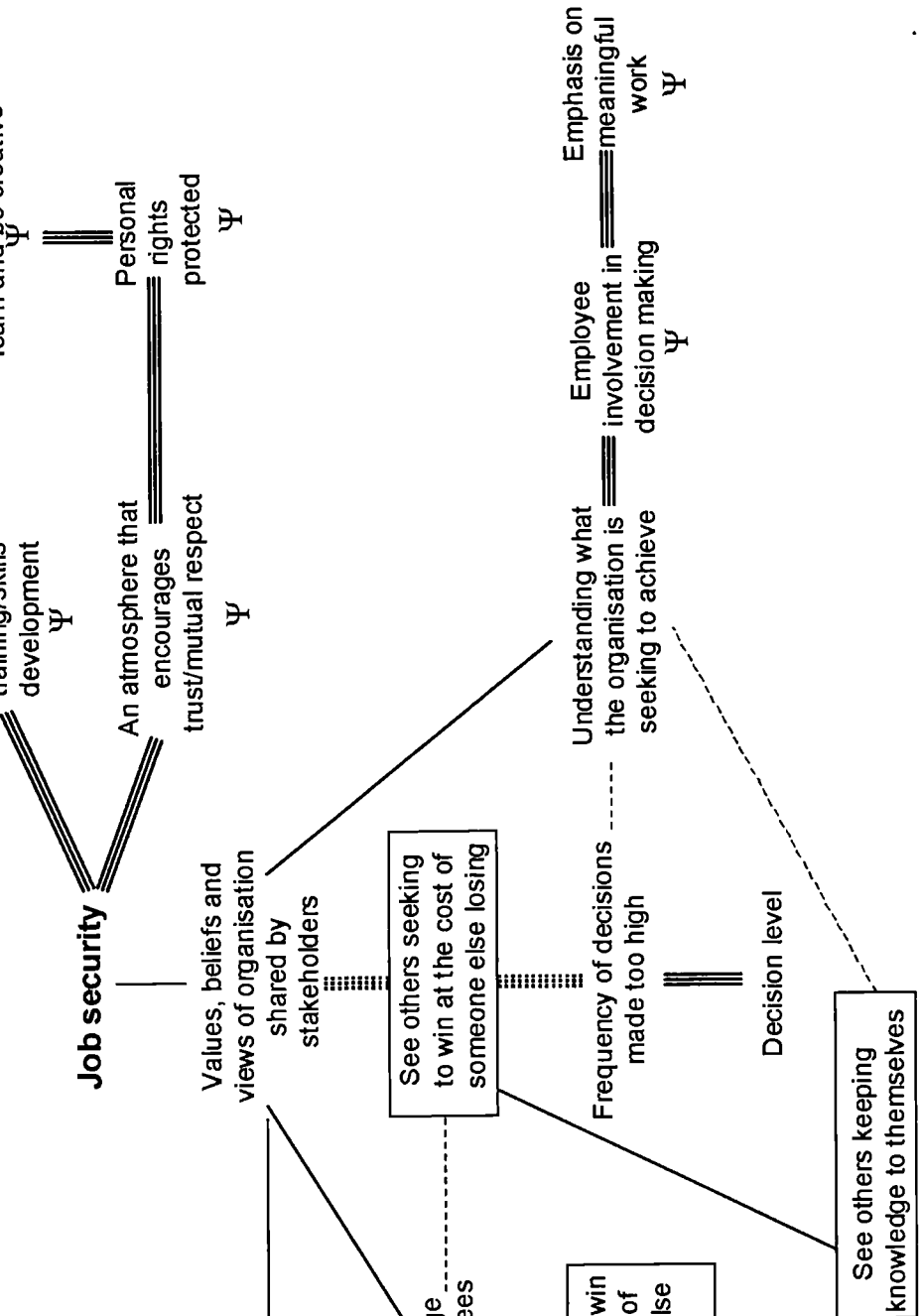


Figure 34 Below CEO/director level respondents' correlation matrix

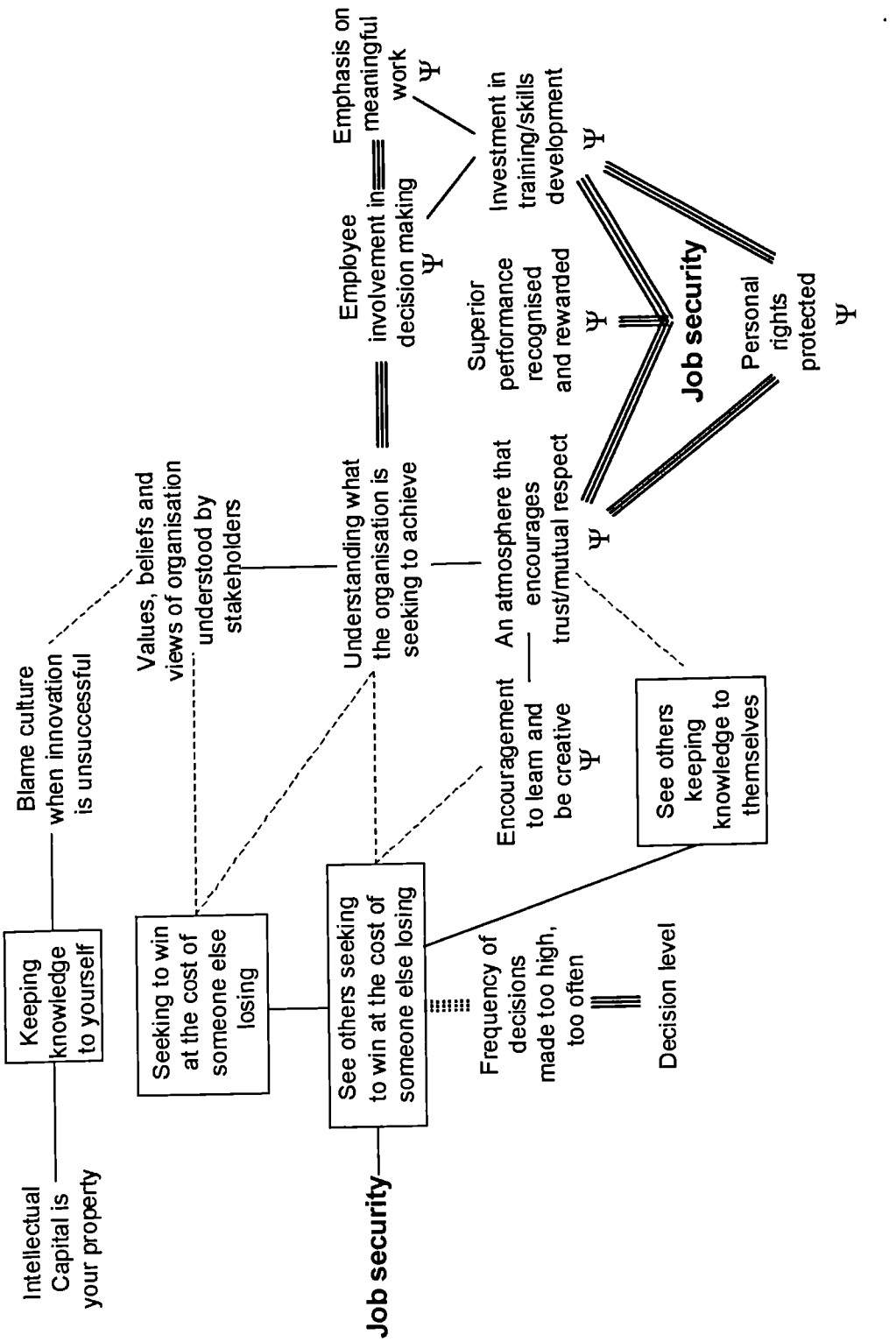


Table set 89 **Sub-group correlations for components of the psychological contract, components of factor analysis, Mann Whitney components, and outcomes**

KEY: *Bold italics = factor analysis component* (O) = Outcome

ψ = component of factor analysis (MW) = Mann Whitney component

Intellectual Capital is your personal property (Mann Whitney component – Clinical/non-clinical split)	Clinical	Non-clinical	CEO/directors	Below CEO/director
Keeping knowledge to yourself (O)		.581		.530
Working to your own standards rather than those of your team			.745	

An emphasis on meaningful work (Mann Whitney component – Clinical/non-clinical split)	Clinical	Non-clinical	CEO/directors	Below CEO/director
Organisational achievement				-.539
Attention paid to getting users' views				.504
Stakeholder confidence				.503
Skills of employees		.833		
Success is recognised by key people in the organisation (MW)				.663
Personal standards match the organisation	.695			
Others aware of your professional standards		.854		
Job security	.577			.541
Working to your own standards rather than those of your team	.595			
Seeing others seeking to win at the cost of someone else losing (O)	-.578			
Employee involvement in decision making ψ	.909	.503	.808	.607
Investment in training/skills development ψ				.517

Organisational reaction to pressures for change (Mann Whitney component – Split above/below director level)	Clinical	Non-clinical	CEO/directors	Below CEO/director
Decision levels				-.551
Frequency decisions taken too high		-.510		
Attention paid to getting users' views	.580			
Stakeholder confidence				.511
Networks to learn from other organisations	.522			
Relationships with other organisations		.520		.541
Stakeholders know & understand organisational values, beliefs and views				.508
Understanding what the organisation is seeking to achieve			-.687	

Relationships with stakeholders (Mann Whitney component – Clinical/non-clinical split)	Clinical	Non-clinical	CEO/directors	Below CEO/director
Organisational achievement	.692			.554
Frequency decisions taken too high				-.555
Attention paid to getting users' views	.612			
Organisational reaction to pressures for change (MW)		.520		.541
Stakeholder confidence	.602			.544
Skills of employees	.669			
Knowledge of employees	.659			
Stakeholders know & understand organisational values, beliefs and views	.938	.552		.599
Stakeholders share organisational values, beliefs and views				.533
Personal standards match the organisation	.754			
Personal standards match those of your function/profession			.671	
Understanding what the organisation is seeking to achieve	.634			
Job security			-.881	
Working to your own standards rather than those of your team	.660			
Seeking to win at the cost of someone else losing (O) (MW)				-.532
Personal responsibilityψ			.853	

Success recognised by key people in your organisation (Mann Whitney component – Split above/below director level)	Clinical	Non-clinical	CEO/directors	Below CEO/director
Organisational achievement	.755			.603
Decision levels	..621	-.494	-.756	-.509
Frequency decisions taken too high	-.796	-.531		-.609
Attention paid to getting users' views				.549
Stakeholder confidence		.505		.511
Knowledge of employees				.620
Opportunities to develop knowledge and skills		.530		
Staff motivation	.726			.538
Networks to learn from other organisations	.601			
Information professionals integrated into other teams			.756	
Stakeholders know & understand organisational values, beliefs and views				.635
Stakeholders share organisational values, beliefs and views	.806			.530
Personal standards match the organisation		.554		.557
Understanding what the organisation is seeking to achieve	.716			.566
Job security				.511
Working to your own standards rather than those of your team	.649			
Seeing others seeking to win at the cost of someone else losing (O)			-.723	-.676
Seeking to win at the cost of someone else losing (O) (MW)				.549
'Well done for trying' when innovation fails	.708			.646
Not encouraged to be innovative		-.516		-.513
The number of managers (MW)				.498
An atmosphere that encourages trust/mutual respect ψ	.681	.593		.756
Encouragement to learn and be creative ψ		.587		
The number of self-managing teams ψ				.498
Investment in training/skills development ψ				.605
Protection of personal rights ψ				.584

Staff motivation	Clinical	Non-clinical	CEO/directors	Below CEO/director
Organisational achievement			.694	
Decision levels	-.695			-.525
Frequency decisions taken too high		-.591		.553
Skills of employees		.649		
Knowledge of employees		.663		.535
Opportunities to develop knowledge and skills				.574
IT/Information training & development opportunities		.530		
Networks to learn from other organisations			.701	.584
Information supports performance review		.530		
Stakeholders know & understand organisational values, beliefs and views		.517		.527
Stakeholders share organisational values, beliefs and views		.491		.591
Success is recognised by key people in the organisation (MW)				.538
Personal standards match the organisation		.544		
Understanding what the organisation is seeking to achieve		.573	.667	.542
Seeing others seeking to win at the cost of someone else losing (O)	-.596			-.587
The number of self-managing teams ψ				.555
An atmosphere that encourages trust/mutual respect ψ	.571			
Protection of personal rights ψ	.587			
Encouragement to learn and be creative ψ		.498		

Stakeholders share organisational values, beliefs and views	Clinical	Non-clinical	CEO/directors	Below CEO/director
Frequency decisions taken too high		-.541		-.554
Attention paid to getting users' views	.746			
Stakeholder confidence	.837			.659
Skills of employees	.775			.575
Knowledge of employees	.751		.878	
Opportunities to develop knowledge and skills		.533		.514
Staff motivation		.517		.591
Information/IT strategic plan			.878	
Information professionals integrated into other teams	.751			
Information sharing is a corporate objective			.878	
Networks to learn from other organisations				.529
Information supports performance review			.878	
Seeing others keeping knowledge to themselves (O)		-.538		
Relationships with stakeholders				.533
Stakeholders know & understand organisational values, beliefs and views		.758	.841	.713
Stakeholders share organisational values, beliefs and views				
Success is recognised by key people in the organisation (MW)				.635
Personal standards match the organisation	.845			
Personal standards match those of your function/profession			.828	
You know standards of others			.828	
Understanding what the organisation is seeking to achieve	.924	.547		.719
Job security	.882			.551
Seeing others seeking to win at the cost of someone else losing (O)	-.775	-.702		-.727
Seeking to win at the cost of someone else losing (O) (MW)				
Employee involvement in decision making ψ	.802			.716
Investment in training/skills development ψ				.574
An atmosphere that encourages trust/mutual respect ψ				.503
Encouragement to learn and be creative ψ		.569		.620

What the organisation is seeking to achieve is understood	Clinical	Non-clinical	CEO/directors	Below CEO/director
Organisational achievement	.760			.507
Frequency decisions taken too high		-.549	-.793	-.539
Attention paid to getting users' views	.620			.604
Organisational reaction to pressures for change (MW)			-.687	.625
Stakeholder confidence	.636			.606
Skills of employees	.561	.593		
Knowledge of employees		.567	.678	
Opportunities to develop knowledge and skills		.579		.554
Staff motivation		.573	.667	.542
Information/IT strategic plan			.833	
IT/Information training & development opportunities		.502	.775	
Information supports performance review		.520	.705	.532
Seeing others keeping knowledge to themselves (O)		-.515	-.793	
Relationships with stakeholders	.634			.632
Stakeholders know & understand organisational values, beliefs and views		.547		.579
Stakeholders share organisational values, beliefs and views	.924			.719
Success is recognised by key people in the organisation (MW)	.716			.566
Failure is evident to people outside the organisation	-.706			
Personal standards match the organisation	.640			
Seeing others seeking to win at the cost of someone else losing (O)	-.619	-.488		-.538
Blame culture when innovation unsuccessful				.488
Employee involvement in decision making ψ	.683	.615	.690	.623
An atmosphere that encourages trust/mutual respect ψ		.630		
Protection of personal rights ψ		.507		
Encouragement to learn and be creative ψ		.539		.503

Decision level	Clinical	Non-clinical	CEO/directors	Below CEO/director
Organisational achievement	-.698			
Frequency decisions taken too high	.573			
Organisational reaction to pressures for change (MW)				-.551
Staff motivation	-.695			-.525
IT/Information training & development opportunities		-.599		-.562
Information supports performance review		-.579		
Seeing others keeping knowledge to themselves (O)			.776	
Stakeholders know & understand organisational values, beliefs and views		.536		-.561
Success is recognised by key people in the organisation (MW)	-.621	-.494	-.756	-.509
Seeing others seeking to win at the cost of someone else losing (O)	.740	.511	.949	.580
The number of self-managing teams ψ		-.499		

Frequency of decisions made too high	Clinical	Non-clinical	CEO/directors	Below CEO/director
Organisational achievement	-.754	-.577	-.854	-.504
Decision levels	.573	.755	.776	.689
Organisational reaction to pressures for change (MW)		-.510		
Stakeholder confidence		-.493		
Knowledge of employees		-.637		-.534
Opportunities to develop knowledge and skills		-.671		-.526
Staff motivation		-.591		-.553

Organisational achievement	Clinical	Non-clinical	CEO/directors	Below CEO/director
Decision levels	-.698			
Frequency decisions taken too high	-.754	-.577		.504
Stakeholder confidence		.510		.521
Skills of employees		.589		.566
Knowledge of employees		.684	.849	.539
Opportunities to develop knowledge and skills		.593	.849	
Staff motivation			.694	
Information/IT strategic plan		.565	.810	
Commitment to information at Board level	.618	.614		
Information supports performance review		.621		
Seeing others keeping knowledge to themselves(O)			-.854	
Relationships with stakeholders	.692			.554
Stakeholders know & understand organisational values, beliefs and views	.650			.559
Personal standards match the organisation	.578		.698	
Understanding what the organisation is seeking to achieve	.760			.603
Seeing others seeking to win at the cost of someone else losing (O)	-.814			
Seeking to win at the cost of someone else losing (O) (MW)			-.826	

Stakeholders understand the values, beliefs and views of your organisation (Component of factor analysis)	Clinical	Non-clinical	CEO/directors	Below CEO/director
Organisational achievement	.650			.599
Decision levels		-.536		-.561
Frequency decisions taken too high		-.571		-.600
Attention paid to getting users' views	.669			
Organisational reaction to pressures for change (MW)				.508
Stakeholder confidence	.655			
Skills of employees	.640		.801	
Knowledge of employees		.598	.874	.530
Opportunities to develop knowledge and skills		.530		
Staff motivation		.491		.527
Information/IT strategic plan				
IT/Information training & development opportunities		.691		.608
Commitment to information at Board level	.728			
Information supports performance review				
Seeing others keeping knowledge to themselves (O)				
Keeping knowledge to yourself			-.798	
Relationships with stakeholders	.938	.552		.776
Stakeholders know & understand organisational values, beliefs and views				
Stakeholders share organisational values, beliefs and views	.758	.841	.713	
Success is recognised by key people in the organisation (MW)				.579
Personal standards match the organisation	.792			
Personal standards match those of your function/profession	.712	.541		.570
Understanding what the organisation is seeking to achieve				.579
Seeing others seeking to win at the cost of someone else losing (O)		-.526		-.591
Seeking to win at the cost of someone else losing (O) (MW)	-.867			
Employee involvement in decision making ψ				.496
Encouragement to learn and be creative ψ		.490		

Keeping knowledge to yourself (Outcome)	Clinical	Non-clinical	CEO/directors	Below CEO/director
Frequency decisions taken too high	-.592			
Information/IT strategic plan		-.505		
Intellectual capital is your own property (MW)		.581		.530
Stakeholders know & understand organisational values, beliefs and views			-.798	
Personal standards match your function/profession	-.598			
Personal standards the same as those you work with			.756	
Seeing others seeking to win at the cost of someone else losing		.534		
Blame culture when innovation unsuccessful		.518		.541

Seeing others keeping knowledge to themselves (Outcome)	Clinical	Non-clinical	CEO/directors	Below CEO/director
Organisational achievement			-.854	
Decision levels			.776	
Frequency decisions taken too high		.538	1.00	
Skills of employees	-.544			
Knowledge of employees			-.742	
Opportunities to develop knowledge and skills		-.608		
Information/IT strategic plan	-.531		-.776	
IT/Information training & development opportunities		-.528	-.804	
Information supports performance review	-.659			
Stakeholders share organisational values, beliefs and views		-.538		
Personal standards match the organisation	-.652			
Understanding what the organisation is seeking to achieve		-.515	-.793	
Seeing others seeking to win at the cost of someone else losing			.736	
"What could we learn" when innovation unsuccessful		-.545		
The number of managers (MW)			.736	
An atmosphere that encourages trust/mutual respect		-.664		-.523
Encouragement to learn and be creative		-.509		

Seeing others seeking to win at the cost of someone else losing (Outcome)	Clinical	Non-clinical	CEO/directors	Below CEO/director
Organisational achievement	-.814			
Decision levels	.740	.511	.949	.580
Frequency decisions taken too high	.548	.521	.736	.627
Skills of employees	-.659			
Knowledge of employees	-.555			
Opportunities to develop knowledge and skills				-.577
Staff motivation	-.596			-.587
IT/Information training & development opportunities				-.497
Information supports performance review				-.486
Seeing others keeping knowledge to themselves			.736	
Keeping knowledge to yourself		.534		
Stakeholders know & understand organisational values, beliefs and views	-.775	-.702		-.737
Stakeholders share organisational values, beliefs and views	-.725	-.526	-.723	-.676
Personal standards match the organisation	-.664			
Understanding what the organisation is seeking to achieve	-.619			-.586
Job security				-.538
Seeking to win at the cost of someone else losing (O) (MW)		.625		.574
"Well done for trying" when innovation unsuccessful	-.618			
"Blame culture when innovation unsuccessful		.541		
An atmosphere that encourages trust/mutual respect				-.491
Encouragement to learn and be creative				-.506

Seeking to win at the cost of someone else losing (Outcome) (Mann Whitney component – Split above/below director leve)	Clinical	Non-clinical	CEO/directors .	Below CEO/director
Organisational achievement			.724	
Skills of employees			.833	
Knowledge of employees			.699	
Information supports performance review				-.496
Relationships with stakeholders (MW)				.532
Stakeholders know & understand organisational values, beliefs and views	-.867			
Success is recognised by key people in the organisation (MW)				-.513
Personal standards match the organisation			.971	
Others have different standards to your own	.603		.680	
Working to your own standards rather than those of your team			.777	
Seeing others seeking to win at the cost of someone else losing		.625		.574
'Blame' culture when innovation unsuccessful	.601			

Case studies

As part of the research one case study was undertaken in HA1 and two case studies were undertaken of individuals in HA2. HA1 had experienced the appointment of e new Chief Executive and HA2 had experienced the recent appointment of a new Chair. HA1 had been without a Chief Executive for several months. Relationships between the Chair and the Chief Executive in HA2 had been steadily declining over a period of about six months following the appointment.

CASE STUDY ONE

HA1 was going through a period of organisational crisis. The Chief Executive had left 6 months before the case study that was shortly after the survey was undertaken. Since the Chief Executive had left, the planned organisational change programme had faltered to the extent that external consultants had been brought in to facilitate change. The case study was based on interpretations made from the survey data and comparisons made with survey data from HA2. The interpretations were then discussed with a member of the consultancy team to determine the accuracy of interpretation.

Survey Question	Interpretation	Comments by consultant
How much of what your organisation says it will achieve does it actually achieve?	Employees believe HA only achieves 60% of what it says it will achieve	Unable to comment – issues not discussed with staff
Are management decisions generally made at levels that are ....?	Half the employees believe decisions are made *too high*	Agreed. Consultant commented that "Directors do this too often"
How often are management decisions made at levels that are *too high?*	Half the employees believe decisions are made too high, *often* or *all the time*	Agreed that this was true (see above)
How much effort is put into getting views of the general public?	64% of employees believed that the effort put in was *inadequate* or *barely adequate.* 33% of employees in HA2 gave the same response.	Unable to comment – issues not discussed with staff
How does your organisation generally react to pressures for change?	27% of employees said that change was *resisted* or *reluctantly accepted.* In HA2 the same response was given by just 7% of employees	Agreed that this was a problem for the HA.

How much confidence do stakeholders have in your organisation?	54% of employees believed that levels of confidence were *low/low to moderate.* 33% of employees in HA2 gave the same response.	Unable to comment – issues not discussed with staff
What is the level of employees' job related knowledge?	90% of employees believed levels of knowledge were *adequate* or *very adequate.* 77% of employees in HA2 gave the same response.	Consultant commented that employees were "very knowledgeable people".
How much opportunity is their for employees to develop their skills and knowledge?	45% of employees said that there was *quite a bit* of opportunity. 21% of employees in HA2 gave the same response.	Consultant commented that "in the past whoever wanted training got it"
How motivated are employees?	45% of employees said staff were *de-motivated* or *not very motivated.* 23% of employees in HA2 gave the same response	Agreed that this was a true reflection
How many employees understand what your organisation is seeking to achieve?	64% of employees said that what the organisation was seeking to achieve was understood by *very few employees* or *a minority of employees.* 49% of employees in HA2 gave the same response.	Agreed that this was a true reflection. Consultant commented that "There is poor communication"
How often do you see people seeking to win at the cost of someone else losing?	64% of employees said that they observed this *sometimes* or *often.* 73% of employees in HA2 gave the same response.	Agreed that this was a true reflection. Consultant commented that "It is a bit divisive"
How often do you seek to win at the cost of someone else losing?	20% of employees said they did this *sometimes.* 14% of employees in HA2 said they did this *sometimes* or *often.*	Agreed that this happened.
To what extent is there a blame culture when innovation has been unsuccessful?	29% of employees said this was the case compared with 36% in HA2	Agreed that this was happening now and that "it will come" (to higher levels)

The overall impression gained from the survey data was one of an organisation where there was nervousness about personal job security and where the Chief Executive had a reasonably high level of power – either charismatic or self-sustained. This had led to Directors feeling the need to maintain their authority and positions of power through keeping decision-making at director level. The knock-on effect was that employees felt uninvolved with decision-making and generally unsure of the organisation's direction. There was ample opportunity for the psychological contract to be broken and this was confirmed by analysis of the following matrix of responses to survey questions on components of the psychological contract.

Percentage response to question G6
(Components of the psychological contract denoted by ψ)

Component of the psychological contract	HA	Much less/ much smaller	Less/ smaller	About the same	More/ larger	Much more/ much larger
Employee involvement in decision making ψ	HA1		**36.4**	54.5	9.1	
	HA2	6.9	13.8	58.6	20.7	
Emphasis on *meaningful work* ψ	HA1		**27.3**	54.5	18.2	
	HA2	7.1	14.3	53.6	25.0	
Individual responsibility	HA1		10.0	60.0	**30.0**	
	HA2	3.7	18.5	63.0	14.8	
The number of managers	HA1	**18.2**	**27.3**	54.5		
	HA2	3.4	3.4	58.6	34.5	
The number of self-managing teams	HA1	**18.2**	9.1	63.6	9.1	
	HA2		10.7	75.0	14.3	
Investment in skills/training development ψ	HA1	9.1	18.2	63.6	9.1	
	HA2	7.1	14.3	60.7	**17.9**	
Atmosphere that encourages trust/mutual respect ψ	HA1	9.1	**45.5**	27.3	**18.2**	
	HA2	13.8	31.0	63.0	7.4	
Protection of personal rights ψ	HA1	9.1	**45.5**	36.4	9.1	
	HA2	14.8	14.8	63.0	7.4	
Encouragement to learn and be creative ψ	HA1	9.1	18.2	72.7		
	HA2	6.9	13.8	65.5	**13.8**	
Recognition and reward for superior performance ψ	HA1	**18.2**	18.2	63.6		
	HA2	6.9	24.1	62.1	**6.9**	
Size of managerial teams	HA1	**18.2**	9.1	63.6	9.1	
	HA2		21.4	64.3	10.7	3.6
The need for staff with specialist skills	HA1	**10.0**	20.0	30.0	30.0	10.0
	HA2		10.3	41.4	37.9	10.3

In summary, the status of the psychological contract in HA1 is that there is now:

- less employee involvement in decision making
- less emphasis on meaningful work
- less investment in skills/training development (compared with HA2)
- less atmosphere that encourages trust/mutual respect
- less protection of personal rights
- much less recognition and reward for personal performance

The analysis of components of the psychological contract in HA1 supports the analysis of data, supports the interpretation made, and was supported by comments made by the consultant working with HA1.

CASE STUDY TWO

The respondent was asked to describe what it was like to work in the health authority (HA2). In particular they were asked for any views they had on their job security, decision-making levels and frequency, recognition and reward for superior performance, trust and mutual respect, protection of personal rights, and investment in their training and skills development. They were also asked how well information was shared and whether they saw people trying to 'win'.

There is a lack of communication, lack of consideration and lack of explanation. There is an MI5 ethos. You get an awful feeling you are being kept in the dark. They say words like ' we will communicate' but they don't do it. There was a letter in Finance the other day with 'not to be shown to other members of staff' written on it. Nothing seems to change. The Chief Executive is a super bloke but things get hung up at the Executive Director/senior manager level. Others have a wish to sort things out. Restructuring should be open. Perhaps they think it (telling us) will de-motivate us.

Job security is OK for me. My job came to an end earlier this year. I wasn't told if I was to be slotted in or if I was to be in a new job. Nobody talked to me about it.

Decision-making is too high up the tree – Directors where line managers should be (taking decisions). This happens all the time.

There is no philosophy of information sharing, or the information is misleading. Yes, I see other people keeping information to themselves. Sometimes I do it myself. When people don't share information they blame others for not trying to find out. People see this as a threat to job security.

The respondent then rated the following components of the psychological contract both at the time of the interview and at a time 12 – 18 months ago.

Case study two	Likert scale 1 – 10 (1 = least/lowest)	Likert scale 1 - 10 (1 = least/lowest)
	NOW	12-18 months ago
Encouragement to learn and be creative	5	4
Personal rights protected	6	6
Investment in training and skills development	1	1
Atmosphere encourages trust and mutual respect	2	1
Involved in decision making	2	1
Superior performance recognised and rewarded	5	8

The respondent had been in HA2 for many years and had completed the initial questionnaire. Responses showed little change compared with 12 – 18 months ago with all current responses at or below a mid-point. Three components were at the lowest end of the scale.

Narrative responses concur with the analysis of the survey population and accord with responses to the specific questions relating to the psychological contract.

CASE STUDY THREE

The respondent was asked to describe what it was like to work in the health authority (HA2). In particular they were asked for any views they had on their job security, decision-making levels and frequency, recognition and reward for superior performance, trust and mutual respect, protection of personal rights, and investment in their training and skills development. They were also asked how well information was shared and whether they saw people trying to 'win'.

I only started here in April. Before that I was in local government and the education sectors. I found myself de-motivated in my first job. I moved to the education sector but the job criteria never really added up. My ways of motivating staff were different from the boss's ways. I was pulled into the boss's office and told not to socialise with staff. Rotas were changed without discussion to ensure that this (socialising) was not possible. I handed in my notice with no lace to go. My input was not valued. There were high levels of sickness and absence.

Here there is a lot of unease. Flow of communication is poor. There is an 'I'm OK' culture. There is poor interdepartmental communication. Finance are not liked. Staff are de-motivated. I would go tomorrow if I had something (to go to). It is only (named person) that makes me (want to) stay here. It's frosty – child-like in the way they treat you. Eyebrows are raised if you arrive at 9.05 (a.m.) even if you were at work until 11(p.m.) the previous night, and yet you are told to be flexible. Elsewhere you are respected. Directors like to be seen to do rather than actually doing.

I feel fairly secure in my job. I have my piece of paper – my (professional) qualifications.

People (Directors) aren't happy to have decisions made at lower levels. This happens quite often. They hold on (to decision making) as power and information. You should be able to trust people that they have the competence to make decisions.

I see people trying to win quite a bit, especially at higher levels. I'm quite cautious.

People keep knowledge to themselves to such a point that it makes working difficult. It is embarrassing in meetings. I don't (keep knowledge to myself) – I like to think I work in a different way)

The respondent then rated the following components of the psychological contract both at the time of the interview and at a time 12 – 18 months ago.

Case study three	Likert scale 1 – 10 (1 = least/lowest)	Likert scale 1 - 5 (1 = least/lowest)
	NOW	12-18 months ago
Encouragement to learn and be creative	2	10
Personal rights protected	2	10
Investment in training and skills development	1	1
Atmosphere encourages trust and mutual respect	3	1
Involved in decision making	4	10
Superior performance recognised and rewarded	1	4

This respondent had only been in post for 3 – 4 months and had not completed the initial questionnaire.

With one exception the respondent rate the status of the psychological contract components as being considerably less satisfied than when they started. The exception (working in an atmosphere that encourages trust and mutual respect) may be the result of the respect in which he holds his line manager, as stated in the narrative.

The almost entirely negative narrative accords with the responses to questions on the status of psychological contract components both past and present. This also accords with the findings of Kotter (1973) about the importance of ensuring that new managers have their psychological contract established at, or even before, they start work in the organisation.

The previous experiences, related in the narrative, suggest that a psychological contract had not been established satisfactorily with any of their employers to date.

SUMMARY

Pre- and post-survey reviews of the questionnaire and responses allowed grouping of respondents and responses that facilitated analysis. Homogeneity of data was assessed and differing levels of response identified between health authorities, between clinical and non-clinical respondents, and between those at CEO/director level and those below this level. The level of data homogeneity was sufficient to allow use of a single data set for overall analysis.

The literature review had identified (Argyris) that there was unlikely to be any correlations between biographical data and responses to any other questions. This turned out to be so and supported the theories of defensive behaviour that Argyris postulated and found during his research.

Correlations between outcomes supported the theories of defensive behaviour. Respondents who saw 'others seeking to win at the cost of someone else losing' were likely to perceive that those people were 'keeping valuable knowledge and information to themselves' and as a reaction. Respondents were then likely to 'seek to win at the cost of someone else losing' as a reaction.

Correlations between these elements and respondents 'keeping valuable knowledge and information to themselves' were not at high levels of predictive significance but equally could not be dismissed as a null hypothesis. This latter assessment was made on the basis of arguments put forward by Argyris about self-deceit, but non-supportive responses could also be accounted for by the possibility of respondents giving socially desirable answers. The concept of giving socially acceptable answers is supported by the high number of respondents who observed others keeping information to themselves and high number of respondents who reported seeing 'win/lose' scenarios compared with those who said they did these

things themselves. In other words 'I see others doing this but of course I don't do these things myself'. Taken together, these factors suggest that the hypotheses Argyris proposed are sound and that his findings from directly observable behaviour are applicable to those who formed part of this survey.

Factor analysis identified key components from responses that matched well with the original theoretical construct. Components of the psychological contract were analysed and shown to correlate significantly with components of factor analysis. Correlations between components of factor analysis and components of the psychological contract were undertaken and represented diagrammatically, showing the additional links to staff motivation and job security. The number of highly significant correlations between components of the psychological contract and 'job security' appear to confirm the link between the theory of the psychological contract in actuality. The number of significant correlations between components of the psychological contract and components of factor analysis also add further weight to the hypothesised links between components of the psychological contract and Argyris' theories of defensive behaviours.

These components and elements experience dynamic tensions that ultimately determine whether each of us sees other people seeking to win at the cost of others losing, sees other people keeping valuable information to themselves and as a result whether we feel willing to share knowledge or not. It was noted at this stage that these issues are, as Argyris described them, 'self-sealing' i.e. once you see others seeking to win, you seek to win, at which point others see you seeking to win so they seek to win again - a continuous loop.

It is the relationship of components of the psychological contract, components of factor analysis, outcomes, impact on job security and staff

motivation, theories of defensive behaviour and consequent barriers to knowledge that will be further analysed and interpreted in the next chapter against issues identified through the literature review.

CHAPTER FIVE
DISCUSSION

This section reviews the findings against issues identified through the literature review. A review is made of the concept of 'organisation' and 'effectiveness' when applied to the organisations in this research. Responses to components of questions in each section of the questionnaire identified through factor analysis are discussed.

Components of the theoretical construct are reviewed in relation to components identified through factor analysis. Components of the psychological contract are discussed and their relationships with, and impact on defensive behaviour and attitudes to knowledge sharing critically examined.

The Theoretical Construct

The model of organisational dynamics, the psychological contract and defensive routines originally proposed for this research (figure 26) was tested and found to be valid. The revised model was summarised in figure 28 and table set 83, and the correlation of components with other response categories was summarised in table set 84.

The original and revised models both incorporated components of *emergent dynamics* (*relationships, knowledge* and *self-reference*), identified through the literature review. Both models also incorporated *the psychological contract* as a concept that was new to the NHS and only reflected in NHS policy following the publication of *Working Together*. These incorporations were developments of existing organisational framework models identified through the literature review. Incorporation of emergent dynamics and the psychological contract into existing

models adds to both knowledge and understanding of how organisations in the NHS function in their current business environment, and in the organisational arrangements that prevail in the late 1990s.

Organisation

Schein described the concept of *organisation* as being made up of four basic ideas:

1. Co-ordination of effort in the service of mutual help
2. Achievement of common goals through co-ordination of effort
3. Division of labour
4. Integration through an accepted hierarchy

Co-ordination of effort implies that people work together willingly and that they share a common vision of why they are working together. In general employees have applied for, and been appointed to jobs, and it is thus reasonable to concluded that there is a willingness to work with other people. 39% (n=15/41) of respondents reported their belief that what their organisation was seeking to achieve was understood by about half the employees. Another 17% (n=7/41) of respondents reported that only a minority of employees knew what the organisation was seeking to achieve. These responses indicate that the majority of employees in the organisations surveyed are not clear about what their organisation is seeking to achieve.

The *achievement of common goals* (Schein) implies the achievement of both organisational and personal goals. Achievement of organisational goals is the concept of *effectiveness* used for this research. 40% of respondents (n=15/38)

reported their beliefs that their organisation achieved 60% or less of what it set out to achieve. Respondents' perception of organisational achievement was identified as a component when the data set was analysed using factor analysis. With regard to achievement of personal goals, a discussion of the impact of the psychological contract is presented towards the end of this chapter.

Division of labour was seen by Schein as necessary because of the various skills, knowledge and expertise that are required in a successful organisation. Schein also concluded that these smaller units needed to be grouped to satisfy overall organisational needs. Respondents assessed skill and knowledge levels and most believed that the levels of *job related knowledge* and *job related skills* were *adequate* or *very adequate*. The grouping of people and their interactions are discussed later in this chapter.

Integration through an accepted hierarchy implies that the hierarchy is known as well as accepted as valid. Respondents were asked about their perceptions of the power base. Whilst a rank could be determined, it was clear that there was not a clear hierarchy of power at the 'top-of-the-shop'. 53% (n=19/36) of respondents believed that their Chief Executive exerted the most power over their organisation, 31% (n=11/36) reported that national politicians exerted the most power with 24% (n=10/36) believing the most power lay with the NHS Executive. This could present a confusing picture to employees who could become unsure which 'master' to satisfy first when the pressure is on. (Respondents apportioned equal ranks to some response categories and as a result the percentages do not add up to 100%).

The *health* of the organisations in this survey was assessed against the model defined for this research. It is reasonable to accept Schein's theoretical

construct as valid and reasonable therefore to conclude that several of the ideas that describe *organisation* were absent in those organisations surveyed. This implies that those organisations surveyed were not healthy, organised or functioning in ways that are likely to result in an effective organisation.

Outcomes - Win or lose, to share or not to share knowledge?

Employees can find themselves in a dichotomy, do they share their knowledge freely and be seen as a *company worker*, running the risk of sharing all their knowledge and having no bargaining power or do they retain some knowledge as *power* or a means of control and perhaps be seen as a non-team player?

If organisations continually offer opportunities to learn and be creative, then this may overcome some of the inherent defensiveness. In this survey it was found that respondents reported skills and knowledge to be *adequate* or *very adequate*. However, nearly a quarter of those surveyed saw very few opportunities to develop knowledge and skills, and another half saw only *some* opportunities. This view was supported by nearly a quarter of respondents who reported that investment in training and skills development was now *less* or *much less* than it had been 12-18 months previously. The same proportion of respondents reported encouragement to learn and be creative as being *less* or *much less* over the same period.

Knowledge sharing behaviours were an outcome of the survey. More than one third of respondents reported that they saw others keeping knowledge to themselves *frequently*. Less than half the respondents reported that they kept knowledge to themselves with over half saying that they *never* did this. The

arguments apply here relating to socially acceptable answers, self-delusion and self-belief that one did not set out to keep knowledge secret.

Knowledge sharing (with the perceptions of power or control that this gives the owner), and the propensity to seek to win revealed some interesting correlations. Overall there was a significant correlation between seeing others seeking to win and perceiving those people as keeping knowledge to themselves. The link between Argyris' framework and the concept of defensive behaviours being manifested in knowledge sharing behaviours is therefore sound. Similarly, there was a significant correlation between observing others seeking to win and the observer/recipient of this behaviour seeking to win as a natural reaction as predicted by Argyris' theory and his empirical research.

There were differences in responses worth exploring. Those at Director or CEO level showed a much greater correlation between seeing others seeking to win and the belief that they were keeping knowledge to themselves. This could be viewed as a group of people being particularly suspicious or that they tend to accept less of what they are told at face value. Alternatively these people may be interpreting non-sharing of knowledge as others seeking to win (at the cost of those at CEO/director level losing). There is a possibility that the non-reporting by this group of retaliatory win/lose seeking is masking a reality of personal win/lose taking place. This is supported by respondents reporting observed behaviour, with self-reporting following the socially acceptable/self-deceit pattern of response.

Those below Director level showed a strong correlation between respondents seeing others seeking to win and doing so themselves. There were weaker, but still significant correlations between these respondents seeing others

seeking to win and keeping knowledge to themselves, as well as keeping knowledge to themselves if they observed others displaying the same behaviour.

The clinical/non-clinical split also revealed some interesting differences in response. The responses of clinicians revealed no significant correlations between questionnaire responses, nor any correlations that even approached significance. Non-clinicians, however, showed significant correlation *between seeing others seeking to win* and *keeping personal knowledge to themselves*; between *seeing others seeking to win* and *seeking to win yourself*, and *seeing others keeping knowledge to themselves* as those people seeking to win.

There was a similar significant difference in reporting the belief that personal knowledge was intellectual capital where none of the clinicians surveyed reported a personal belief that this was so. Non-clinicians showed a significant correlation between belief in intellectual capital and propensity to keep knowledge to themselves – the greater the belief in personal knowledge being intellectual capital, the greater the likelihood that individuals will keep knowledge to themselves.

This is important when considering policies about knowledge sharing. Organisational cultures and personal/team development needs to focus on those issues that might most easily ensure that defensive barriers are broken down or their occurrence avoided.

One could infer that clinicians are more open about knowledge sharing and more relaxed about win/lose scenarios. It is arguable that this emanates from the clinical need to share knowledge for the effective treatment of patients but further research would be needed to confirm this hypothesis. What is evident is that

clinicians and non-clinicians reported significantly different observations and interpretations of essentially similar situations.

Significantly, win/lose scenarios and knowledge sharing behaviours were both identified as components through factor analysis.

Defensive behaviours

Argyris found that our reasoning was based on personal values, beliefs and cultures, and that these elements acted as barriers to organisational effectiveness when they did not align with the organisation with which we interacted, with individual parts of it or individuals associated with it.

Argyris proposed the concept of our *master programme*, defining it in terms of three elements:

Espoused theories - values and beliefs that we claim to work to in certain situations e.g. when trying to help individuals share knowledge, minimise actions that may make them defensive.

Operating assumptions – our thoughts and actions regardless of context e.g. people will always use knowledge as power.

Theories in use – what we actually do in certain situations.

Responses to questions about win/lose scenarios and keeping secret/sharing valuable knowledge showed that espoused theories and theories in use did vary. 20% (n=8/40) of respondents reported that they *often* observed others seeking to win at the cost of someone else losing. Nearly 60% (n=23/40) of

respondents reported this happening *sometimes*. However, when respondents were asked how often they did this themselves just one respondent said they did this *often* with 13% (n=5/38) saying they did this *sometimes*. There are several interpretations of this finding:

Responses are genuine and valid. If this were the case then the survey evoked responses from respondents who genuinely did not seek win/lose for themselves and were valid in interpreting the actions of others when perceiving others seeking a win/lose position.

Responses are genuine but disguised. Self-reporting of win/lose scenarios could be the result of the tendency of people to give socially acceptable responses. It could also be that respondents believed that they did not seek win/lose deliberately (even though others may observe this as being so). The converse could also be true that respondents observed other people seeking win/lose but that was not what the other people were consciously doing. This fits with Argyris' proposal that people may not be aware of the differences between their espoused theories and their actions.

Responses are not genuine and are not valid. This would imply that none of the respondents were giving their real response to these (and indeed any) questions in the questionnaire. This would be an unlikely scenario and certain 'truth' questions lend credence to the rejection of this possibility.

There remain the scenarios of genuine responses that are either valid or disguised. Argyris found that our espoused theories and theories in use do vary. Espoused theories were found by Argyris to vary enormously, reflecting global,

social values and beliefs. However, Argyris found that the acting out of these espoused theories (theories in action) revealed significant differences.

Espoused theories should mean that respondents report very low (or no) incidents of seeking to win at the cost of someone else losing, and very low (or no) incidents of respondents reporting keeping knowledge to themselves. Reporting of theories-in-action is achieved by using respondents as observers of the frequency with which other seek to win at the cost of someone else losing, and observing others keeping knowledge to themselves. If Argyris' theory, and his empirical research, were to be valid for those NHS organisations surveyed, then mean ranking of theories-in-use responses should be higher than espoused theory responses. From the survey it was identified that overall and for each individual subgroup, theory-in-use responses were at least one rank scale higher than espoused theory responses. This implies that those surveyed were displaying the same characteristics as all those whom Argyris himself surveyed. This confirms that Argyris' theories can be applied to organisations in the NHS.

To answer the question about the characteristics of UK work and cultural ethics we must return to the work done by Hunt who revealed international cross-cultural differences in goal orientation. UK managers were identified as having the highest drive for avoiding risks, a low drive for belonging to a team, a high need for task achievement to be recognised and a high need for independence, innovation, personal challenge and development.

In response to risk taking, two thirds of respondents reported that their organisations did not congratulate them for having tried something new when it had failed. Only half reported their organisations adopting a *learning* approach in such circumstances. 31% (n=12/39) of respondents reported a blame culture when

innovation failed and 15% (n=6/39) reported that they were not encouraged to be innovative.

Nearly one third of respondents reported that *recognition and reward for superior performance* had become *less* or *much less* over the proceeding 12-18 months.

Nearly a quarter of respondents reported that *encouragement to learn and be creative* had become *less* or *much less* over the proceeding 12-18 months. The same proportion reported *investment in training/skills development* and *meaningful work* as being *less* or *much less* with nearly a quarter also reporting the latter as *more* over the preceding 12-18 months.

Risk avoidance is a feature identified through the survey. The elements that Hunt identified as a high need for task achievement to be recognised and a high need for independence, innovation, personal challenge and development are elements that respondents reported as having become less available to them over the last year or so. This would suggest an impact on the motivation of individuals that was found to be the case through this research.

Goffee looked at intercultural differences in work-related values. He found that those in the Anglo-Saxon bloc (of which the UK is part) showed highly individualistic tendencies and a moderate need to avoid uncertainty. Goffee also found a high preference for masculine values (assertiveness, ambition and achievement) and a moderately low 'power distance' (those further away from the top of a hierarchy not accepting this distance of power away from them as legitimate). Goffee's findings agree with those of Hunt and are in agreement with these findings.

Argyris tested his theories with over 2000 people world-wide. Whilst he found espoused theories varied enormously he found almost no variance in theories-in-use. Argyris found that his model applied in 99% of cases.

In summary Argyris found that each of us:

- wants to achieve our intended purpose
- seeks to maximise winning and minimise losing
- suppresses negative feelings
- behaves according to what each of us considers rational

We seek to achieve this by:

- advocating our own position
- evaluating our thoughts and actions against those of others
- attributing causes for whatever we are trying to understand

The outcomes are described as *consequences* in Argyris' model I: miscommunication, mistrust, protectiveness, self-fulfilling prophecies, self-sealing processes and escalating errors.

Argyris argued that we see many of these issues as *undiscussable* and that we programme into ourselves an *ignorance* of mismatches between our espoused theories and our actions because acknowledging them would be embarrassing and challenging for us. He argued that most people choose to save face, avoid self-analysis issues and avoid discussing them with others. This in turn inhibits discussion of the governing values of others that one works with.

Argyris' expansion of his model to incorporate organisational-individual interactions (model O-I) reflects Hunt and Goffee's findings about risk avoidance and incorporates an escalation matrix that incorporates win/lose dynamics, increasing tribalism, increasing *game playing* and protectionism. The conclusion of his model is the potential inability of an organisation to learn or overcome defensive behaviours. The ability/inability to learn was described by Argyris' model of single/double loop learning. Only in double loop learning do we examine *consequences* and analyse these against our governing values (our master programme).

The process of learning can have both positive and negative effects on each of us in terms of punishments and rewards. Argyris developed this concept into his double-loop learning success-brittleness model that is closely linked to the concept of the psychological contract. Each of us usually enters into a situation with high aspirations for success accompanied by a high fear of failure. Success brings with it feelings of personal well-being, pride and exhilaration, high energy for work, expectations of a good reputation and further high aspirations of success. Failure brings feelings of shame and guilt, loss of self-esteem, a lack of self-confidence, fear of a bad reputation and fear of further failure.

The outcome of success is a *moderate inoculation* against brittleness (our concern about failing). The outcome of failure is likely to be a low tolerance for unnecessary pressure, an inability to cope with further failure and enhanced brittleness (avoidance of situations where we might fail, and an inability to deal with the consequences of failure). This is also known as the concept of *learned helplessness* (Makin, Cooper and Cox 1996).

This research revealed significant proportions of people in those organisations surveyed who reported declines in elements that make up values, beliefs and ambitions which Anglo-Saxon/UK citizens display as cultural norms. Many of these elements form part of the psychological contract. The research highlighted the significant links between these elements and perceptions of job security that Argyris linked to the propensity for people to act defensively.

Knowledge is now a prime commodity of organisations and of individuals. Each of us has unique knowledge which forms part of our intellectual capital and can be used to bargain with. Organisations need this knowledge if they are to be effective and satisfy the needs of stakeholders. However, the current trend towards portfolio careers and the downsizing of NHS organisations puts additional pressures of insecurity on individuals that they have probably not had to deal with before. Organisations need to react in the way they organise themselves and in the ways they seek to motivate staff.

Biographical influences

There were no significant correlations between any element of biographical data (age, gender or line relationships of respondents, the profession of the respondents or the function that the respondents worked in) and responses to any other questions in the questionnaire. Argyris also found that his theories were independent of age, gender etc. and the findings of this research therefore come as no surprise and support the hypothesis being based on the models and theories that Argyris proposed.

Organisational Framework

The theoretical construct was supported by the outcome of factor analysis. The component parts of the theoretical construct were assessed using the Cronbach Alpha test to determine the internal validity of questionnaires. The outcome score of 0.72 strongly suggested internal validity. The theoretical construct was therefore taken as valid.

The following discussion addresses those issues identified as components of factor analysis.

Organisational arrangements

Respondents identified their organisations as being largely organic in nature. This was a feature that had been identified from the literature review as being a pre-requisite requirement for organisations to function effectively in the current business environment. At a base level this is represented by Mintzberg's *adhocracy* form that matches the way the NHS is organised and is characterised by:

Size of organisation	-	Medium to large
Environment	-	Highly complex and dynamic
Key dimensions	-	Technical professionals with support staff
Formalisation	-	Not formalised – team based working

The NHS should be characterised by Mintzberg's summary of the advantages and disadvantages of the adhocracy form (table 90).

Table 90 Advantages and disadvantages of adhocracy organisational form

Advantages	Flexibility to adapt to change
	Ability to maximise along several dimensions
	Strong culture
	Empowered employees
Disadvantages	Unpredictability
	Inefficiency
	Potential inconsistency
	Employee stress

However, the literature review suggests that the advantages are not immediately evident as being the general rule in the NHS and responses to the questionnaire confirm this.

As an element of Environmental Awareness, *organisational responsiveness to pressures for change* was reported by most respondents as *accepting* or *being quick to accept* change. However, there was a significant difference in response with all those at CEO/director level reporting that their organisations had only positive attitudes towards change but below Director level 12% (n=5/41) respondents reported their organisation *reluctantly accepts* or even *resists* change. Those at CEO/director level appear either not to be acknowledging or not aware of their employees' negative attitudes toward change.

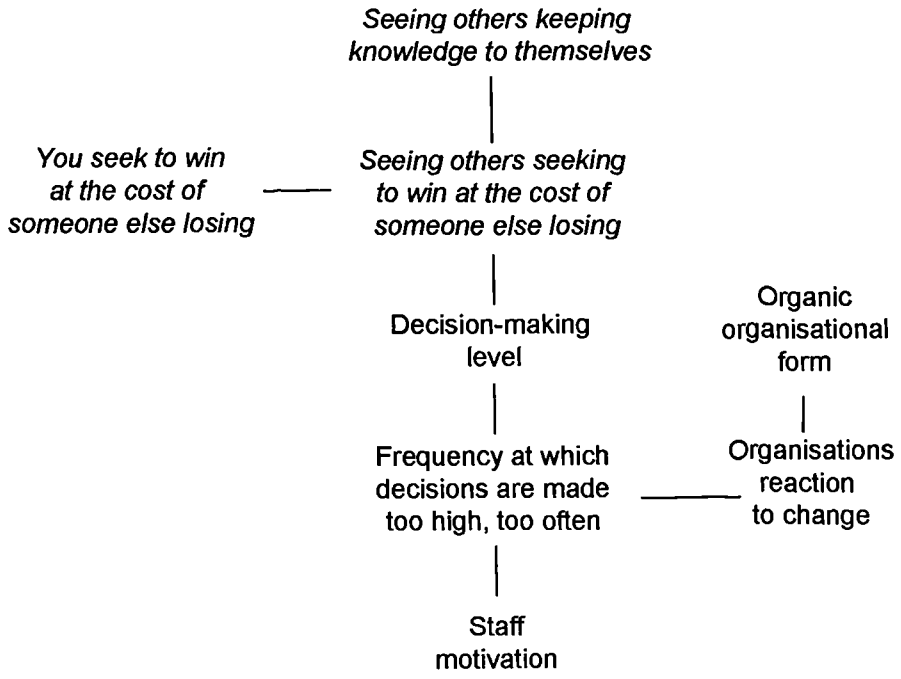
Organisational responsiveness to change was identified as a component of factor analysis and this scenario contributes towards our understanding of why those below CEO/director level become defensive. This component was identified as having significant correlations with learning links with other organisations. This

suggests that learning links to other organisations are not as evident to those below CEO/director level or such links are weaker or less available.

Organisational reaction to change also has fairly strong correlations with perceptions of the appropriate level at which decisions are made ($p=.012$, $r_s=-.442$, $n=40$) and organisations being organic are made ($p=.012$, $r_s=-.446$, $n=31$). The negative correlation with *decision level* implies that the more respondents perceived decisions were taken at levels that were *too high*, the lower their opinion of the organisation's ability to react to change positively.

Decisions making levels correlated significantly with *seeing others seeking to win at the cost of someone else losing* which itself correlated significantly with *seeing others keeping valuable information and knowledge to themselves* and *you seek to win at the cost of someone else losing*. The latter correlation is an example of the self-sealing nature that Argyris proposed and observed – if you see someone taking a win/lose stance then you do the same as a self-protecting defensive behaviour. One then becomes the object of other people observing you taking a win/lose stance and the process thus becomes circular and self-sealing. Decisions perceived as being taken at levels that are *too high* correlated significantly with respondents' perceptions of staff motivation. This matrix is summarised in figure 35.

Figure 35 – matrix of organisational arrangements and links to outcomes



Those below CEO/director level are more likely to perceive their organisation as predominantly functional (non-organic), more likely to perceive decisions being made at levels that are too high and that these decisions are made too high, too often. The consequences would be those below CEO/director level being:

- less motivated/de-motivated
- more likely to see others seeking to win at the cost of someone else losing
- more likely to see others keeping knowledge to themselves
- more likely to seek to win themselves at the cost of someone else losing

Mintzberg identified one potential advantage of organic organisations as having the ability to maximise along several dimensions. However, the NHS is continually faced with demands that it cannot afford and is unlikely to be able to

afford in the future being publicly funded. This advantage is therefore not a reality for the NHS.

Mintzberg also identified that organic organisations were likely to have a strong culture. The literature review, however, identified high levels of disparate professionalism, cultural differences and tribalism. Goffee described cultural differences and tribalism as "collective mental programming – deep assumptions not directly accessible, which may be reflected in values, attitudes and behaviours by individuals and groups". As a main focus of this research this has, and will be shown to apply to the NHS, as will the effect on knowledge sharing and defensive behaviours generally.

The impact of cultural diversity was explored in this research by questions on *self-reference* and *personal standards*. Whereas most respondents reported that their personal standards *mostly* matched those of their organisation, 30% (n=12/40) reported that their match was *quite a bit* and 20% (n=8/40) reported the match as only being *slight*.

Perhaps not surprisingly, respondents felt their personal standards aligned more with their profession or the function they worked in than the organisation they worked for. This was found to be particularly true for respondents who classified themselves as *clinical*.

A quarter of all respondents reported the match of their personal standards to those of their organisation as only *slight* or *not at all'*. This match was found to have significant correlations with many other components identified through factor analysis, the most important link being to *understanding what the organisation is seeking to achieve* which correlated directly to *seeing others seeking to win at the cost of others losing* and the subsequent matrix shown in figure 35.

The foregoing suggests that the culture of the NHS as an organisation is not strong but that culture for individual professions is strong. There are therefore opportunities for tribalism to develop with its associate *game playing* in ways that are likely to promote defensive behaviours developing.

The final advantage that Mintzberg saw for organic organisations was the empowering of employees. This was addressed by questions relating to the psychological contract and is addressed later in this chapter. However, it was clear from the research that there are multiple links between elements of the psychological contract, job security and components of factor analysis that link through a matrix to defensive behaviours, win/lose scenarios and staff motivation.

The research revealed significant correlations at moderately high levels of predictability between these and other components identified through factor analysis. Organisational arrangements have been identified through the literature review and the outcomes of this research as significant when considering issues of defensive behaviour, the psychological contract and the propensity of people to see others seeking to win at the cost of others losing, see others keeping knowledge to themselves and as a consequence themselves seek to win at the cost of others losing.

The differing responses between clinicians and non-clinicians, CEO/directors and those below CEO/director level strongly suggest that current organisational arrangements are likely to promote divisions and suspicions as to motives, are unlikely to overcome defensive behaviours generally and unlikely to overcome barriers to knowledge sharing behaviours in particular.

Environmental responsiveness

Adequate attention being paid to obtaining the views of service users was not a component of factor analysis but was identified through the literature review as an important issue. Just over 40% of respondents reported this to be *inadequate or barely adequate.*

Organisational responsiveness to pressures for change has already been discussed but an additional component of factor analysis relating to environmental awareness was the confidence that stakeholders had in the organisation. This correlated significantly with how many employees knew *what the organisation was seeking to achieve* which itself correlated significantly with *seeing people seeking to win at the cost of others losing* and onward into the matrix shown in figure 35. This implies that if an employee is not sure what their organisation is seeking to achieve then stakeholder confidence in that organisation is likely to be low and employees are more likely to report that they observe others seeking to win at the cost of someone else losing. On average respondents reported the confidence of stakeholders as *moderate* but more than one third of respondents reported confidence as *low* or *low to moderate.*

In turn, 17% (n=7/41) of the respondents reported their belief that *a minority of employees* knew what the organisation was seeking to achieve and 37% (n=15/41) of respondents reported that only *about half the employees* knew what the organisation was seeking to achieve.

The significance of correlations lead directly to the matrix in figure 35 and the likelihood that those in the organisations surveyed would be likely to display defensive behaviours generally and that barriers to knowledge sharing behaviours in particular would be evident.

Competencies

Knowledge of employees was the singular element identified as a component through factor analysis. This correlated directly and significantly with *Keeping knowledge to yourself* which directly correlated significantly with *seeing others seeking to win at the cost of someone else losing* and again onward in the matrix shown in figure 35.

Knowledge of employees was identified through the literature search as needing to be *at high levels* and yet most respondents reported the levels overall as being just slightly more than *adequate*. However, one third of respondents reported levels as being *very adequate* or *more than adequate*. There were no significant differences in response between any sub-groups and variances did not exceed one standard deviation.

These responses show that for the majority of employees, levels of their knowledge do not reach high levels being described mostly as just *adequate*. This implies that keeping knowledge secret to oneself would be taking place whether this was self-reported or not. From the survey, just under half the respondents admitted that they did this *sometimes* with just over half reporting that they *never* did this.

Again, there is a likelihood that those in the organisations surveyed would display defensive behaviours and that barriers to knowledge sharing behaviours in particular would be evident through employees keeping knowledge to themselves.

Information and Knowledge

As already identified, keeping knowledge to oneself was a component of factor analysis. In addition, factor analysis identified two other elements under this

heading – *Board understanding of, and commitment to information issues* and *information support to performance review.*

Board understanding and commitment had only two significant correlations. The first was that when Board commitment to information issues was perceived to be low, respondents perceived that there was a *blame culture if employees tried something new but that this was unsuccessful.* Two thirds of respondents reported that Board commitment was present but one third reported that it was absent. Secondly, two thirds of respondents reported that there was no blame culture in such circumstances but one third said there was.

41% (n=16/39) of respondents reported that information supported performance review *in parts* with two respondents reporting that information did not support performance review at all. 23% (n=9/39) of respondents believed information supported performance review *mostly* or *completely.* There were no significant differences for any sub-groups.

Perceptions of how well information supports performance review correlated significantly with perceptions of how well the organisation achieved what it set out to achieve. Perceptions of organisational achievement correlated significantly with many other responses to questions. There were strong, significant correlations with:

- Decision-making levels
- Frequency of decisions made too, too often
- Knowledge of employees
- Staff motivation
- Organisational success being recognised by key people in the organisation
- Employees understanding what the organisation was seeking to achieve

and weaker but still significant correlations with:

- Staff motivation
- Stakeholders understanding the values, views and beliefs of the organisation
- Seeing others seeking to win at the cost of someone else losing

The links to elements of the matrix in figure 35 are several and direct. The conclusion from responses must be that, once again, those organisations surveyed would be likely to display defensive behaviours and that barriers to knowledge sharing behaviours in particular would be evident through employees responding to observing others seeking to win at the cost of them losing.

Relationships

Both components identified through factor analysis were associated with organisational values – whether stakeholders shared them and whether stakeholders understood them. Both these components linked directly and correlated significantly with seeing others seeking to win at the cost of someone else losing and so directly in the matrix shown in figure 35.

Overall, respondents reported their belief that stakeholders knew and understood their organisation's values only *slightly* or *moderately*. Only one respondent believed that these values were understood *mostly* or *entirely*.

Responses to the extent to which stakeholders *shared* the same values revealed a lower mean than the *knowing and understanding* with value sharing assessed by most respondents as *slight* or *moderate*.

Both of these components correlated significantly and directly with *seeing people seeking to win at the cost of someone else losing*. Again there is the onward link into the figure 35 matrix.

Responses and the significant correlations identified, again imply defensive behaviours would be likely to be displayed, and that barriers to knowledge sharing behaviours in particular would be evident through employees responding to observing others seeking to win at the cost of them losing.

Self reference

Only one component was identified through factor analysis, that of *employees understanding what the organisation was seeking to achieve*. This component has already been discussed but it worth noting the high number of strong correlations this component has with:

- Perceptions of organisational achievement
- The level of effort put into getting the views of service users
- Frequency of decisions being made too high, too often
- Confidence of stakeholders
- Skills of employees
- Knowledge of employees
- Staff motivation
- Stakeholders understanding, sharing and knowing organisational values
- Personal standards matching those of the organisation
- Employee involvement in decision making

and weaker, but still significant links with:

- An atmosphere that encourages trust/mutual respect
- Encouragement to learn and be creative
- Organisational success being recognised by key people in the organisation
- Seeing others keeping knowledge to themselves

The links to elements of the matrix in figure 35 are again several and direct. Those organisations surveyed would be likely to display defensive behaviours and barriers to knowledge sharing behaviours in particular would be evident.

Personal standards

Personal standards held the most components identified through factor analysis. This was encouraging as a first step in the analysis as this section of the questionnaire contained references to the psychological contract.

The primary link to outcomes was the identification of 'seeing others seeking to win at the cost of someone else losing' as a component as this links directly into the matrix shown in figure 35. The secondary link came through respondents reporting that they were *not encouraged to be innovative*. This latter component correlated significantly with *organisational success being recognised by key people in the organisation* which in turn linked to *seeing others seeking to win at the cost of someone else losing* and again onward in the figure 35 matrix. This negative correlation meant that the less organisational success was being recognised by key people in the organisation, the more employees in these organisations would be to perceive others they worked with seeking to win at the cost of someone else losing. As a defensive reaction the observer commences to

seek to win and onward into the self-sealing processes previously described. The inevitable conclusion again was that defensive behaviours were likely to be displayed by those organisations surveyed and that barriers to knowledge sharing behaviours would be evident.

The other components identified in this section related to elements of the psychological contract.

The Psychological Contract

Argyris (1960) was the first person to make reference to the psychological contract. This set of unwritten expectations involves, for example, employees' expectations of being treated as human beings, having meaningful work, feeling they have dignity and worth, as well as having opportunities for growth and learning. Perceived negative changes in psychological contract components would be expected to have a negative effect on other components of the psychological contract as well as other components of the organisational framework.

The survey revealed a matrix of significantly correlating components of the psychological contract (figure 29). There were significant correlations between components of the psychological contract and job security. *Job security* correlated significantly to stakeholders sharing the same values as the respondents' organisations. This implies that where these values are perceived as not being shared, employees feel their job security is threatened and elements of the psychological contract with their employer have been damaged or broken. Perceptions of stakeholders not sharing the same values also have direct links to

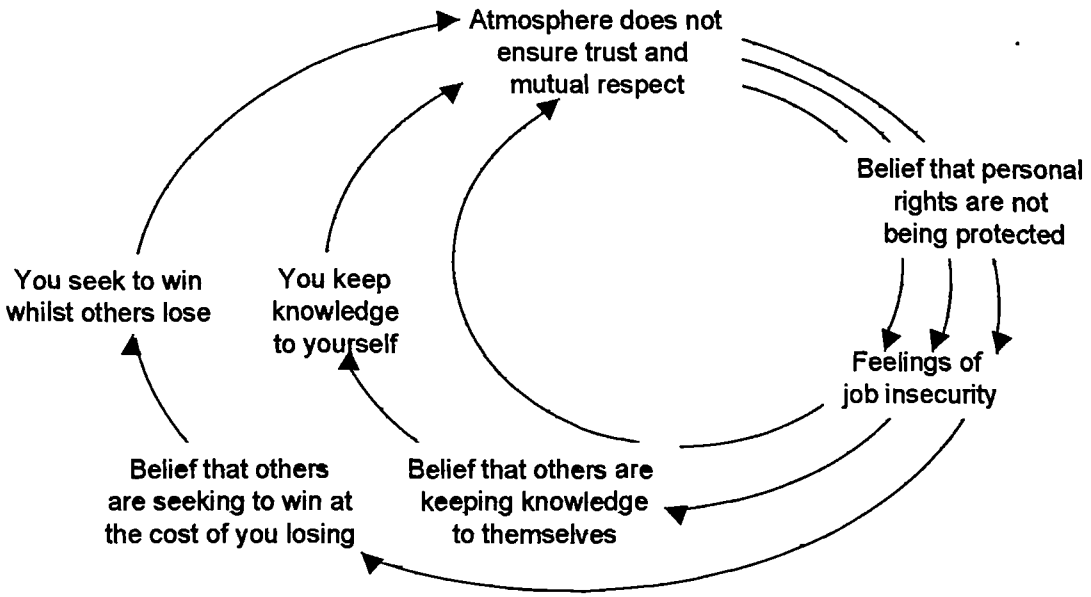
seeing others seeking to win at the cost of someone else losing and again onwards into the figure 35 matrix.

Also linked to the figure 35 matrix is *an atmosphere that encourages trust/mutual respect.* This linkage is through *organisational success being recognised by key people in the organisation* which feeds into the matrix via perceptions of whether there are *opportunities to develop skills/knowledge* and perceptions of the frequency with which decisions are made at levels that are *too high.*

Components of the psychological contract also display self-sealing properties. For example, if people feel there is not an atmosphere that encourages trust and mutual respect, they will start to feel that their personal rights are not being protected. If perceptions are that personal rights are not being protected, then feelings of job insecurity will arise, making people feel that there is an atmosphere that does not encourage trust and mutual respect. This process will make people feel defensive and encourage the belief that people are seeking win at the cost of that observer losing. The observers enter into win/lose behaviour themselves as defensive behaviours and there is a reluctance to share knowledge. Others then observe this win/lose behaviour, and fail to share knowledge and there is then a secondary self-sealing process. Because job security is threatened people become reluctant to discuss this and so the process becomes both self-fulfilling and self-sealing. These relationships are shown diagrammatically in figure 36.

Perceptions of the extent to which stakeholders share the same values are therefore critical and pivotal, as are perceptions of success being recognised by key people in the organisation.

Figure 36 Example of self-sealing defensive behaviour following violation of the psychological contract



Dale (unpublished 1999)

The comparatively large number of issues on *personal standards* in the questionnaire that were identified as components of factor analysis pointed strongly to the belief that components of the psychological contract played significant roles in respondents perceptions of job security. This impacts on damage to elements of the psychological contract that have the effect of encouraging development of defensive behaviours in general and unwillingness to share knowledge in particular.

A quarter of respondents reported that *involvement in decision making* was now *less* or *much less* compared to 12-18 months previously. The same proportion believed that there was *less* or *much less* emphasis on meaningful work, *less* or *much less investment in training/skills development* and *less* or *much less encouragement to learn and be creative.* A third of respondents reported that *recognition and reward for superior performance* was now *less* or *much less.*

Just under half the respondents reported that there was now *less* or *much less* of *an atmosphere that encouraged trust/mutual respect* and nearly 40% (n=14/36) of respondents reported the belief that their personal rights were *less* or *much less* protected.

The implication from these responses, and the significant correlations that were identified, would be that stakeholders would not fully share the same values as the respondents' organisations and the success would not be fully recognised by key people in the organisations. This was supported by analysis of responses that revealed that:

1. Respondents had been asked to rank the extent to which individual stakeholders shared organisational values. The mean ranking of 2.7 implies that sharing of values was only *slight* or *moderate* and supporting.

2. Perceptions of success being recognised by key people in the organisation also showed a mean rank of 2.7 implying that success was recognised more than *occasionally* but not *frequently*.

These findings suggest that defensive behaviours and keeping knowledge secret would both be evident.

Sub-group variance

The most important issue to analyse is the variance in response from each sub-group when answering questions relating to correlation matrices of psychological contract components with other key factors. The results were shown in figures 29-35 and table set 88.

The variance in response patterns was clear from a visual scan of significant responses and this translated into differing correlation patterns for each sub-group matrix.

Clinicians

Responses from clinical respondents showed significant correlations for components that related to their professional standards which linked significantly with stakeholders understanding and sharing values, beliefs and views of the organisation of which they were part.

Non-clinicians

Non-clinicians showed two characteristics not found for the clinical group. Firstly, whereas no clinical respondents reported intellectual capital being their property, significant numbers of non-clinical respondents did. Additionally this belief correlated significantly with *keeping knowledge to yourself.* This finding suggests that non-clinical respondents were more likely to keep knowledge to themselves as they believed it to be their property. Secondly, non-clinical respondents reported a higher level of *blame culture when innovation is unsuccessful* which correlated significantly with *keeping knowledge to yourself.* This also implies that where blame cultures exist, non-clinical respondents were more likely to keep knowledge to themselves as a defensive behaviour.

It is notable that the matrix of psychological contract components covers virtually all components of a full psychological contract matrix.

CEO/directors

Those at this level showed fewer significant correlations compared with any other sub-group. Particularly in relation to staff motivation, those at this level formed neural links with only three issues – *organisational achievement*, *understanding what the organisation is seeking to achieve* and *encouragement to learn and be creative*. Clinical respondents formed links with four elements, non-clinical respondents formed links with ten components, and those below CEO/director level formed links with eleven elements. This finding implies that those in senior management positions have a much more simplistic view of what motivates those staff they manage whereas the reality for those *managed people* is considerably more complex. In general, those at CEO/director level had a simpler view of working life than those they managed, except for knowledge sharing. When responding to the question about the frequency with which they saw others keeping knowledge to themselves, those at CEO/director identified the following (not in rank order):

- Organisational achievement
- Decision level
- Frequency of decisions made too high
- Knowledge of employees
- Information/IT strategic plans
- IT/information training and development opportunities
- Understanding what the organisation is seeking to achieve
- Seeing others seeking to win at the cost of someone else losing
- The number of managers

Those below CEO/director level had only one link, that with *an atmosphere that encourages trust/mutual respect* – one of the few links that those at CEO/director level did not make.

Below CEO/director level

This sub-group displayed the most complex correlation matrix that again included the majority of psychological contract components. Win/lose outcomes and outcomes of keeping/seeing others keeping knowledge to your/themselves were the closest in the matrix to psychological contract components. For this sub-group, this implies that psychological contract components most significantly affect defensive behaviours.

The conclusion is that clinicians link components of the psychological contract and factor analysis together in different ways to non-clinicians and that those at CEO/director level also link components of the psychological contract and factor analysis together in different ways from those below this level.

The generic matrix of psychological contract components shows that these core components are linked to job security as would be expected from the work done by Argyris. What have importantly been identified through this research are those components that correlate significantly with job security. This adds significantly to the knowledge of those psychological contract components that need to be satisfied for all employees in this survey and hence provide a focus for developing a sound psychological contract with the employees which were the focus of this research. i.e.

- An atmosphere that encourages trust/mutual respect
- Investment in training/skills development
- Superior performance recognised and rewarded
- Personal rights protected

The psychological contract has been linked to job security, staff motivation and defensive behaviour. The analysis has shown that there are strong links to feelings of job security but interestingly no direct links to components of the psychological contract were found although there were strong links to many other components of the theoretical concept.

This contrasts with the IPD finding that staff motivation was a direct predictor of the psychological contract being in place. Staff motivation was found to link directly with:

- employees understanding what the organisation is seeking to achieve
- the knowledge that employees believe they have
- opportunities to develop skills and knowledge
- organisational success being recognised by key people inside the organisation
- the frequency that decisions are made *too high*

In their 1996 survey* the IPD found that 65% of respondents were not worried at all about job loss. This survey found that 58.5% of respondents expressed the same feelings. The common core of the psychological contract identified through this research compares well with the 'causes' that the IPD used for their model.

* Random sample of 1000 of the working population working in companies with 25 or more employees. Survey conducted by Harris Research Centre between 24 July and 12 August 1996. Results based on weighted sample.

The core components identified were:

- An atmosphere that encourages trust/mutual respect (IPD *Trust* element)
- Protection of personal rights (IPD *Fairness* element)
- Investment in training/skills development (IPD *Delivery* element)
- Employee involvement in decision making (IPD *Delivery* element)

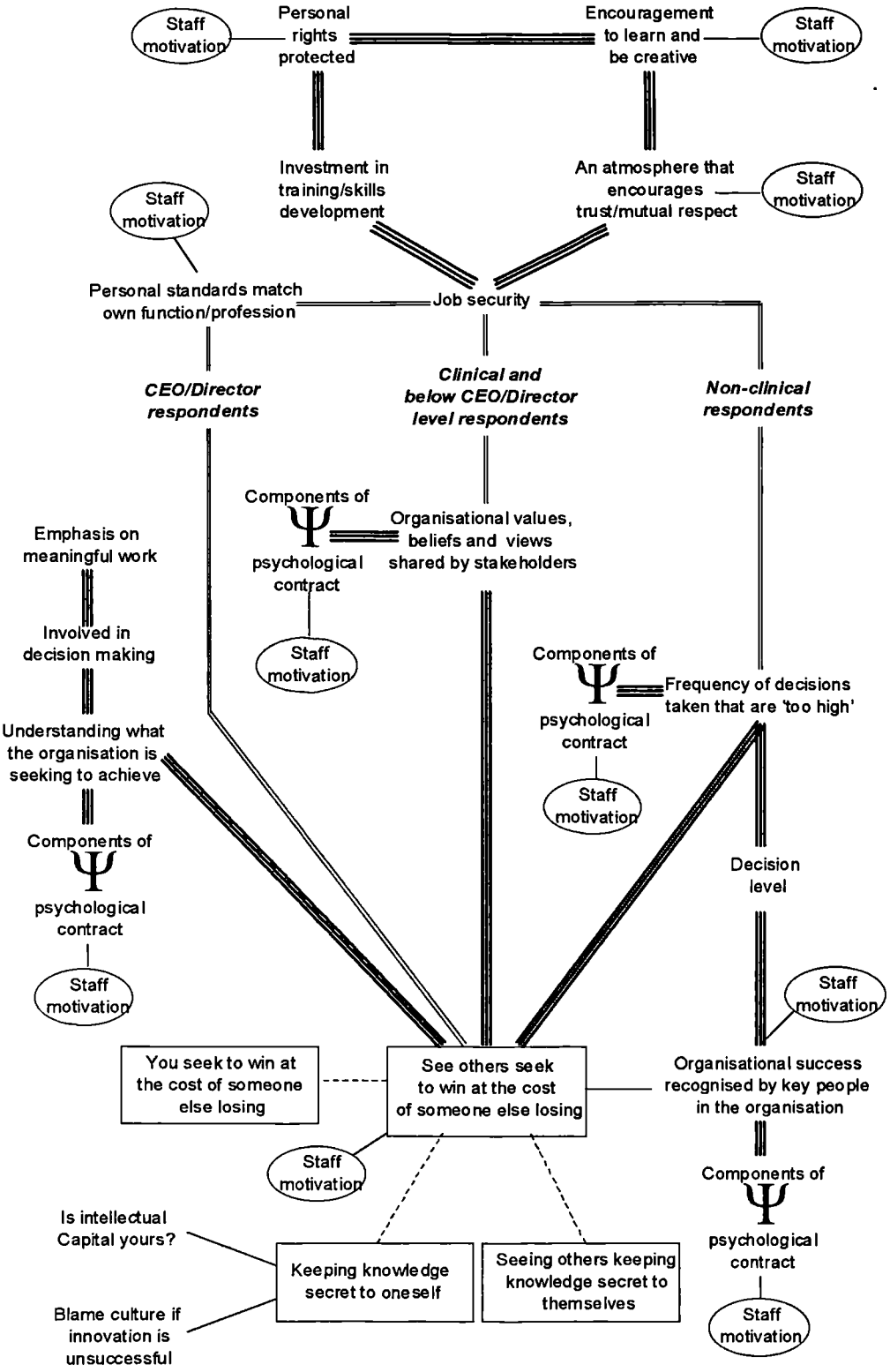
The first three of these components were found to link directly to *job security*, as the IPD model would predict. This finding gave added confidence to the model developed as part of this research. Other significant correlations were with:

- Encouragement to learn and be creative (IPD *Delivery* element)
- The number of self-managing teams (IPD *Delivery* element)
- Superior performance being recognised and rewarded (IPD *Fairness* and *Delivery* elements)

Together with the outcome of the Cronbach Alpha test there is significant confidence that the use of these issues as components of the psychological contract is valid.

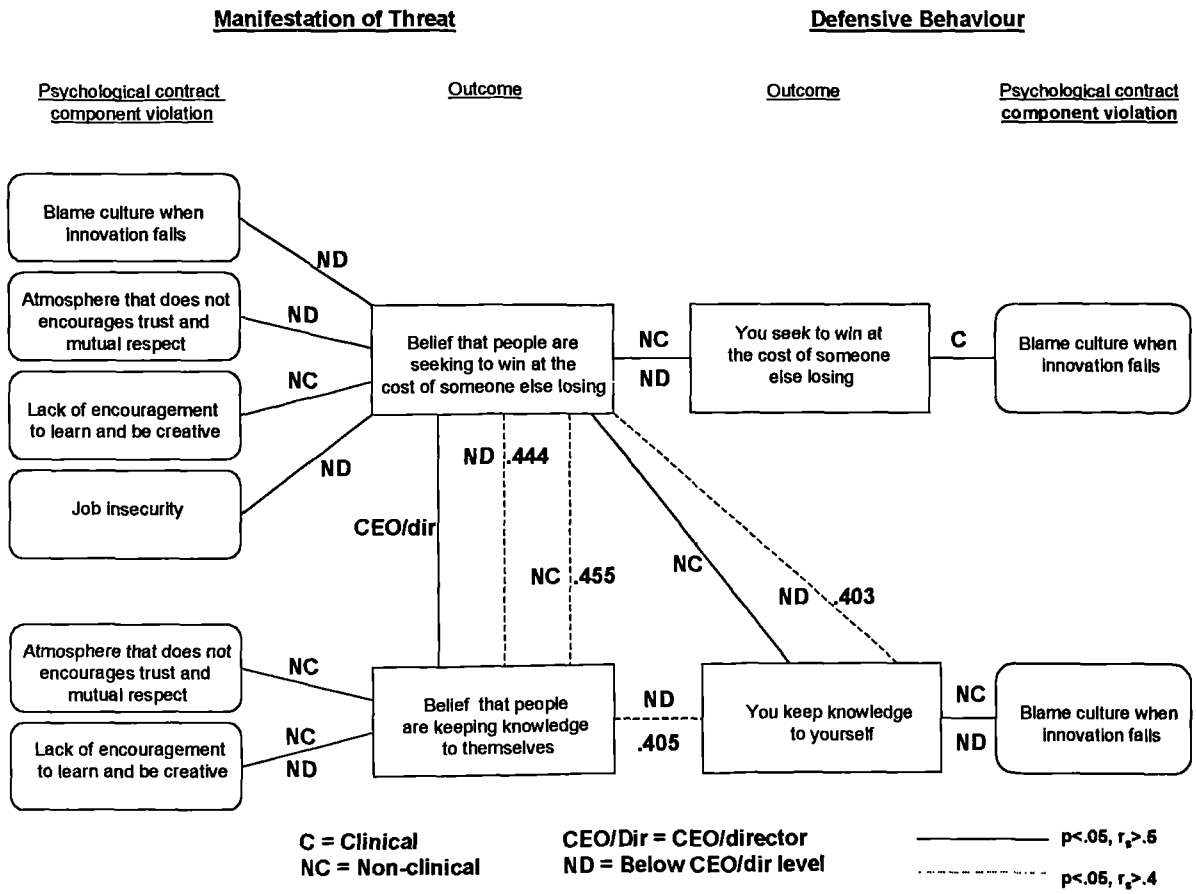
As a consequence there is also confidence that use of these components as predictors of defensive behaviour outcomes (propensity to seek to win, and propensity to keep knowledge secret to oneself) is also valid. The closeness of psychological contract components to job satisfaction, staff motivation, and the outcomes tested in this research is shown in figure 37.

Figure 37 Linkage of core components with each other and with staff motivation



The importance of variance between clinical/non-clinical employees and variance between those at CEO/director level and those below this level has been highlighted several times. Key variances are summarised in figure 38 which highlights the direct links between components of the psychological contract, the outcomes that are manifestations of perceived threats, and outcomes that are defensive behaviours.

Figure 38 Sub-group variance correlations of threat manifestation and defensive behaviours



Dale (unpublished 1999)

What these correlations imply is that components of the psychological contract impact directly on win/lose behaviours, and on defensive behaviours towards knowledge sharing. The impact is also sub-group specific i.e. the impact can be different for clinical employees, non-clinical employees, those at CEO/director level and employees below CEO/director level.

Of particular importance is the role that *blame cultures* play. For clinicians in the survey in particular this had a direct impact on the likelihood that they would seek to win. No other sub-group reported the same behaviour. Non-clinical and those below CEO/director level showed a direct link between blame cultures and keeping knowledge to themselves, and also between blame cultures and their belief that people were seeking to win at the cost of them losing. Of most importance is the absence of any significant correlation between blame cultures and any outcome for those at CEO/director level. This implies that they do not form this link in their minds. The result may well be that they enter into win/lose behaviour and keep knowledge to themselves, without regard for the impact they might have on everyone else.

Two significant components of the psychological contract (*an atmosphere that encourages trust and mutual respect*, and *encouragement to learn and be creative*), both impact directly on non-clinical employees and those below CEO/director level perceiving that threats are manifesting themselves. Feelings of job insecurity have the same effect on these two groups of employees.

With the singular exception of clinicians and the impact of blame cultures on win/lose behaviour, neither clinicians nor those at CEO/director level formed links in their minds between components of the psychological contract and win/lose or defensive behaviours. They do form links but these are largely focused:

- external to their organisation (e.g. relationships with stakeholders, ensuring that organisational values, beliefs and views are shared with, and understood by stakeholders)
- or internal on personal issues (e.g. the match of their own standards with others they work, the match of their personal standards with their own profession, others understanding the own standards)

At first site those at CEO/director level display some unusual behaviour. These respondents linked high levels of *winning* behaviour with their belief that:

- large numbers of their organisations understood what the organisation was seeking to achieve
- high levels of employee skills
- high levels of employee knowledge
- high levels of staff motivation

One interpretation is that those working at CEO/director level seek to win when they perceive high levels of employee skill, knowledge etc. This would imply that those working at this senior level found this a threat. Alternatively it could be argued that it was because those at CEO/director level sought to win that those they managed had high levels of skill, knowledge etc. Interviews were sought with these senior managers as part of this research but both health authorities were in states of turmoil and change and interviews were not considered appropriate at this time.

Irrespective of the interpretation, those below CEO/director level reported that as win/lose behaviour increased they believed that:

- decision levels was increasingly being made too high
- decisions were increasingly made too high, too often
- opportunities to develop skills and knowledge became fewer
- staff motivation became increasingly lower
- information supported performance review increasingly less
- there were increasingly fewer IT/information development opportunities

- stakeholders increasingly knew less about, and understood less, the organisational values, beliefs and views
- fewer employees understood what the organisation was seeking to achieve
- there was increasingly less job security
- people were increasingly seeking to win at the cost of someone else losing
- there was a decline in an atmosphere that encouraged trust and mutual respect
- there was increasingly less encouragement to learn and be creative

If those responsible for directing and encouraging employees are unaware of the impact that violations of the psychological contract can have on their employees and others they work with, then general defensive behaviours by others will be a consequence and knowledge sharing behaviours will be adversely affected.

Those at CEO/director level have a responsibility to motivate and encourage those that work for them and yet the implications of this research are that those at CEO/director level appear to ignore or be unaware of a fundamental way in which this could be done. This research suggests that raising awareness of the impact of violation of the psychological contract, the ways in which win/lose behaviours are entered into, and the ways in which win/lose behaviours are interpreted, would make a significant impact on defensive behaviours and overcoming the barriers to knowledge sharing.

Summary

Analysis of the data (Mann Whitney test) confirmed that the data sets could be treated as homogeneous for the general purposes of analysis and highlighted those differences between clinical and non-clinical staff as well as those at or below CEO/director level that were worthy of further investigation. Key components of the organisational framework were identified through factor analysis that supported the belief that the theoretical construct was sound. Internal reliability of the questionnaire was assured by application of a Cronbach Alpha test. The same test showed high levels of reliability for the construct of components of the psychological contract.

Significant correlations of elements and components were identified at sufficiently high coefficient levels to confirm their use as robust predicators of outcome.

A significant proportion of those surveyed (37%, n=15/41) believed only about half the employees knew what the organisation was seeking to achieve. 40% (n=15/38) of respondents reported their organisation as achieving 60% or less of what it set out to achieve. Job-related knowledge and skills were currently assessed as slightly more than adequate. Whilst the Chief Executive was assessed by nearly all respondents as being at the top of the power 'tree' there was a confused picture of who exerted the most influence after that with the NHS Executive, Regional Office and national politicians all having nearly equal ranking.

The concept of 'organisation' is one that does not appear to fit the NHS particularly well and suggests a looser association of multi-professionals with more divergent values, beliefs and cultures than many other organisations might

reasonably expect to be in evidence. The focus on patient care and improvement in health status is the thread that binds them together.

Knowledge-sharing and win/lose outcomes showed significantly strong correlations and confirmed the links between observing/personally entering into win/lose scenarios and defensive knowledge sharing behaviours and supported the theories that Argyris proposed and later successfully tested empirically. Analysis of significantly different response rates revealed those at CEO/director level as being more likely to interpret reluctance to share knowledge as that person seeking to win at the cost of someone else losing. Analysis also showed that those below CEO/director level were much more likely to personally seek to win at the cost of someone else losing if they observed others doing this first. Responses by clinicians displayed none of these correlations and yet non-clinicians did, the latter entering into a self-sealing process of observing win/lose behaviour taking place, entering into the same behaviour themselves and keeping knowledge to themselves. This presents a potential picture of clinicians interacting with non-clinicians about organisational business (as opposed to clinical business), observing power struggles taking place but not really knowing what they are seeing or why this behaviour is taking place.

Defensive behaviours were identified as having roots in differences in cultural and work-related values. Defensiveness was identified as potentially leading to 'brittleness' and the probability of future avoidance of the issues that caused the brittleness either through non-discussion or defensive behaviour.

There were found to be no significant correlations between elements of biographical data and any other responses. This would be expected if Argyris'

theories and empirical research were to be valid for the population that made up the population surveyed.

The NHS appears to be an adhocracy and yet the advantages of such organisational forms are not immediately evident for those organisations surveyed although the disadvantages were evident. Those at CEO/director level reported a much stronger belief in their organisation being organic in nature compared with those below CEO/director level. Those below CEO/director level reported lower levels of employee motivation than those at CEO/director level believed to be the case.

The foregoing suggests that those at CEO/director level may be looking at their organisation through rose-coloured spectacles whilst those below this level are suspicious of the motives of other people, more easily enter into win/lose discussions and become defensive about sharing knowledge.

Environmental responsiveness showed similar divergence to that expected for 'healthy' organisations with over 40% of respondents (n=17) reporting the attention their organisation paid to getting views of service users as 'inadequate' or 'barely adequate'. More than one third of respondents reported organisational responsiveness to pressures for change as 'low' or 'low to moderate'.

Employee knowledge was overall reported by respondents as 'adequate'. with one third of respondents reporting levels as 'very adequate' or 'more than adequate'. For the majority of employees this does not appear to represent the 'high levels' of knowledge required for a 'healthy' organisation.

Information was reported by nearly half of the respondents as supporting performance review only 'in parts' or 'not at all'. One third of respondents reported that Board commitment to information issues was absent.

Respondents reported overall that stakeholder understanding of their organisations' values as only 'slight' or 'moderate'. The same response was given to whether stakeholders shared the same values as their organisation.

Responses to questions on 'personal standards' showed some confusion as to who had the second most influence on their organisation after the Chief Executive.

Schein had concluded that psychological dynamics cannot be seen if personal motivation or organisational dynamics are examined in isolation from each other. This research supports this hypothesis and that element of the organisational framework need to be 'healthy' in order for defensive behaviours generally to be minimised and for defensiveness toward knowledge sharing to be minimised. Elements of the psychological contract were shown to correlate significantly and strongly with each other, with 'job security', with staff motivation through components identified through factor analysis, and with elements that determined whether win/lose scenarios and defensive behaviours were likely to be encountered.

The role played by the psychological contract has been shown to be an important determinant of defensive behaviours generally and attitudes towards knowledge sharing in particular. The findings that there are differences in responses between clinical/non-clinical respondents and between those at CEO/director level and those below are supported by concepts that espoused

theories vary from theories-in-action. This accords with the theories, models developed, and empirical research undertaken by Argyris.

This research implies that defensive behaviours generally, and especially defensive behaviours toward knowledge sharing could be overcome by ensuring that there is organisational 'health' and consequently ensuring that the psychological contract, as described for the purposes of this research, is in place and perceived as being upheld by both employee and employer.

CHAPTER SIX

CONCLUSION

There are still few direct references to defensive behaviours toward knowledge sharing with most human resource references having the narrow information systems perspective as Scarborough et al has found. References to these defensive behaviours were found almost exclusively in the literature on the psychological contract from the field of organisational psychology. This research will add to knowledge of this application in the NHS. This research also provides a model and an analytical tool with which to audit organisational health and the status of the psychological contract. The outcome would be an ability to identify where development needs to be focused in order to minimise defensive behaviours generally and defensiveness towards knowledge sharing in particular. The research concludes that the findings provide some of the first sound evidence about the link between the psychological contract and defensive behaviours toward knowledge sharing in the NHS.

The concept of *organisation* was explored as part of this research. One of Shein's ideas that make up the concept of *organisation* is that of *integration through an accepted hierarchy*. A result of this research has been the identification that employees in the survey had a confused picture of this hierarchy. Although overall Chief Executives were believed to have the most influence over their organisations, significant numbers of those in this survey ranked the NHS Executive, NHS Executive Regional Offices and national politicians as having the most influence. This confused picture leads to the conclusion that the NHS is not *organised* in a way that generic models of *organisation* suggest and adds to our

knowledge about the ways in which we need to consider *organisation* in the NHS. For example, if NHS managers believe there to be a dichotomy about which master to satisfy as a priority, they might choose to make a least risk decision which may not necessarily be the best decision. This proposal is supported by Mintzberg's general finding that *potential inconsistency* and *employee stress* are two disadvantages of adhocracy organisational forms as well as *unclear accountability, role conflict due to dual loyalty,* and *complex and slow decision making*. Mintzberg saw employees in functional forms as potentially working to professional loyalties as a priority with co-ordination across functional areas being difficult and costly. The functional form can also result in change being slow. Similarly, Mintzberg saw geographic forms as potentially leading to divisional rather than company loyalty, poor co-ordination across divisions and decreased communication. This research concludes that these disadvantages were present in those organisations surveyed.

Hunt had found UK/US managers sought avoidance of discomfort and stress, avoided risk and sought clarity, order and structure. Hunt also found these managers wanted to manage and control others, and sought freedom, independence, novelty, challenge and development. These findings are at odds with the way the NHS is organised and managed, and may go some way to explaining the dichotomy that managers in the NHS face when trying to reconcile the competing demands of political masters and inherent cultural characteristics. This dichotomy is likely to lead to self-protectionism and inherently a display of defensive behaviour and unwillingness to share knowledge if this is perceived as giving the holder of such knowledge a position of power. This implies that whilst the NHS remains organised and managed as a government department,

clinicians, managers and employees could find a conflict between personal, professional and organisational priorities and standards As a result, overcoming defensiveness through the psychological contract may only be partly successful.

The NHS has, arguably, more professional groups than most other employers. This cultural and professional diversity is a natural breeding ground for turfism and tribalism. Scepticism about motive has been a feature of the medical professions view of Government proposals since the inception of the NHS and this has scepticism has often spilled over onto managers in the NHS who by association are seen as those people seeking to implement change. The encouragement of clinicians to take responsibility for change – through Fund holding and Primary Care Groups – has been seen as an attempt to harness the considerable potential of clinician-led services. However, actions taken by clinicians to enhance their position on Primary Care Groups and the views that some, such as the BMA, have expressed, suggest that for some the effective team working of clinical and non-clinical people in Primary Care Groups could be a little way in the future. Potentially the same process of audit and review used for this research could be applied to PCGs with considerable opportunities to facilitate team working and knowledge sharing as a result.

Change in the NHS is usually accompanied by claims about the potential improvement to delivery of clinical services, improvements in health delivery and health status, or reduction in bureaucracy. The literature review identified the forgoing as being evident in the NHS and yet the disadvantages of new organisational arrangements appear to receive little or no attention. It would indeed be uncommon to publicly state the potential disadvantages of change but recognition at an operational level might be expected. However, experiences tell

us that this is often seen as failing to be a *company worker* and not being supportive of the proposed changes. If speaking up on these issues is seen to put job security at risk then defensive behaviours will again take over. The knowledge that individuals might have on this subject will not be shared – not because of the power it might bestow but because of the personal threat (e.g. to job security) that disclosure might bring.

The conclusion is that the NHS needs to fully embrace its claims about continuous learning, openness in its interactions with staff and encourage potential disadvantages to be addressed and face the challenges they bring. This will facilitate defensive behaviours generally being overcome and defensiveness towards knowledge sharing in particular being minimised.

Another conclusion of this research is that the in NHS one will see pursuit of personal, professional and organisational goals that are not always the same. This may be the result of cultural or professional differences, through failure to understand what the organisation is seeking to achieve, failure to recognise and understand the values and beliefs of others or any combination of the factors identified through this research. If such conflicts of standards are accompanied by perceived threats to professional standing or perceived threats to job security then defensive behaviours generally, and unwillingness to share valuable knowledge in particular, will become evident. This will manifest itself in individuals seeing others seeking to win at the cost of someone else losing, and individuals seeing others keeping valuable knowledge to themselves. The reaction will be for those observing this behaviour to become defensive themselves – seeking to win whilst others lose and keeping knowledge to themselves as a bargaining tool.

The model developed through this research has been shown to be valid for the purposes of examining barriers to knowledge sharing in particular but also allows a more general examination of organisation health.

The model developed for this research allows NHS organisations moving into the 21st century to be audited in a way that reflects their business environment, as well as current and emerging organisational arrangements. It offers significant opportunities to review organisational arrangements for *health* and enable both organisational and personal development to take place in more structured and focused ways. This especially applies to the psychological contract, a relatively new concept for the NHS but one that has been identified as having considerable, and yet often hidden, powers to avoid defensive behaviours in general.

The health of NHS organisations has been identified from the literature review and through this research as being linked to the psychological contract in ways that rely on the two being interrelated and not looked at in isolation. The model developed as part of this research reflects this interrelation and allows an holistic 'audit' to be undertaken to determine where barriers to knowledge sharing are present and identify what action is necessary to overcome, or at least minimise these barriers.

Three core groups of components were identified through the research and their interrelation with each other and with staff motivation were summarised in figure 35. This model adds significantly to our knowledge about the impact of the psychological contract on defensive behaviours generally but specifically the part that the psychological contract plays in defensive behaviours towards knowledge sharing.

Whilst demonstrating that all NHS employees in the survey shared common groups of components, there were subtle differences in the ways clinicians. non-clinicians, CEO/directors and those below CEO/director level linked these groups. Again this adds to our knowledge of the ways in which these different sub-groups think, act and react. For example, responses in this survey imply that clinicians do not believe knowledge is intellectual capital but non-clinicians do, especially those below CEO/director level. Clinicians made aware of this difference may choose to behave in ways that minimise the risk of non-clinicians not sharing knowledge freely.

Similarly, the research implies that those at CEO/director level in the organisations surveyed need to consider what motivates those they manage as there were considerably more motivators for those below CEO/director than those operating at the higher level. Most significantly, the only significant correlation below CEO/director level with *seeing others seeking to win at the cost of someone else losing* was with *an atmosphere that encourages trust and mutual respect.* Ironically this common component of the psychological contract was one of the very few correlations that was not made by those at CEO/director level in this survey. For those below CEO/director level the link between seeing others seeking to win and other outcomes is fairly direct. The conclusion would be those if those at the senior level in the organisations surveyed are not seeing this linkage, then people will continue acting out win/lose scenarios and choosing not to share knowledge. If true for the general population of NHS employees, this and other findings add to the knowledge about the type of organisational, team and personal development needs required in the NHS generally.

Handy introduced the concept of *Twin Citizenship* that should be encouraged in the NHS if some of the barriers to knowledge sharing are to be overcome. The *matrix* organisational form, which is prevalent in the NHS, identified the need for high levels of interpersonal skills and this research concludes that there is a necessity to ensure that this component is fully addressed to overcome defensive barriers. Similarly, the *dynamic network* form prevails in the NHS and its success depends on *full disclosure* and *trustworthy transactions*. These are features of the model that Argyris proposed to overcome defensive behaviours, the latter feature also being a component of the psychological contract.

The impact of working in a blame culture is significant. For clinicians, working in a blame culture means the likelihood that they will enter directly into win/lose behaviour. For non-clinical employees and employees below CEO/director level, working in a blame culture increases the likelihood that these employees will directly enter into defensive behaviour of keeping knowledge to themselves.

This research concludes that Argyris' model does hold true for those NHS organisations surveyed with the research also concluding that double-loop learning (the psychology of success-brittleness syndrome) is a key feature in defensive behaviours especially when linked to the psychological contract. This knowledge should enhance abilities to recognise when cultures and working practices need changing in ways that encourage high aspirations for success and minimise high fear of failure as the former encourage the dismantling of barriers to knowledge sharing.

Argyris concluded that to overcome defensive barriers one needed to adopt an approach he characterised as model II. This model put emphasis on governing values being based on valid knowledge; differing values, beliefs and cultures being known and understood; action strategies clearly displaying how those that prepared it reached their conclusions; errors being detected and corrected as part of a learning organisation; and there being trust and respect. This research concludes that Argyris' models apply to the NHS and if barriers to knowledge sharing are to be overcome the findings of this research need to be applied. Additionally this research concludes for those NHS organisations surveyed, and by implication all NHS organisation, need to ensure that there is:

For organisational *health*:

- an understanding by employees of what their organisation is seeking to achieve
- perceptions by employees that they are sufficiently involved in decision making
- perceptions by employees that they are undertaking meaningful work
- understanding by stakeholders of organisational values, beliefs and views
- perceptions by employees that decisions are not made too high
- perceptions by employees that decisions are not made too high, too often
- recognition of success by key people in the organisation

For the psychological contract:

- perceived encouragement to learn and be creative
- perceived, adequate investment in training and skills developed
- perceptions that personal rights are being protected
- perceptions that an atmosphere exists that encourages trust and mutual respect
- avoidance of blame cultures

The conclusion from the research is that defensive behaviours towards knowledge sharing are significantly influenced by components of the organisational framework developed as the theoretical construct for this research, and that the psychological contract plays a significant part in the development of defensive behaviours. When employees perceive that the psychological contract is intact, staff will feel their job is more secure, staff motivation will be higher, *win/lose* positions will be less likely to be adopted and defensive behaviours towards knowledge sharing will be minimised.

This research has used Argyris' belief that one needs to go beyond espoused theories and collect directly observable data from which to infer theories in use. To achieve this, respondents were asked to self-report and act as the observers.

The null hypothesis for this research was that no significant correlations would be found between threats to employment or personal threats that employees perceived at work with components of the psychological contract, or with other key factors identified as forming part of the theoretical concept. This hypothesis was rejected through survey, analysis and discussion in favour of the alternate hypothesis that if employees feel under threat in any way, or they perceive that their psychological contract has been broken, they will display defensive behaviours towards knowledge sharing.

This research concludes that defensive behaviours generally, and especially defensive behaviours toward knowledge sharing could be overcome by ensuring that organisations are healthy and that the psychological contract, as described for the purposes of this research, is in place and perceived as being upheld by employee and employer.

Subsequent Research Opportunities

The survey was undertaken with two health authorities and whilst it is believed reasonable to extent the results to NHS organisations in general, it would be prudent to undertake an extended survey.

During the course of this research the NHS underwent a considerable change with Fund holding giving way to Primary Care Groups, and ultimately Primary Care Trusts. The composition of PCGs is similar in many ways to health authorities and it is believed that the audit tool developed for this research would be highly applicable and facilitate their development.

Further surveys of CEO/directors would strengthen the analysis.

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Annex A

School of Postgraduate Medical Education

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Chairman:
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Dear colleague

Sharing of Knowledge

I have worked in the NHS for 23 years and am currently undertaking a PhD at The University of Warwick. I am researching the concerns people in the NHS have about security of employment and the effects this might have on their willingness to share all their knowledge with colleagues if they feel that by doing this they are giving away their 'bargaining power' to stay in employment.

This work is both academic and practical. It has already helped identify organisational development and employee support needs elsewhere in the NHS whilst keeping individual identities confidential.

The confidentiality of your own questionnaire will be respected at all times.

The questionnaire takes about 15-20 minutes to complete. There are no trick questions – all I am asking for is your honest answers!

Thank you in advance for your help

Andrew Dale

THE UNIVERSITY OF
WARWICK

Telephone: (01203) 523523
Ext: 3913

SURVEY QUESTIONNAIRE

Biographical Information: (This information is used solely to enable me to analyse your responses It will not be used to identify individual responses to questions)

1. Age (Please circle): <21 21-30 31-40 41-50 51-60 >60

2. Gender (Please circle) : M / F

3. If the Chief Executive is 1st in line of a management 'hierarchy' what level are you?: (Please tick)
   e.g. Director is usually 2nd in line, person reporting to Director is usually 3rd in line etc.

   1st ( ) 2nd ( ) 3rd ( ) 4th ( ) 5th ( ) 6th ( )

   Other relationship (please state) e.g. not Director but reporting to Chief Exec.

   .....

4. What would you classify as your **Profession**?: (Please tick)

Medicine/Dental	( )	Nursing	( )	General management	( )
Pharmacist	( )	Finance	( )	Commissioning	( )
Information Management	( )	IT	( )	Primary Care Support	( )
Professions Allied to Medicine	( )	Administration	( )	Planning/Strategy	( )
Primary Care Development	( )				

   Other (Please state) .....

5. Which **functional department** do you **mostly** work in?: (Please tick)

Public Health	( )	Nursing	( )	Professions Allied to Medicine	( )
Finance	( )	Secretarial Pool	( )	General management	( )
Planning/Strategy	( )	IT	( )	Primary Care Support	( )
Commissioning	( )	Pharmacy	( )	Primary Care Development	( )
Administration	( )	Clerical Pool	( )	Information Management	( )

   Other (Please state) .....

6. Which of the following have you experienced over the last 12 months? (Please tick)

Technology changes	( )	Top management changes	( )
Tighter work schedules	( )	New policies and procedures	( )
Merger	( )	New values and expectations	( )
Redundancies	( )	Reorganisation	( )
Cutting staff by natural wastage	( )	Extra organisational responsibility	( )
Start of new organisational direction	( )		

Notes for completion of questionnaire:

- Questions need a response as either a tick (✓), percentage (**x%**) or ranking (**1,2 3** etc)
- Some questions have categories such as 'Trusts' and 'GPs'. For these questions please respond with your opinion of issues raised that apply **in general** to Trusts, GPs etc. that relate to your Authority

THANK YOU IN ADVANCE FOR YOUR HELP AND CO-OPERATION

A. ORGANISATIONAL ARRANGEMENTS

		Not known	No Opinion
1. ***Looking at the total work done by your organisation, what proportion do you believe is done in:*** (Please express proportions as percentages)			
Functional/process teams organised hierarchically	i.e. working as separate departments e.g. finance, IT, Human resources etc.		
Geographic/product teams	i.e. working in teams on external, locality/geographically-focused projects from start to finish		
Matrix management/project teams	i.e. working in teams on corporate/planning issues - team members come from relevant departments		
Hybrid arrangements	*i.e. functional/process/geographic and corporate teams all existing at same time*		
Flexible arrangements	i.e. there are high levels of contract staff that come and go in response to demand for their services		
Network arrangements	i.e. working in informal, entrepreneurial and innovative groups that work together and trust each other		
Other approach (please describe)		( )	( )

2. ***Please rank the following in terms of the power you believe they can exert on your organisation:*****(1 = most powerful, 2 = 2nd most powerful etc.)**

Chief Executive ( ) Directors ( ) Senior manager ( ) GPs ( ) Social Services ( )
Local politicians ( ) Media ( ) National Politicians ( ) General public ( ) Regional Office ( )
NHS Executive ( ) Other (Please state)..... ( ) ( )

3. ***In your opinion how much of what your organisation says it will achieve does it actually achieve?***

<50% ( ) 51% - 60% ( ) 61% - 70% ( ) 71% - 80% ( ) 81% - 90% ( ) 91% - 100% ( ) ( ) ( )

4. **In your opinion, are management decisions in your organisation generally made at management Levels that are:**

Too low ( ) Appropriate ( ) Too high ( ) ( ) ( )

5. ***In your opinion, how often are management decisions in your organisation made at levels that are 'too high':***

Never ( ) Occasionally ( ) Frequently ( ) Often ( ) All the time ( ) ( ) ( )

B. ENVIRONMENTAL RESPONSIVENESS

1. ***In your opinion, is the effort your organisation puts into obtaining views of the public :***

Inadequate ( ) Barely Adequate ( ) Adequate ( ) Very adequate ( ) More than Adequate ( ) ( ) ( )

2. ***In your opinion, if your organisation is faced with pressures for change how does your organisation generally react? :***

Resists change ( ) reluctantly accepts ( ) accepts ( ) quick to accept ( ) pioneers change ( ) ( ) ( )

3. ***Rank the following in the order of influence that you believe they have on your organisation's strategic and financial plans and annual objectives :***
(put '1' in the box where you believe the greatest influence comes from, '2' for the second greatest influence etc. down to 5)

central government (e.g. through NHS Executive plans/priorities) ( )
local politicians/councillors ( )
corporate (internal to organisation) priorities ( )
locality teams/geographic teams/primary care groups ( )
Other (Please state) ( ) ( ) ( )

4 ***In your opinion, what level of confidence have the following generally got in your organisation:*** **(Please tick relevant square for each group)**

	Very low	Low	Moderate	High	Very high	Not Known	No Opinion
Trusts						( )	( )
Other Health Authorities						( )	( )
Hospital clinicians						( )	( )
GPs						( )	( )
Regional Office						( )	( )
Social Services						( )	( )
Local politicians						( )	( )
General public						( )	( )
Media						( )	( )

C. COMPETENCIES

1. ***Do you believe the job-related skills of most employees in your organisation are generally:***

   Inadequate ( ) Barely Adequate ( ) Adequate ( ) Very adequate ( ) More than Adequate ( ) ( ) ( )

2. ***Do you believe the job-related knowledge of employees in your organisation are is generally:***

   Inadequate ( ) Barely Adequate ( ) Adequate ( ) Very adequate ( ) More than Adequate ( ) ( ) ( )

3. ***In your opinion, how much opportunity are employees in your organisation generally given to develop their skills & knowledge?***

   None ( ) Very little ( ) Some ( ) Quite a bit ( ) Extensive ( ) ( ) ( )

4. ***In your opinion are most employees in your organisation :***

   De-motivated ( ) Not very motivated ( ) Quite motivated ( ) Fairly motivated ( ) Very motivated ( ) ( ) ( )

D. INFORMATION AND KNOWLEDGE – In your organisation.....

	Yes	No		
1. ***Do you believe that there is a clear strategic plan for information/IT development?***	( )	( )	( )	( )
2. ***In your opinion are there good opportunities for training and development in IT and use of information?***	( )	( )	( )	( )
3. ***Is 'development of information seeking, sharing and use' an organisational objective?***	( )	( )	( )	( )
4. ***In your opinion do staff have good links with people in other organisations in order to learn from them?***	( )	( )	( )	( )
5. ***Do you believe there is understanding and commitment to information/IT issues at Board level?***	( )	( )	( )	( )
6. ***In your opinion are information professionals integrated with other teams?***	( )	( )	( )	( )
7. ***Do you believe that personal knowledge is 'intellectual capital' and belongs to you?***	( )	( )	( )	( )

8. ***How well do you believe available information supports performance and review processes?***

   Not at all ( ) In parts ( ) Quite well ( ) Mostly ( ) Completely ( ) ( ) ( )

9. ***How frequently have you experienced people keeping knowledge and information to themselves?***

   Never ( ) Sometimes ( ) Frequently ( ) Most of the time ( ) All the time ( ) ( ) ( )

10. ***Over the last twelve months, how often have you kept valuable information and knowledge to yourself rather than share it?:***

    Never ( ) Sometimes ( ) Frequently ( ) Most of the time ( ) All the time ( ) ( ) ( )

E. RELATIONSHIPS (Please tick relevant square for each group)

In your opinion, how good are relationships of your organisation generally with:

	Very Poor	Poor	Adequate	Good	Very good	Not known	No opinion
Trusts						( )	( )
Other Health Authorities						( )	( )
Hospital clinicians						( )	( )
GPs						( )	( )
Regional Office						( )	( )
Social Services						( )	( )
Local politicians						( )	( )
General public						( )	( )
Media						( )	( )

2. *In your opinion, how well are the values, beliefs and views of your organisation understood by:*

	Not at all	Slightly	Moderately	Well	Very well		
Trusts						( )	( )
Other Health Authorities						( )	( )
Hospital clinicians						( )	( )
GPs						( )	( )
Regional Office						( )	( )
Social Services						( )	( )
Local politicians						( )	( )
General public						( )	( )
Media						( )	( )

3. *In your opinion, how well are the values, beliefs and views of your organisation shared by:*

	Not at all	Slightly	Moderately	Well	Very well		
Trusts						( )	( )
Other Health Authorities						( )	( )
Hospital clinicians						( )	( )
GPs						( )	( )
Regional Office						( )	( )
Social Services						( )	( )
Local politicians						( )	( )
General public						( )	( )
Media						( )	( )

4. *Is success in your organisation recognised by key people in your organisation?*

Never ( ) Occasionally ( ) Frequently ( ) Often ( ) All the time ( ) ( ) ( )

5. *Are failures in your organisation seen by key people outside your organisation?*

Never ( ) Occasionally ( ) Frequently ( ) Often ( ) All the time ( ) ( ) ( )

F. SELF-REFERENCE – *In the following, the word 'standards' is used to describe 'values, culture & beliefs'*

1. *How strongly do your personal standards match those of the organisation you work for?*

Not at all ( ) Slightly ( ) Quite a bit ( ) Mostly ( ) Entirely ( ) ( ) ( )

2. *How strongly do your personal standards match those of the function/profession you work in?:*

Not at all ( ) Slightly ( ) Quite a bit ( ) Mostly ( ) Entirely ( ) ( ) ( )

		Yes	No	Not known	No opinion
3.	*In your opinion, do others you work with have standards that differ from your own?*	( )	( )	( )	( )
4.	*Do you believe you know what the standards are of others you work with?*	( )	( )	( )	( )
5.	*In your opinion, are people you work with aware of your personal/professional standards?*	( )	( )	( )	( )

6. *How secure do you feel in your current job? :*

Very insecure ( ) Quite insecure ( ) Neutral ( ) Quite secure ( ) Very secure ( ) ( ) ( )

7. *In your opinion, is what your organisation trying to achieve understood by:*

Very few employees ( ) a minority of employees ( ) about half the employees ( ) a majority of employees ( ) nearly all employees ( ) ( ) ( )

G. PERSONAL STANDARDS

1. *If you are working in a team where <u>your</u> standards are in conflict with those of the team, do you <u>most likely</u>:*

<u>Quietly</u> disagree and work to the standards of the <u>team</u> ( ) <u>Openly</u> voice your disagreement but work to the standards of the <u>team</u> ( )
<u>Openly</u> disagree and <u>openly</u> work to your own standards ( ) <u>Openly</u> voice your disagreement but <u>quietly</u> work to your own standards ( )
<u>Quietly</u> disagree and <u>quietly</u> work to your own standards ( ) ( ) ( )

2. *If standards are in conflict which standards do you work to? (Please rank: 1= first set of standards you would work to, 2= second set etc.)*

Team (multidisciplinary) standards ( ) Your Personal standards ( ) ( ) ( )

3. *During the course of your work, how often do <u>you observe</u> others seeking a to 'win' at the cost of someone else 'losing;?*

Never ( ) Seldom ( ) Sometimes ( ) Often ( ) Always ( ) ( ) ( )

4. *During the course of your work, how often do <u>you seek</u> to win whilst others lose?*

Never ( ) Seldom ( ) Sometimes ( ) Often ( ) Always ( ) ( ) ( )

5. *If innovation is tried but does not succeed the <u>general</u> response of your senior managers is <u>most likely</u> to be* **(tick <u>all</u> those that apply)**

"well done for trying" ( ) "what could we learn for next time?" ( ) 'we ought not to be trying new things – let others try them first next time" ( )
"let's forget about it" ( ) "whose fault was it" ( ) or.....I do not feel that I am encouraged to be innovative ( ) ( ) ( )

6. *What is your opinion of the following <u>NOW</u> compared with 12 –18 months ago:*

	Much less/ much smaller	Less/ smaller	Much the same	More/ larger	Much more/ much larger		
Employee involvement in decision making						( )	( )
Emphasis on 'meaningful work'						( )	( )
Responsibility for individual employees						( )	( )
The number of managers						( )	( )
The number of self-managing teams						( )	( )
Investment in training/skills development						( )	( )
Atmosphere that encourages trust/mutual respect						( )	( )
Protection of personal rights						( )	( )
Encouragement to learn and be creative						( )	( )
Recognition and reward for superior performance						( )	( )
Size of managerial groups						( )	( )
The need for staff with specialist skills						(.)	( )

THANK YOU FOR YOUR HELP AND CO-OPERATION –