# NICE: Obesity PDG

## Short paper on organizational issues

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The paper presents a brief summary of key themes which may provide relevance and application to the deliberations of the Obesity PDG (Preventing obesity: working with local communities). It addresses three key themes:

1. Leadership (including distributed leadership)
2. Partnership working
3. Corporate social responsibility

## Leadership

Leadership can be defined thus:

> "*the process (act) of influencing the activities of an organized group in its efforts towards goal setting and goal achievement" (Hartley et al, 2008, p.8).*

A key distinction is often made between *transactional and transformational leadership*. The former refers to the contractual relationship between the leader controlling organizational resources and the follower providing services. The latter refers to leader's charismatic role in gaining followers trust and loyalty so as to minimize their self-interest.

Much of the leadership literature is descriptive or anecdotal, focusing on prescribed behaviours or requisite competences. The literature is often normative, advising on personal characteristics or individual traits. This approach is often described as the `heroic' approach to leadership, focusing at the individual level. Equally, leadership can be conceived at three levels:

- personal leadership qualities,
- leadership positions within organizations, and
- relationships between leaders and followers

A more conceptual approach is presented by Hartley *et al* (2008) who propose 6 dimensions of leadership:

1. Concepts: what is meant by leadership?
2. Characteristics: what roles do leaders play and how do these vary?
3. Contexts: how do aspects of the wider environment impinge upon leaders?
4. Challenges: what are the key challenges, purposes or aims of leadership?
5. Capabilities: what skills and abilities enable effectiveness of a leader?

6. Consequences: how can leadership be measured and by which dimension is it deemed to be effective? (p.7).

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*Distributed leadership:*

Leadership roles are especially unstable when (organizational) power is dispersed or diffuse. Where leadership is addressing `wicked' problems (such as obesity), adaptive leadership is often required to "mobilise a range of people to focus on the problem, recognise their responsibility in addressing it, and gain their contributions to solving it in new and creative ways" (Hartley *et al*, 2008, p.16/7)

Rarely is organisational change through an individual (leader) but rather through a network of individuals (in different organizations/institutions). This network may be defined into 3 groups: change generators, implementers and adopters (Ottaway, 1983). Whatever classification, it is commonly recognized that change processes are distributed within and across organizations. Accepting this notion of distributed leadership undermines some of the `prescriptive' literature which sees leadership as unproblematic and change as rational and linear.Notions of distributed leadership can thus illustrate how organizational change may be unsuccessful (Buchanan *et al*, 2007).

Notions of distributed leadership can be allied to those of networks. Networks may be effective in tackling `wicked' problems which refer to problematic social situations where: there is no obvious solution, many individuals and organisations are involved; there is disagreement amongst the stakeholders, and there are desired behavioural changes (Ferlie *et al*, 2009). The issues are wicked in that potential solutions extend beyond any single organization and that actions of one agency may be counter-productive to those of another.

Ferlie and Pettigrew (1996) identified the individual characteristics associated with effective networks. They include:

1. Strong interpersonal skills (including skills in persuasion and in developing sustsinable relationships,
2. Ability to cross (organizational, professional and cultural) boundaries, and
3. Ability to disseminate knowledge in different contexts.

Networks are consistent with Herrick's (2009) argument that "tertiary structures and mediating partnerships" are increasingly the mechanisms by which social problems are tackled (p.54). The implications are, however, a proliferation of diverse stakeholders involved in this process.

## **Partnership working**

In many areas of public life, policy outcomes cannot be achieved by individual organizations, whether public, private or third sector. Moreover, the configuration of

organisations (and their responsibilities) produces unintended consequences such as service fragmentation. Such observations also lie at essence of governance in that it relates to the inability of organisations to achieve their own objectives without the cooperation of others over whom they have no direct authority or control (see `Distributed leadership', above). Given these truisms, it is logical that partnership working has long been sought though rarely achieved. Health and social care have been especially prone to problems of partnership working (Callaghan *et al*, 2000)

Although the term partnership working' is used here, various others have been used including: collaboration, partnerships, inter-organisational cooperation, joint working, joined-up government, networks.

Partnership working has been invoked by policy-makers and practitioners, assuming various benefits. These largely relate to the avoidance of `problems' such as

- Organisational individualism,
- Repetition (where two or more agencies undertake the same task),
- Omission (where important tasks are not undertaken),
- Divergence (where tasks become diluted across agencies),a nd
- Counter-production: agencies work in conflict against each other (Huxham and MacDonald, 1992)

Also, partnership working is pursued in the search for a seamless service to users. It can also avoid major structural reform, instead promoting organisational re-configuration.

However, the barriers to partnership working are also numerous. They largely refer to differences in:

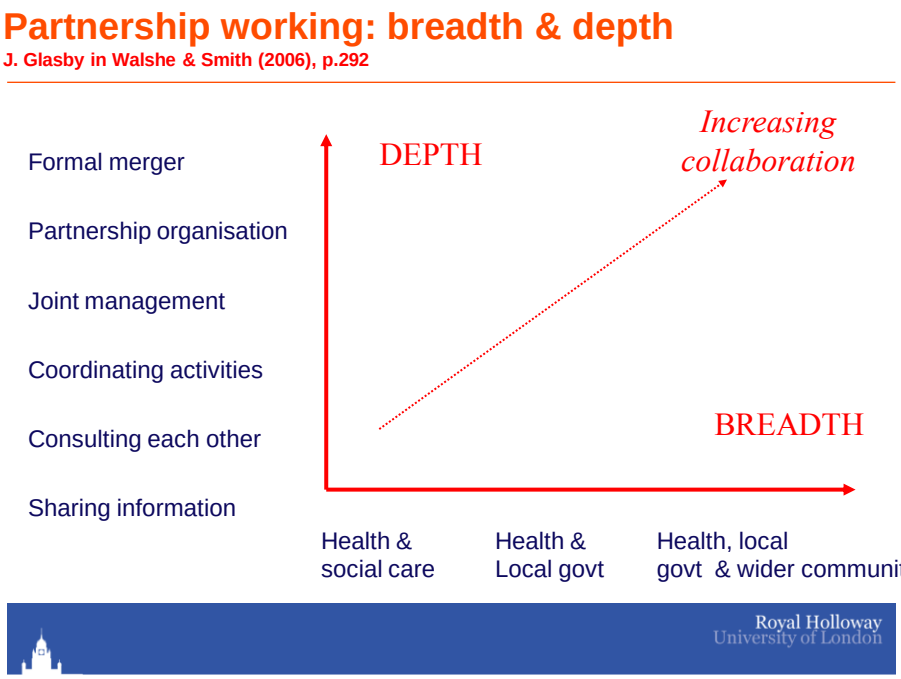
- Aims, language, procedures, culture and perceived power (Huxham, 1996).
- Organisational traditions,
- Professional status and values,
- Financial arrangements,
- Planning procedures, and
- Accountabilities (managerial, political and financial).

Assuming partnership working is not simply a binary characteristic (present/absent, effective/ineffective), it follows that there are degrees of partnership. Various `measures' of the extent of partnership have been proposed; three are highlighted here. The first includes a spectrum of five stages:

a. *Isolation:* Absence of joint activity
b. *Encounter*: Some contact; Informal and *ad hoc*; Marginal to agencies' goals; Loose-knit networks; Rivalry remains
c. *Communication*: Formal and structured networks; More frequent interaction; Willingness to share/exchange; Clearer responsibilities; Activity still marginal

d. *Collaboration*: Collaboration is core activity; Trusting relationship; Very connected network; High degree of trust; Recognition of shared goals; Shared tasks, jobs, resources
e. *Integration:* No longer a separate identity; Consider new agency; Long-term obligations; Shared systems & processes.

The second extends this spectrum by considering the breadth and depth of partnership working – the former in terms of the number and type of agencies, and the latter in terms of the extent of partnerships.




The third extends Glasby's (2006) model by identifying activities in the breadth and depth of partnerships, in what Leutz (1999) called `levels of integration.'

| Levels → Activities ↓ | **Linkage** | **Coordination** | **Full integration** |
|---|---|---|---|
| **Information** | Provide when asked | Define & provide items routinely | Use a common record |
| **Service delivery** | Refer & follow up | Smooth the transition between settings, coverage & responsibility | Control or directly provide care |
| **Clinical practice** | Understand & respond to special needs | Know about & use key workers | MDTs manage all care |
| **Finance** | Understand who | Decide who pays for | Pool funds to |

| | | | |
|---|---|---|---|
| | pays for each service | what in specific cases | purchase from both sides & new services |

Adapted from Leutz, 1999, p.86-87

Simply enumerating the dimensions (breadth/depth) of partnership working can become a misleading and fruitless exercise. Ways to achieve `better' partnership working are thus sought. For example, Hudson *et al* (1999) offer 10 components of `collaborative advantage':

1. Context: expectations and constraints
2. Recognition of the need to collaborate
3. Identify legitimate basis for collaboration
4. Assess collaborative capacity
5. Articulate clear sense of collaborative purpose
6. Build up trust from principled conduct
7. Ensure wide organisational ownership
8. Nurture fragile relationship
9. Select appropriate collaborative relationship
10. Select collaborative pathway

Kanter (1994) argues that partnerships should be about creating new `value', not just exchange. Partners must therefore:

1. Have something to contribute
2. Seek long-term strategic goals
3. Need each other
4. Be prepared to invest resources
5. Share information and communicate
6. Develop links at all levels
7. Ensure mutual trust

Leutz (1999, 2005) goes further than either Hudson *et al* or Kanter, presenting "laws of integration":

1. You can integrate some of the services all of the time, all of the services some of the time, but you can't integrate all of the services all of the time
2. Integration costs before it pays
3. Your integration is my fragmentation
4. You can't integrate a square peg into a round hole
5. The one who integrates calls the tune
6. All integration is local

## Corporate social responsibility

Corporate social responsibility (CSR) (also termed business ethics) has been defined as a "way of running the entire business in a way that allows the company to manage its

total impact on society and the environment commensurate with the core objective of generating stakeholder value" (Brock, 2006, p.58).

CSR refers to the conduct of businesses which ensure that is "economically profitable, law abiding, ethical and socially supportive" (Carroll, 1983, p.608). As such, it is commonly seen to comprise four sets of responsibilities: economic, legal, ethical and philanthropic (Carroll, 1979). Whilst the first two are been ever-present in business, it is only in recent years that the last two have become significant factors.


CSR ''demands that business takes responsibility for social problems, social issues, social and political goals beyond their core business activities'' (Drucker, 1973, p. 315). As CSR is normally involved in maintaining a company's reputation or social acceptance, it is possible to discern CSR in terms of 3 levels:

- *Instrumental level*: the corporation's ability in terms "the skills and competences that are necessary to deliver products or services in the quality expected by its customers."
- *Transactional level*: the corporation's integrity in terms of compliance with "the legal and moral rules of their societal context. Its transactions are transparent, its behavior is fair. It keeps its promises and acts with consistency."
- *Transformational level*: the corporation's benevolence in terms of its willingness "to transcend self-interest for the sake of the common good" (Palazzo and Richter, 2005, p.396).

CSR can apply to all aspects of commercial life (such as BP oil leaks in 2010, phone hacking scandals or cricket betting scandals; http://craneandmatten.blogspot.com/). Although it is rarely considered as a `CSR' issue, the health sector is replete with ethical issues, most recently including (for example) PIP breast implant (January 2010) and Mid-Staffordshire NHS Foundation Trusts (Francis, 2010). Arguably, the most visible expression of CSR in this sector has been tobacco control (Palazzo and Richter, 2005). A more recent development has been the growing commercial influence on public health action which can be "understood as accommodating to corporate concerns and priorities" (Koivusalo and Mackintosh, 2011, p.539).

CSR is `practised' (in the health context) through measures such as health information websites, educational resources, teaching materials, sports sponsorship, community interventions, national health initiatives and product health claims (Herrick, 2009). As a result of latter initiatives, the boundary between public (health) policy and commercial activities has narrowed (or even blurred) in terms of health promotion.

Herrick (2009) raises the question as to "how and why health has become a Corporate Social Responsibility (CSR) strategy for the global food and drink industry (FDI) in the context of current governmental and public calls to address mounting obesity rates" (p.51). The Nuffield Council on Bioethics (2007) questions whether the CSR in the FDI is "driven by governance or marketing aims, as some companies may simply seek to establish themselves as providers of healthier food because they perceive an associated market advantage (para.5.17, p.87). By contrast, Herrick (2009) foresees a malign influence and deduces three contentions:

1. "That health and well-being may be used to secure brand value and consumer goodwill"
2. That the FDI may promote a "narrow epidemiological understanding of obesity", and
3. That CSR reporting has enabled the FDI to assume responsibility for health promotion. This has the effect of problematising the state's role in the obesity crisis and creating a defensive response to the threat of government regulation.

The Nuffield Council too recognises ulterior motives of the FDI but offers three optimistic positions: (i) that healthier food options have indeed been made available, (ii) that the FDI may help shift attitudes towards healthier food options, and (iii) that healthier food options may not be less financially rewarding to the FDI in the long-term.

However, it follows from Herrick's contentions that the FDI has emphasised (still further) notions of consumer choice (note, for example, use of the term "healthy choices") which are largely defined by business (rather than government). At the same time, the FDI has re-framed the `choice' debate in terms of `energy balance' (Herrick, 2009). The combined effect has been to shift the blame away from the FDI to individual consumers. The FDI has sought to increase brand value whilst avoiding blame through, according to Herrick (2009), three strategies: investment in R&D, support for physical activity programmes, and undertaking its own "health promotion and education" over the internet and in schools.

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Related NHR resources:

- Leadership in health care. A review of the literature for health care professionals, managers and researchers

http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1601-148

- The impact of leadership factors in implementing change in complex health and social care environments: NHS plan clinical priority for mental health crises resolution teams

http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1201-022

- Leadership and better patient care: Managing in the NHS

http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1601-137

- Delivering Health care through managed Clinical Networks (MCNs): lessons from the North

http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1518-103

- Changing management cultures and organisational performance in the NHS (OC2)

http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1501-94

- The management and effectiveness of professional and clinical networks

http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1518-104

- Evaluation of the mental health improvement partnerships programme

http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1504-108#

- Partnership Working and the Implications for Governance: Issues affecting public health partnerships

http://www.sdo.nihr.ac.uk/projdetails.php?ref=08-1716-204

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