Self-directed Team Models in Healthcare Settings: What is Their Potential for Adding Value to the Intellectual Capital of Healthcare Organisations?

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Abstract: The concept of intellectual capital (IC) in organisations has been widely researched and its application is well understood, particularly in relation to business and commercial sectors. Despite the unique and vital role that healthcare organisations have in supporting the essential health and wellbeing of populations, awareness of IC and its implications may be underdeveloped in these organisations. Healthcare organisations rely on the expertise of a variety of medical, nursing, and other staff, thus optimisation of this human capital resource must surely be of interest to those that manage, fund, or direct policy in healthcare. Team working is a common feature of healthcare organisations, and it is of interest that a number of IC research papers have drawn attention to team styles in organisations. One particular mode of team working is that of the “self-directed team” model, and there is a substantial body of empirical research that describes the application of self-directed teams in various organisational settings. Within this body of research there are a small number of studies about the use of self-directed teams specifically in healthcare settings. The paucity of these studies and the diverse nature of methodologies employed in them means that it is difficult to generalise findings. This paper is premised on the idea that self-direction in healthcare teams is worthy of further exploration in order to determine whether self-direction is compatible with the expansion of intellectual capital in healthcare organisations. The aim of this conceptual paper is to propose a framework for describing the relationship between self-directed teams and intellectual capital in healthcare-specific settings. Drawing on a range of perspectives and examples from our own and others’ work, we explore the application of a model of team self direction in a healthcare organisation, and attempt to ascertain the value adding potential of self-directed teams to the organisation’s intellectual capital. We then outline some considerations for further research. Using an existing framework that describes IC in the healthcare sector we sketch out the elements we would expect to see in the IC landscape of a health organisation. We then critically examine both the potential contribution that the self-directed team model may make to the IC of healthcare organisations, and factors that might hinder the agency of the self-directed team model.

Keywords: Self-directed teams; healthcare organisations; intellectual capital; value adding potential

1. The purpose and aims of this paper

The purpose of this conceptual paper is to explore the potential relationships between intellectual capital (IC) in healthcare and self-directed teams in healthcare settings, in order to ascertain the role that could be played by self-directed teams in adding value to the intellectual capital of healthcare organisations. The aims of this paper are to propose a framework to situate self-directed teams in relation to IC in healthcare-specific settings; to explore the application of a model of self-directed teams in a healthcare organisation; to attempt to ascertain the value-adding potential of self-directed teams to the IC of healthcare organisations; and to outline considerations for further research.

2. Background

2.1 Intellectual Capital and Healthcare

Intellectual capital (IC) has its basis in practice, being rooted in ideas about understanding the nature and value of non financial assets in organisations in order to achieve better management of the things that generate value (Petty and Guthrie, 2000) and realise competitive advantage (Brennan and Connell, 2000). The emergence of the concept of IC seems, in part, to have been a response to a new business economy based on the widening availability of knowledge through new technologies. Stewart cited in Robert (1997) suggests that IC is a source of “wealth” not just for the organisation but also for the employee. “It is an object of common ownership, and both parties must seek to extract the greatest returns possible from it”. (Robert, 1997)
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From these initial thoughts about exploiting the knowledge contained within an organisation, other investigations of IC have followed. Marr et al (2003) suggest that early work regarding IC was concerned with raising awareness of the existence and value of IC in organisations and developing frameworks for its classification. From subsequent work on intellectual assets the concept of the knowledge-based organisation emerged. A further spin-off from this has been knowledge management (KM) in organisations, and how KM performance outcomes can be measured in organisations (Choy et al, 2006).

IC appears to follow two paths: the strategic route and the measurement route. The strategic route focuses on the creation and use of knowledge, notably tacit knowledge and the relationship between knowledge and value creation. The measurement path challenges traditional value measures by demanding measurement of non financial data as well as financial ones. The management of these paths was found to be important for an organisation’s long term success as those that managed their own IC out-performed others (Brennan and Connell, 2000). In order for healthcare organisations to successfully perform in markets increasingly characterised by competition, those organisations must demonstrate their advantage over other competitors. Healthcare organisations need to be acquainted with all of their assets, including those that appear to be more difficult to define such as intellectual capital, in order to exploit this IC. This is likely to require an enlarged understanding of IC amongst health organisations. The comparatively small number of studies about intellectual capital in healthcare settings may indicate a lack of acknowledgement or understanding of the concept of IC in the healthcare setting. Alternatively it is possible that IC has become unconsciously embedded into the language of healthcare via terms such as “knowledge management” and “organisational learning”, or integrated into health services performance measurement systems through tools such as the Balanced Scorecard (Kaplan and Norton, 1996). Whilst useful, these lenses on IC do not reflect its totality.

4 recent studies were found that explored the concept of IC in a healthcare setting. A study by Liu and Lin (2007) asserted that in order to remain competitive in the healthcare market, hospitals need to develop customer capital. Their study aimed to provide a taxonomy for cultivating market-based organisational learning, leading to the accumulation of customer capital and ultimately improved financial performance in the hospital setting. A study by Donato (2002) looked at 6 healthcare organisations in Tuscany to evaluate whether the performance measurement systems of these organisations encompassed intangible assets. Habersam and Piber (2003) used a qualitative case study to explore the relevance and awareness of IC in hospitals. Peng, Pike and Roos (2007) investigated how hospitals in Taiwan viewed the worth of IC and performance in the healthcare sector. They suggested that healthcare organisations combine characteristics of a people-centred approach with a process-oriented approach. This notion was supported in results from the study in that human capital was identified as the most important element of IC. This reflected the mission of those healthcare organisations for “people to care for people”.

IC papers in the field of nursing have explored ideas about evaluating intellectual capital within nursing and the potential influences of this capital. One study looked at nurses’ knowledge stocks, skills and experience, and the sorts of influence these may have on outcomes for patients and the organisation (Covell, 2008). The concept of measuring nurse productivity as an intellectual capital asset was discussed by Moody (2004) and McGillis Hall (2003). Clarke and colleagues (2008) set up nursing interventions designed around the rationale that people can pursue goals and objectives that contribute to their perceived quality of life. Nursing interventions were designed to increase patients’ knowledge and choice in their use of health and social care services as a way of stimulating growth in human capital. One conclusion we might draw from these studies is that IC has the potential for being a valid strategic management conceptual framework for NHS providers. In fact, the above discussion would suggest that a thorough understanding of and commitment to the development of IC within the NHS could increase healthcare organisations’ competence and capability to deliver competitive and effective services in the future. NHS organisations must therefore be able to define and classify IC, deploy, protect and renew intellectual assets, and measure them in a way that facilitates decision making.

3. Self-directed teams in Healthcare

In healthcare organisations multi-disciplinary teams are commonly established in relation to particular work processes or service areas: for example - hospital surgical teams, physiotherapy teams, and
community mental health teams. This paper is interested in how one particular team conceptualisation, referred to here as the “self-directed team”, functions in a healthcare-specific setting. Other definitions for the self-directed team include the “autonomous team”, “self managed team”, “self managing team”, “semi-autonomous work group”, “self-leading team” and “high performance work team”. Whilst there is no single prototype that determines all applications of self-directed teams in healthcare, an earlier study did identify a number of underpinning principles commonly shared by these teams. A qualitative meta-synthesis of 7 papers derived from empirical studies (Molesworth, 2008) found that the implementation of self-directed teams in healthcare settings was commonly informed by the principles of enhancing team work; promoting flattened organisational structures; and effecting cultural change (Macdonald and Bodzak, 1999; Hurst et al, 2002; Woodward and Wilson, 2006; Robinson and Rosher, 2006; Yeatts and Cready, 2007; Cready et al, 2008). The participation and empowerment of staff and service users in health settings was identified as a principle of self-directed teams by Parker (2008), although in order for this principle to be realised Parker suggested that teams needed to have the authority to influence strategy and performance, facilitate problem solving, and engage in double loop learning. Self directed teams are seen as the building blocks of a successful organisation. They encourage individual motivation, commitment to quality, flexibility, efficiency and innovation through mutual support (Tranfield and Smith, 2002) thus enabling an organisation to respond to and adapt to the competitive challenges of a complex economy (Espinosa et al, 2005). As the NHS market becomes more competitive, and services that were historically secure are increasingly contested, self directed teams could enable healthcare organisations to adapt more successfully.

Teams represent a key resource of an organisation; its human resource. One of the tools available to an organisation for optimising its performance is human resource management (HRM), and recent research has started to separate out some critical human resources practices that appear to significantly contribute to organisational performance. Based on work by Pfeffer (1998), Viachos (2008) developed a set of hypotheses about the effects of HRM on organisation performance. One hypothesis concerned decentralization and self-managed teams, a combination that promotes commitment and participation amongst employees, and creates a sense of attachment. Decentralization and self-managed teams are highlighted as positively related to organisational performance. Other work by Evans and Davis (2005) drew on theories from social network analysis, and explored the relationship between high performance work systems (HPWS) and organisational performance. Their study described how outcomes in organisations can be examined in terms of patterns of relationships which are described as “ties”. In organisations “ties” have a bridging function, with weak “ties” being more beneficial to organisations than strong “ties” because the former facilitate the flow of information and exchange of resources between groups within an organisation. Evans and Davis (2005) note that “HPWS facilitate the development of bridging ties primarily through the use of flexible work and self-managed teams”. Even though there are few empirical studies that have explored the application of self-directed teams in healthcare-specific settings, evidence from the research literature indicates that the self-directed team model is congruent with high performance in organisations. On this basis the application of self-directed teams to healthcare settings is relevant to academic debate.

4. Approach and methods

In order to explore the IC of a healthcare organisation and the possible contribution of self-directed teams to this IC, we began by identifying research studies that had looked at IC in healthcare-specific settings. From amongst the studies we found Habersam and Piber’s (2003) IC landscape framework for hospital settings which has its origins in the taxonomy proposed by the Meritum Project (2002). The Meritum taxonomy is widely agreed to be the authoritative tool for managing and reporting IC. Our rationale for using Habersam and Piber’s framework in our own study was three-fold. Firstly, whilst Habersam and Piber’s (2003) study mapped empirical data onto a framework, and our study attempted a mapping exercise based on recorded information within an organisation about non financial assets, the notion of mapping IC in healthcare was common to both studies. Secondly, our use of an existing framework was informed by ideas from Miles and Huberman (1984) and Yin (2003) who suggested that frameworks developed from literature act as a guide for analysis and can add validity to the data. Thirdly, Habersam and Piber’s framework expanded on previous structures such as the Balanced Scorecard proposed by Kaplan and Norton (1996), and the Value Platform described by Petrash (1996), cited in Brennan and Connell (2000), by adding an extra type of capital which Habersam and Piber called “connectivity capital”. They posited that connectivity capital becomes
obvious in a hospital setting where “social, organisational and physical frame enables interaction with patients, communication between professional groups, and an intermixture of different competencies”. Habersam and Piber list “self guiding autonomous teams” under connectivity capital, thus supporting the notion that self-directed teams may contribute to IC. For our mapping exercise we used the case of a specific UK healthcare organisation where self-directed teams had been implemented. This organisation is an NHS Trust that provides specialist adult and children's mental health and learning disability services, as well as services to other groups including older people and mentally disordered offenders. We began by mapping the non financial assets of this organisation onto Habersam and Piber's framework (see figure 1). We posited that where the presence of an asset has been recorded in some way within the organisation it becomes identifiable, and can be mapped. Assets may include organisational policies, procedures, plans, meetings, services activities, and systems, as well as all human resources (staff and customers and their abilities, know-how, and experiences).

When we came to the spheres of “intuitive” and “black box” we found that these were much more elusive, and evidence that might indicate the presence of capital in these spheres was not easily located. The complexity of intuitive and black box capital has been raised by Habersam and Piber (2003) who note that intuitive capital can be explained but not written down, and black box capital cannot be explained. How we dealt with this was to acknowledge the complexity, and make an attempt to represent what would likely be within the spheres of intuitive and black box based on our knowledge of the organisation and anecdotal evidence from within the organisation. As we worked through the mapping process we used bold italics to highlight any assets we considered to be specific to the application of self-directed teams. Having completed this mapping exercise our discussion and reflections led us back to consideration of other IC frameworks, particularly Petrash's (1996) Value Platform.

### 5. Results, findings and discussion

<table>
<thead>
<tr>
<th>Our knowledge</th>
<th>Structural</th>
<th>Relational/Customer</th>
<th>Human</th>
<th>Connectivity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Finance</strong></td>
<td>Budgetary controls; Financial plans; Adequate IT; Chairman’s Award; National Awards; Financial reward for teams who engaged.</td>
<td>Commissioners of services.</td>
<td>Chairman’s Award; National Awards; Use of financial reward to teams for developing themselves and the service.</td>
<td>Team meetings; Ref. Practice; Supervision; Team away days/focus groups.</td>
</tr>
<tr>
<td><strong>Metric</strong></td>
<td>Performance Management; Standards for Better Health; Balanced Scorecard; Patient information systems such as CHIPS and other databases; Staff survey; Strategic Planning; Number of distributed leads per self-directed team; Benefits realisation framework; “Delivering Health” (interactive database of individual and team activity)</td>
<td>Person Centred Planning; Care Co-ordination; Talking Therapies; Time spent; Mental Health survey; Patient Public Involvement; Users and carers as team members; Co-designing services.</td>
<td>(Awareness that) Patient and Public Involvement (PPI) generates customer capital; Stress Audits.</td>
<td></td>
</tr>
<tr>
<td><strong>Literal</strong></td>
<td>Accountability; Re-organisation into teams; Team Based Working; “Productive Ward”; “Creating Capable Teams” Service Line Management; Job descriptions or plans/KSF; Agenda for Change Certification (ISO, Healthcare Commission, IIP, IWL, and others; Policy &amp; procedures;</td>
<td>Care plans; Discharge planning; Case conferences; Leaflets; Education, promotion; Networking – inter-agency; Press/media; Leaflets about services; Leaflets about self-directed team model.</td>
<td>Statutory and mandatory training; Training needs analysis; Personal Development Plans; “New Ways of Working”; Problem solving; Solution Focused Approaches; Supervision/reflecting on care process; Distributed leadership – task delegation;</td>
<td>Reflection; Vision and values; Teamwork; Trust membership; Governors; Carers/patient groups; Positive feedback; Credibility and trust document; Users and carers as team members.</td>
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Spheres of Transparency

<table>
<thead>
<tr>
<th>Literal (continued)</th>
<th>Structural</th>
<th>Relational/Customer</th>
<th>Human</th>
<th>Connectivity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Audit; PALS lead in each team to highlight PPI; Guidance/explanation about Distributed Leads in teams.</td>
<td>Patients involved in care; Staff/service user interaction – may be defined in terms of care and/or emotion; Long-term relationship between staff/organisation and service users (due to long term usage of services); Patients as co-producers of their health; Teams feeling trusted (not having to ask permission)</td>
<td>Additional responsibilities &amp; additional freedom; Team Directions and PDP.</td>
<td>Reflection/sense making; Pushing the boundaries; Capacity to embrace change.</td>
</tr>
<tr>
<td>Intuitive</td>
<td>Corporate induction; Mobilising previous experience and existing knowledge more effectively (as a result of common understanding).</td>
<td>Mental models; Personal history; Positive Mental models; Passion; Experience of freedom vs possible conflict/tension in terms of adherence to policies/procedures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black box</td>
<td>Organisational memory.</td>
<td>Uncaptured/non-verbalised service user experience (specific client groups); Service users' history and experience; Impact of service user empowerment on service users</td>
<td></td>
<td>Culture; Team solidarity; Organisational development; Experience of freedom – what it is about freedom that is shared, and what is not shared, for staff, service users, and carers;</td>
</tr>
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Figure 1: UK healthcare organisation intellectual capital landscape

Columns of relational, human, and connectivity capital, these assets were also present to a similar degree in the column of structural capital. We reflected on possible explanations for why assets relating to self-directed teams showed up so obviously as structural capital. One likely reason was that in our example of a healthcare organisation, when self-directed teams were being implemented a lot of explanation was required about what self-directed teams were and what was expected of staff for the implementation of self-directed teams. Explanations were given to staff and, over time, these were written down and became more formalised, sometimes as policies and procedures. Instead of teams looking to the underpinning philosophy and spirit of self-direction to inform implementation, they now had policies and procedures to follow instead. This raises the important question of how you increase human and relational capital without increasing processes, and placing too great an emphasis on structural capital. A study by Parker (2008) highlighted that centrally controlled cultures encourage the mechanistic behaviours that foster an emphasis on cost containment, efficiencies and traditional performance measurement. Recent regulation and policy changes in the UK National Health Service (for example: Standards for Better Health, and systems specifically designed to improve productivity and efficiencies) have placed a further emphasis on these behaviours, and as Peng et al (2007) have argued, a growing focus on structural capital. Peng and colleagues (2007) found that the balance across the different types of capital is critical, but that in healthcare organisations there is a tendency to invest most in organisational and relational capital and least in
human capital. The capitals are interrelated as Peng and colleagues (2007) suggest, and it is the connectivity capital (Habersam and Piber, 2003) that enhances the relationships and therefore the value of each of the capitals.

"Human capital is connected with structural capital, for instance, by participative leadership, becoming confident in others or knowing the myths and stories of the organization, working in autonomous teams, an intense communication and democratic exchange of ideas, and a specific cultural background to react adequately in cases of emergency." (Habersam and Piber, 2003)

Having mapped self-directed teams as connectivity capital we then considered the implications of this, taking into account that it is through the activity of self-directed teams that connectivity capital is seen. As the UK healthcare environment has become more competitive conditions have been created where healthcare organisations compete with each other in terms of the quality and delivery of services they provide. Competition has been accompanied by a shift in the way that patients and service users are perceived with more reference to them as customers of healthcare services. In the healthcare organisation which is our example, a key element of self-directed teams is that service users and carers become members of the team, and that this is demonstrated through a range of involvement activities. Theoretically this shifts the role of service users and carers from recipients of services to participating members of the team, potentially enabling a different relationship to exist between service users and staff. This is captured in the framework as relational/customer capital, suggesting that self-directed teams have a role in extending this type of capital. Co-membership of teams by service users and carers enables service user and carer experience to be more readily captured through, for example, patient stories. Participation of service users and carers in the team can also be through shared decision making, and exercising influence over developments in the service for which the team has responsibilities. These activities and the learning gained from them, when more widely disseminated in the organisation, become the connectors between individual service users and carers and the organisation, and can be termed connectivity capital.

Another connector we mapped onto the framework was vision and values. A recent qualitative study about self-directed teams by Beddows (2008) noted that for self-directed teams to be effective they needed to have a shared vision and values in order to make sense of their shared purpose. This finding is reflected in other examples of implementing self-directed teams in healthcare settings (Robinson and Rosher, 2006; Yeatts and Cready, 2007; Cready et al, 2008), where training, preparation, and culture change activities helped to support the development of shared vision and values. For self-directed teams to enhance the intellectual capital of healthcare organisations it is likely that investment in activities and training that support a common vision and values amongst staff will need to be a priority.

Self-directed teams in our example of a healthcare organisation were implemented and supported using organisational development (OD) tools. Andriessen (2007) suggests that the origins of IC as outlined by Sveiby (1997) and Edvinsson (1997) are founded on the same principles as OD in that both are driven by a desire to create a healthy, sustainable organisation that seeks to release human potential and apply a holistic view. They argue that by using OD tools the hidden IC of an organisation can be uncovered. Habersam and Piber's (2003) intuitive, literal, and black box spheres of transparency reflect similar activities. The focus of OD is usually to identify and understand connections and relationships in organisations, requiring qualitative rather than quantitative methods. An overview of 14 empirical research studies on intellectual capital in organisations (Brennan and Connell, 2000) showed, unsurprisingly, the dominance of qualitative methodologies. Peng et al (2007) argue that in countries such as the UK where there is greater government control over the healthcare industry, the focus is on more traditional performance measures with little emphasis on IC. At the level of individual organisational culture, Peng et al (2007) suggest that where directive decision making and strong control measures were in place emphasis was placed on metrics to gain understanding. However where the culture focussed on participative decision making and people then IC was measured and understood through more literal and intuitive evaluation and dialogue. This may suggest that in organisations where decisions are made lower down the organisation, and particularly where decisions are made in conjunction with patients (e.g. the self-directed team model), a more comprehensive understanding of IC is possible.

The framework mapping exercise seems to indicate that implementing self directed teams in a healthcare organisation did not increase assets in the black box sphere of transparency under the
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column of structural capital. Possible explanations for this are that organisational memory simply is
the only black box asset for structural capital, and we cannot establish whether self-directed teams
have a role in generating or contributing to organisational memory. Alternatively it could be that self-
directed teams need to become sufficiently embedded in the organisation in order for black box
assets to be revealed within structural capital.

The mapped framework suggests that black box assets were present for relational, human, and
connectivity capital. In our NHS Trust example the type of disabilities of some client groups means
that it is not possible to access and capture their first hand experience, and often the best that can be
achieved is the interpretations of their experiences via carers or advocates. Thus it may be that the
capital of a proportion of service users remains an unknown quantity. In self-directed teams in
healthcare the involvement of service users and carers as part of the team is a factor that can help to
bring to visibility the stories and experiences of service users (customer capital), and can also harness
the customer capital of service users in being co-producers of their health.

6. Conclusions

Whilst the discussion of findings points to a lack of understanding of intellectual capital and its value in
healthcare organisations, there are promising signs that self-directed teams have potential to add
value to intellectual capital in a number of ways.

Self-directed teams seem to be able to add value to relational/customer capital by situating service
users and carers differently in relation to the team. Actively including service users and carers in
decision-making, facilitating their influence on services, and improving opportunities for service users
and carers to be better informed about services and support, may all be evidence of this. Despite the
tendency of healthcare organisations to invest most in organisational and relational capital, the
framework mapping exercise suggests that self-directed teams can also add value to human capital.
This may happen through the giving of incentives to support team development and service
development; supporting teams to become more aware of the impact of what they do, for example in
terms of how they situate service users and carers in relation to the rest of the team; the giving of
freedom and greater autonomy to teams and the impact this can have both professionally and
personally; and the excitement and passion that teams may experience in relation to a new model of
team working.

Earlier we noted that our reflections on the mapping exercise led us back to other IC frameworks, in
particular the value platform of Petrash (1996). This framework is interested in increasing the number
of inter-relationships between the types of capital, in order to maximise the value. Habersam and
Piber’s (2003) connectivity capital is essentially a connector which could be viewed as increasing the
inter-relationships between capitals. In our mapping exercise we situate self-directed teams as
connectivity capital, which may suggest that self-directed teams add value by, for example, being the
bridge between service users and carers and the wider organisation. Teams are uniquely placed to
understand both the language of individual service users and carers and that of the organisation. This
may best position them to facilitate the wider organisation in receiving and making sense of service
user and carer experience. Connectivity capital may also be added to through team solidarity, teams’
participation in organisational development, and the experience that teams gain of advanced
autonomy or freedom.

This paper draws attention to potential new lines of research enquiry in the area of intellectual capital
in healthcare. The chief goal of such enquiry should be to expand the concept of IC in healthcare
organisations. To work towards this goal we propose that a future research agenda requires two
concurrent strands. One strand should focus on exploring the benefits to healthcare organisations of
their IC assets. This would likely include empirical studies that draw both on the case study approach
used by Habersam and Piber (2005), and the work in identifying indicators of IC in healthcare
organisations conducted by Donato (2002). Refinement of existing methodologies to increase their
pertinence to healthcare organisational settings should also be considered. Habersam and Piber
suggested that in order to achieve more transparency in the areas of literal, intuitive, and black box
capital, practices of representing IC such as storytelling, narratives, or visualisations could be made
greater use of.
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The second strand would be further exploratory research about the value adding potential of self-directed teams to IC in healthcare organisations. The scarcity of empirical studies about self-directed teams in healthcare settings may in part indicate the difficulties associated with measuring their impact, yet the work of Evans and Davis (2005) and Vlachos (2008) which offered evidence supporting the alignment of self-directed teams with high performance work systems, may be a useful starting point for further studies. We suggest that nested qualitative investigations of self-directed teams in healthcare organisations to explore their potential contribution to IC may also lead to a better overall understanding of their value within healthcare settings. Focusing on the little known territory of self-directed teams in healthcare may also offer an innovative lens for looking at IC.

In addition, for both strands outlined here it is suggested that the research methodologies employed should engage with the notion of organisational development and change. This is advocated in a number of IC studies, including Andriessen (2007) who used a design based research approach to construct and test a tool for the reporting of IC in organisations, and Habersam and Piber (2005) who stated that IC behaves according to its changing context and that it should be seen as both an object and a dynamic essence that triggers organisational change.

There are potential applications of IC in specific organisational aspects, such as in the area of teamwork. For example, notions such as team innovation and creativity could be re-conceptualised as aspects of intellectual capital. Areas that could be explored are the identification of innovation and creativity and how increases and improvements could be measured.

The contributions that future IC research could make to healthcare organisations seem promising. The development of approaches to mapping, reporting and managing IC in healthcare settings is likely to be of interest to healthcare leaders, particularly in the current economic situation where added value from IC may give a healthcare organisation competitive advantage. IC is a validated lens for looking at organisations, a factor which may help to legitimise it amongst policy makers and commissioners of services, thus making it an acceptable element of the toolkit that organisations use to measure their performance and capability, and to assess outcomes.

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