

Inter-Organisational Clinical Leadership and Engagement

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Abstract

Clinical leadership and engagement across organisational boundaries has been gaining significant attention over the last few years. Within the NHS, there has been an increased focus within policy directives and the literature on partnership working, collaborations, cross-organisational and cross-professional working. These innovative ways of working are seen as a means of improving the quality and co-ordination of patient care across the pathway, thus impacting on the patients' experience.

Despite this focus, the evidence of what constitutes and therefore what can deliver effective inter-organisational clinical leadership and engagement within this context is sparse. This study identifies the characteristics and impact of effective clinical leadership, clinical engagement and team effectiveness when working across organisational boundaries. 'Practical Recommendations' have been developed as a mechanism to disseminate the findings.

This research is based in the real world, which is complex and messy. The study uses an interpretative stance and gains insights from a number of different perspectives. The methodological approach is action research with a single case study design. Both quantitative and qualitative data are used and these are collected through a team effectiveness tool, focus groups and semi-structured interviews.

The study demonstrates there are significant improvements in the delivery of healthcare and patient experience when clinicians work effectively across the whole patient pathway, spanning organisational boundaries. The study findings are: the need for a focus or forum and for clinicians to have the time and space to initiate inter-organisational working; the power of the patient's voice, involvement and leadership in delivering impactful change; the need to understand organisational and personal barriers and risks to inter-organisational working; the

requirement to align incentives and accountability; the need for the NHS to value service improvement approaches as well as randomised controlled trials; the necessity for clinicians to have managerial and leadership skills to effectively run inter-organisational projects; and, the necessity for senior management and corporate engagement.

These findings are supported by the existing literature, whilst also contributing to knowledge and understanding. The study aligns with the current direction of increased inter-organisational working within the NHS, and illustrates the benefits of working in this way. It demonstrates the fundamental role of clinicians (especially doctors) and patients when using this approach. The 'Practical Recommendations' offer clinicians and managers an opportunity to consider the key elements that determine the success of improvement initiatives spanning a whole pathway or health system.

Additionally, this study raises several new research questions and highlights some key recommendations such as: the need to agree the level at which NHS organisations can support inter-organisational working whilst remaining financially and competitively viable; the requirement urgently to review and revise training for doctors to ensure that in the future it equips them for effective participation in inter-organisational working; and the need to ensure the patient voice is focussed on enhancing quality of life through improvements in healthcare, rather than just simple redesign projects.

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Chapter 1

Introduction to the Study

Contextual Setting

The NHS is undergoing a period of rapid and radical change, with an increasing focus on delivery of high quality effective care across the whole patient pathway (DH, 2005a). This will require healthcare professionals to work and lead change across and between traditional service and organisational boundaries using collaborative partnerships (Vangen and Huxham, 2003). This study is designed to contribute to the knowledge and understanding of leadership of change across organisations, where traditional power, influence, accountability and authority patterns are different and complex (Plesk and Greenhalgh, 2001). It is anticipated that this study will substantially contribute to the professional knowledge about working across clinical professions, and contribute to the understanding of effective leadership across healthcare organisational boundaries. It specifically focuses on the clinical leadership and engagement required to lead successful inter-organisational change, with a specific focus on doctors. The aims are to identify the key characteristics and impact of effective clinical leadership when leading change across a patient pathway, which often includes several NHS organisations, and to contribute to the knowledge and understanding about inter-organisational leadership and engagement.

This study sits within the complexity of UK Healthcare (NHS, private and voluntary sectors), characterised by its frequently changing environment, policy context and organisational strategies. Leadership of change is a highly complex activity, involving an array of skills such as setting a direction and motivating and aligning people as described by Kotter (1999). Oshagbemi and Gill (2004) noted that within a single organisation or department, the hierarchical structure could provide the leader with the authority and influence through which changes can be achieved. Schein

(1997) demonstrates the relationship between leadership and culture, and highlights the influence a leader can have on creating culture. However, many improvement initiatives in the current healthcare system cross several organisations within a healthcare economy, resulting in the existence of multiple leaders and varied cultures. In the United States, a report from the Institute of Medicine (2003) identified poor co-ordination of healthcare provision as a key and growing weakness of current healthcare delivery. Influential health policy advisors and academics in the UK (Shortell, 1998, Ham, 2003, Spurgeon, 2001) have commented upon the importance for clinicians of developing leadership qualities and managerial skills, however there is limited evidence of what would create effective clinical leadership of change across healthcare organisations (Gittel et al. 2005). There is also limited significant robust evidence of what constitutes effective cross-organisational clinical leadership and engagement. The intention of this study is to contribute to the knowledge and understanding of these areas by examining a change project.

Political Context

Since the election of New Labour in 1997, the NHS has undergone several structural reforms, which have resulted in an alteration to the dynamics of leading and delivering change within UK Healthcare. The “NHS Plan” (DH, 2000) identified new requirements such as providing patients with more choice within their care needs and the provision of ‘seamless care’ from initial identification of a healthcare need through to the end of that episode of care. The Department of Health (DH) (2001) initiated a climate of devolvement within the NHS, which has in some areas resulted in fewer centrally imposed imperatives and policies. Building upon prior policies the DH (2003b) highlighted the need for cross-professional and cross-organisational working and delivery of care. This focus on delivery of effective care across the whole patient pathway, and the introduction of the choice agenda, has challenged traditional professional and organisational boundaries. The advent of Patient Choice

has been a central tenet of all recent policy directives. However, this policy is not clear. Debates about the definition of choice, the areas in which patients and carers want to have a choice and the likelihood that this policy will deliver better quality of care have been frequent. Following a consultation exercise the NHS Confederation (2003a) concluded that:

'for choice to deliver better quality of care there is a need for a culture change for professionals delivering the care. The patients' voice must be central to this, challenging clinicians to work in new ways, including leading change across organisational boundaries'.

In some health economies, policies such as "Health Reform in England: Update and Commissioning Framework" (DH, 2006a) have led to a small number of professional and organisational change projects across health economies. Despite anecdotal evidence of improvements to patient experience, there are very few published evaluations of these projects and their outcomes. It is therefore difficult to reach any reliable conclusions regarding their success in either implementation or sustainability.

Of significant importance to this study is "Our Health, Our Care, Our Say: a New Direction for Community Services" (DH, 2006b). Its imperative is that services will be more personalised, and that service users (for the purposes of this study "patient" and "service user" have the same meaning) will have a louder voice in driving appropriate service improvements. It provides a clear policy direction, promoting the development of partnership working, and ensuring that effective health and social provision is experienced across the patient pathway, rather than focusing on individual organisational elements of care.

Throughout all these changes, leadership, especially clinical leadership, has been recognised as a critical component for the success of cross-organisational change. There is evidence to demonstrate the link between clinical leadership and improved patient care (Shortell, 1998,

Spurgeon, 2001, Ham, 2003). However, after an extensive literature search and discussion with experts in the field, only limited knowledge, evidence or agreement within the UK healthcare system of exactly what constitutes clinical leadership and engagement when working across traditional organisational boundaries was found. Gittell (2005) supports this stating that within clinical networks there is limited evidence of what creates effective cross-boundary working. A core premise driving this work is that by gaining an understanding of what effective clinical leadership and engagement consists of, and sharing this understanding in a usable form, the findings of this study will be valuable across the NHS. This premise is supported by the rising importance of the policy direction of partnerships and a collaborative style of working, and patient and service user feedback, which demonstrate that this is a vital area to address in facilitating optimal patient experiences.

Study Location

This study is set within an existing project for which I am accountable. For the purposes of this thesis, I will refer to my workplace as the 'change project', and the research project as the 'study'.

I am the Director of a large change project in southeast London, which runs across four local NHS organisations and encompasses the private and voluntary sectors. I am accountable to the Chief Executives of the four NHS organisations. Two of these organisations are acute care hospitals, providing secondary and tertiary healthcare. The other two are Primary Care Trusts, which commission all services on behalf of their local population, in conjunction with the provision of primary, community and social care services. The vision for the change project is to realise profound change in three services (Renal, Stroke and Sexual Health). This is to be achieved by radically redesigning services across the whole patient pathway (across organisational boundaries), from prevention of the relevant disease process, throughout the whole patient's journey to

ensuring high quality end of life care where required. Achieving profound change in these services within the complex social and organisational environment in which they operate requires considerable creativity and flexibility of the service teams involved and of their relationships with the wider health system. As suggested by the DH (2005c), service users, patients and carers are fundamental to the process of redesigning the patient pathway across these services. Clinical engagement and leadership is also essential to gain the full commitment of all partners and the collaboration of non-statutory providers (such as the private and voluntary sectors) and to ensure sustainability of the changes (Ham, 2003).

Traditionally, health and social care has been delivered in functional silos related to specific organisations or even departments or services within an organisation. In some degree, this is due to the regulation of professionals, services and organisations as well as to how care has historically been delivered. Improvements or changes tend to be focused on a small element of the patient pathway. This is meaningless if a patient with a health problem has multiple, complex, interrelated health and psychological needs crossing service and organisational boundaries. Patients access their care either through elements of the pathway or across the whole pathway, and want to travel seamlessly and systematically through the process. Patients' journeys and thus their experiences are rarely of single services, departments or organisations. Patients require integrated care across healthcare boundaries (DH, 2004).

Over the last three years, the extensive service user feedback that the change project has obtained has identified that problems arise in relation to the linkages between the services or organisations (Holmes, 2006). This is specifically related to patients attempting to move across the pathway or those requiring referral to another service. In these cases, patients frequently experience poor communication, become lost in the system and receive conflicting clinical advice and information, which all

combine to create a poor experience. This study considers how clinicians (specifically doctors) working across organisational boundaries can enhance patient experience. The focus within this study is on doctors as clinical leaders. Whilst it is acknowledged that there is a growing professionalism in all healthcare professions, doctors are still highly regarded and powerful (Kenny and Adamson, 1992, Armstrong, 2002). To afford the change project the best chance of success, a significant focus on doctors as the main clinical leaders was taken. For the purposes of this study, therefore the term clinician largely relates to doctors.

Doctors from different parts of the healthcare system lead each of the projects for which I am accountable. They are responsible for leading the redesign of specific services across the patient pathway, rather than just within their own organisation. They all have a team to lead. Consequently, clinical engagement is crucial for the ownership and sustainability of redesign work (Spurgeon, 2001). The focus on the whole patient pathway can result in a fundamental change in the way or place that care is provided. This, in some cases, has resulted in the need for clinicians to pass work traditionally seen as 'their' responsibility to another organisation or sector. This is counter-cultural in terms of crossing professional and organisational boundaries, which have previously afforded clinicians security, status and, in some instances, financial gain and / or research opportunities. It can often result in low levels of engagement from clinical staff, which may negatively influence improvement or change initiatives.

This study is set in a real healthcare setting, which brings many complexities and ambiguities. Cultural differences are frequently experienced, as the study crosses four NHS organisations and the voluntary and private sectors. Different and diverse discourses and power bases exist between the different professional groups, organisations and patients. Changing services and behaviours takes significant time and energy, and is complex to embed. Additionally, to gain meaningful patient involvement requires creativity and flexibility. For example, the significant

confidentially issues that exist in the sexual health arena make patient engagement and involvement difficult to achieve.

This study focuses on doctors leading and delivering changes to specific patient pathways within the southeast London change project. It aims to contribute substantially to professional knowledge about leadership of cross-professional and cross-organisational change programmes. It has the potential to influence future change projects within the NHS, enhancing success and sustainability.

Clinical Leadership

When considering theories and models of leadership, including clinical leadership, it is necessary to attempt to define the term. At the Department of Health's Clinical Leadership Health Summit in February 2007, Andy Burnham (Minister of State for Quality and Patient Safety at the Department of Health) said (DH, 2007):

'Good leadership will be about people who inspire everybody else around them to take on the situation and make changes themselves'.

However, James (2007) comments:

'The concept of clinical leadership is particularly difficult to define as even professionals have different ideas on the meaning of the term'.

Edmonstone (2005) refers to Vance and Larson (2002) who argue that it is fruitless searching for one definition of leadership. Ford (2004, p387) suggests:

'There are as many (if not more) definitions of leadership as there are people who have attempted to define it...an acceptable universal definition of what leadership is continues to be problematic for both practitioners and academics'.

Looking at definitions of leadership in different contexts will help give a better understanding of its complexity and what good leadership is. It will also reveal any common factors. So, although the scope of this thesis does not permit a wide exploration, some key theories are considered.

One theory views leadership as a quality embodied by a charismatic or visionary individual (Weber, 1948, Alimo-Metcalfe and Lawler, 2001). This model has been criticised in the literature on leadership in the health services (Ford, 2004). Alimo-Metcalfe (2004) describes this model (of a distant, visionary, heroic, white male) as being mainly based on work conducted in commercial or military organisations (Alimo-Metcalfe and Alban-Metcalfe, 2003a), and therefore not relevant to the U.K in general. However, before the concept of charisma in leadership is dismissed, it must be noted that this phenomenon is not manifest solely in the individual (who may have a highly effective organisation working for him/her to help enhance this phenomenon). It also has to be attributed to him/her by the individuals and group/s who perceive this charisma. What is relevant for this study is that in all people seen as leaders, at whatever level, the followers must have faith in that person in order to be prepared to abandon or modify the old or take up the new (Alimo-Metcalfe, 1996).

Within the health service, leadership is often distinguished from management. For example, Edmonstone and Western (2002, p35) state:

'Management can be defined as the application of learning already in hand to address situations in which that learning is sufficient to meet the challenges. Leadership, by contrast, enables people and organisations to face adaptive challenges where new learning is required.'

Alimo-Metcalfe (1996, p26) puts it succinctly:

'Management is about producing a degree of predictability and order – leadership is about producing adaptive change, perhaps to a dramatic degree'.

These are relatively mechanistic, as leadership is also about the attitudes of the individuals given that responsibility.

It would be possible to present several more definitions of leadership from both the general and the health literature, but it is worth noting that the issue of clinical leadership is not considered very often (Cook and Leathard, 2004). However, it has been considered more frequently in recent years. What can be concluded is that, although leadership is a highly elusive concept (Alimo-Metcalfe and Lawler, 2001), leaders are people who work towards organisational and individual behavioural change through the use of their leadership skills, whereas managers are concerned with operational skills and competences. In addition, leadership is related to the specific context in which it is enacted (Pettigrew et al. 1991).

Alimo-Metcalfe and Lawler (2001) argue that the terms 'management' and 'leadership' are often used without distinction, and suggest that what is occurring is that old practices are simply getting a new label. A main issue for this study is to differentiate between those leaders or champions who are merely carrying out straightforward management tasks, and those whose tasks and behaviours show genuine leadership skills.

Many models of leadership are offered in the literature. Alimo-Metcalfe and Lawler (2001) acknowledge Weber's typology, which suggests three kinds of leaders: the rational-legal leader who is given leadership within the organisation because his or her qualities have been recognised as such; the charismatic type who one follows gladly because of something

irresistible in his or her personality; and finally, the traditional leader who has leadership conferred by virtue of holding a particular office (e.g. royalty or priesthood). These three models raise the issue of whether leadership skills are inherent or can be learned. The charismatic notion is most likely to be inherent, but the rational-legal model also allows for the potential of learning. The traditional also has scope for learning too, but it is not as central as in the rational-legal leader.

An alternative three-part model is offered by Beech (2002), who suggests trait, style and contingency theories of leadership. Trait theories advocate that there are particular characteristics in people that make them stand out as leaders (similar to Weber's charismatic model). Style theories suggest that groups perform more effectively with a democratic or supportive style of leadership. Contingency theories focus on circumstances and suggest that anyone can become an effective leader through learning from a situation. Thus, it is unclear whether leadership qualities are primarily intrinsic to the individual or essentially extrinsic (and can be developed by anyone), or whether people are born with a predisposition to leadership (and which need to be developed within them).

Clinical leadership operates within the statutory sector of the National Health Service. In a large comparative study of how senior managers in the private and public sectors construct the attributes for leadership, Alimo-Metcalfe and colleagues found that 98.9% of the notions expressed were identical (Alimo-Metcalfe, 2004, p395). However, while the most significant construct in the public sector was integrity, the private sector included six constructs based on the fair distribution of rewards - factors that were not applicable to the public sector. In addition, the study reported that public sector organisations tended to be more 'people-intensive' with intrinsic rewards (Alimo-Metcalfe, 2004, p396), and more focus on job development than in the private sector. The concept of giving service to others was also given greater emphasis in the public sector.

In another survey, Alimo-Metcalfe and Alban-Metcalfe (2003b) asked local government, NHS, education and other public sector workers, and those in the private sector, to score senior managers on a number of factors. Significantly for this study, managers were often found to be the most transformational leaders within an organisation, but could be blocked by those above them who were less willing to change. Interestingly, the least transformational group was not the chief executives or the board members, but the level immediately below - the directors and heads of service.

This raises the question of whether clinical leadership can be distinguished as something specific. Siriwardena (2006) suggests features that one could apply to other sectors of the health service, although he acknowledges the unique power of doctors. Research by Rippon and Monaghan (2001) does not address the distinction at all. Govier (2004) also takes it as a given, and Cook and Leathard (2004, p436) observe:

'Leadership literature has rarely addressed clinical leadership specifically or referred to the difficulties in characterizing effective clinical leaders'.

Cook (1990, p306) defines clinical leadership thus:

'A clinical leader has been defined as an "expert clinician, involved in providing direct clinical care, who influences others to improve the care they provide continuously".'

Whilst the work of clinicians is unique, if there is a unique distinction to be found, it is within the context. A suitably clear definition is offered by Edmonstone (2005, p7):

'Clinical leadership can best be described as leadership by clinicians of clinicians. Clinician in this context means all health

professionals, including doctors, nurses, midwives and allied health professions. Clinical leaders are those who still retain a clinical role, but at the same time take a significant part in direction-setting, resource management, motivation of colleagues, etc. It does not include clinicians who have become full-time managers (Wright et al. 2001). Leadership is therefore not something separate from clinical practice, but 'a continuous and everyday activity that is an explicit part of all senior clinical roles' (Detmer and Ford, 2001)'.

Fitzgerald and Ferlie, (2000) acknowledge that despite significant changes to the structures of the NHS (for example medical executive roles, clinical directorates etc), the historical power gap between doctors and other clinical professionals is the same or may have even got wider. Dopson et al. (2002) comment that doctors still have a higher degree of power and autonomy over their working practices and clinical decision-making. This power and autonomy can at times manifest itself through resistance to changes and service developments, which may be seen to affect current working practices (Dopson et al. 2003, Fitzgerald et al. 2002). These findings support the use of doctors as the key research participants in this study, as within the research setting doctors still hold a high degree of power and autonomy, so became the change projects leads. Dopson et al. (2002) comment on the role of opinion leaders to generate change. These can be both positive and negative in their contribution. Within the study setting, these opinion leaders were largely doctors who used their position of power to influence others. However, as noted by Buchanan et al. (2007b), clinical staff may be held back by a lack of skills such as influencing, resulting in a need to consider the development of these skills to enhance effectiveness. The development of learning organisations focussing on the enhanced skill and professional development beyond technical skills may offer a way forward (Fitzgerald, 1990).

Much of the literature referred to has focussed on the concept of transformational leadership, often in contradiction to transactional leadership (Alimo-Metcalfe, 1996, Alimo-Metcalfe and Alban-Metcalfe, 2003b, Alimo-Metcalfe and Lawler, 2001, Cook and Leathard, 2004, Edmonstone and Weston, 2002, Edmonstone, 2005, Hamlin, 2002). A succinct definition is offered by Edmonstone (2005, p9 -10):

'Transformational leadership is founded on the notion that innovative, inspirational and proactive leaders with the ability to motivate others to pursue high standards and long-term goals are needed to achieve the kinds of changes envisaged in the NHS Plan...It is claimed that transformational leaders recognise that in order to deliver high-quality patient care, an empowering culture needs to be created where communication, strong values (including a powerful belief in human potential), a tolerance for mistakes and mutual respect are paramount (Clegg, 2000). This is contrasted with transactional management, with an emphasis on planning, budgeting, organising and controlling in order to achieve goals.'

Thus, transformational leadership is not a set prescription. It demands particular skills, but it is a mindset - an attitudinal approach that is applied to a particular situation. It is about engaging with other people at all levels within the relevant organisation or segment. Knowledgeable leaders are required throughout multiple levels of organisations to deliver real change (Fitzgerald et al. 2007). Transformational leadership also requires flexibility and adaptability of behaviour and approach (Smith and Edmonstone, 2001). Although Edmonstone and Western (2002) caution against making a simplistic dichotomy between transformational and transactional leadership styles, it is important to point-out that there may be situations where it is more appropriate to adopt a varying emphasis between the two styles at any given time.

Within the NHS the core driver for change often comes from an external source (through government or its agencies). But, for the changes to take effect, these major drivers need to be broken down into small components, with the changes being made incrementally. Neath (2007) and Fitzgerald et al. (2007) argue strongly that whilst the support of senior management is essential, employees at all levels of an organisation need to take on leadership roles. Neath (2007) cites the example of new booking systems for patients in which the consultant's secretary may well be the leader for change rather than the consultant, and the latter then accepts the change when s/he sees the positive impact. Neath (2007) argues for subtlety and flexibility in order to recognise that, within a single organisation, what may have worked well as a method of change in one instance may not work in another. Buchanan et al. (2005) offer insights into factors effecting sustainability such as strong and persistent leadership to set a vision and goals, cultural aspects such as shared beliefs and values, stakeholder management and influence, and credible and feasible managerial plans. These factors influence the sustainability of a change project.

The influence of context in which a change process is occurring is important and affects diffusion success (Fitzgerald et al. 2002). So, for change to occur, the planning must be context-sensitive (Fitzgerald et al. 2003), both historically and situationally, and be customised, to operate through:

'.....consensus and persuasion, rather than through hierarchy and power'. (Fitzgerald et al. 2003, P226).

For Buchanan and Fitzgerald (2007a), context has three dimensions: context internal to the organisation, the external context of the relevant forces which are creating the demand for change, and the context of past and current events. Successful change comes through contextualisation and adaptation for each instance where a particular change is needed, even within one organisation (Buchanan and Fitzgerald, 2007c). It is

through this process that change can become embedded, can become the new norm and can thus be sustained. Buchanan and Fitzgerald (2007a) also give instances in which sustainability may not necessarily be a good thing: existing practices or procedure could become obsolete, current practices could block more significant developments or existing practices could prevent staff from gaining valuable new skills.

Thus, transformational leadership cannot be seen simply as a means of approach for a discrete period of time, it is a whole attitude to work that needs to be embraced by all staff at all levels. It demands a high level of mutual trust and respect and a willingness to put in the time and energy to remain flexible and open to innovation. It requires regular critical appraisal and honesty, but in a way that is seen to help improve the end product (in the context of this study, better services for patients). All this can occur only if staff believe that it is also good for the organisation, and if employees at all levels feel a positive identity with the organisation.

Inter-organisational Clinical Leadership and Engagement – Key Themes

Patients encounter reduced quality of care and poor experiences when their journey crosses traditional hierarchical NHS organisational boundaries (Holmes, 2006). In contrast, clinicians are employed by a single organisation and are therefore accountable to that organisation. This causes an inherent tension as the patients' focus is the journey they take, whereas the clinicians' focus is on their particular service or department located within one organisation, making up just a small element of the patients' journey.

This study reviews the working practices and impact of thirty doctors working within a large cross-organisational healthcare change project. The change project is focussed on improving the whole patient journey. The project has been organic in nature, using formative feedback to learn

from effective changes, whilst incorporating the insights created from mistakes. Within each of the projects, doctors are discovering innovative ways of working outside their traditional organisational boundaries and accountabilities.

'Practical Recommendations' developed by drawing on the key findings and learning from this study have been disseminated widely across the UK healthcare system. Dissemination has been achieved through different methods to ensure maximum impact from this work. This has facilitated the spread of learning and supported its practical application. In addition, the learning has been applied to my own change project.

My Authority and Role

I believe my achievements to date demonstrate that I have significant healthcare experience, knowledge and authority, which enabled me to undertake this piece of work. This is supported by my appointment as Director of the Modernisation Initiative. My impact upon this work is evidenced from the radical improvements that have been implemented with great effect across the three pathways. These are available on the change project's web-site (<http://www.modernisation-initiative.net/>).

Prior to this role, I worked for a national organisation focussed on continuous quality improvement and leadership. The skills and competencies I gained from this experience facilitate my leading the change project and this doctoral study. I aspire to a transformational leadership style (Storey, 2004), attempting to empower all staff, including clinicians, to personally lead and deliver the change projects. I endeavour to provide a clear vision and have the relevant service innovation and improvement skills to ensure outcomes are achieved. The combination of my leadership knowledge and experience, particularly having led a national clinical leadership programme, and my clinical background

provide me with the requisite credibility and knowledge to lead this study and position me as a recognised improvement expert.

Chapter 2

Study Aims, Objectives and Literature Review

Aims and Objectives – Inter-organisational Clinical Leadership and Engagement

The aims of this study are to identify the characteristics and impact of effective clinical leadership and engagement when working across organisational and professional boundaries, and to contribute to the knowledge and understanding about inter-organisational leadership and engagement. The study has a focus on patient pathways and journeys.

The objectives are:

- To critically analyse clinical leadership, engagement and team effectiveness within two change projects, cutting across organisational and professional boundaries
- To explore the characteristics and impact of effective clinical leadership, engagement and team effectiveness across organisational boundaries following specific patient pathways.
- To analyse and explore the characteristics and impact through a team effectiveness questionnaire, focus groups and semi-structured interviews
- To develop 'Practical Recommendations' which can be disseminated widely across the UK healthcare system

The key considerations and therefore boundaries of the study are summarised in Appendix 1.

The research questions are:

- What are the identifiable characteristics and impact of effective clinical leadership, clinical engagement and team effectiveness when working across organisational and professional boundaries?

- Can ‘Practical Recommendations’ be developed that contribute to learning and understanding to enable clinicians and healthcare managers to work effectively across healthcare organisational and professional boundaries?

Literature Review

This review is based on the research questions and aims, and is intended to identify the evidence and literature pertaining to their key themes, resulting in a comprehensive view of the available knowledge. It uses a diverse range of themes, as this is essential in considering the research questions in depth and in justifying the study approach. The literature review considers: the policy context; the role and influence of national policy and politics; the evidence for clinical leadership and engagement; a focus on patient pathways and journeys; the inter-organisational clinical leadership and engagement literature; team effectiveness thinking; the issue of accountability; and, the concept of patient involvement, engagement and empowerment. This review has shaped and influenced the study through a process of integration, synthesis and critique.

Search Methodology

According to Polit and Hungler (1997), the term “literature review” refers to the activities involved in identifying and searching for information on a topic, and developing a comprehensive picture of the state of the knowledge of that topic. In order to review the literature for this study, a three stage process was undertaken over a two year period, starting at the inception of the original idea.

Initially, an extensive literature search was conducted using diverse internet databases such as Cochrane, Medline, Emerald, EBSCO Business and Health Management, BMJ, Clinical Governance Support Team, King’s Fund, National Electronic Library for Health and the

Middlesex University Long Distance Library. The key search words were clinical leadership; clinical engagement; team effectiveness; inter-organisational working; and, cross-organisational working. This search provided a wide range of articles and resources. The analysis of the review was influenced by Greenhalgh's (1997a) and Groves and Addasi's (2004) frameworks for reading scientific papers.

The next stage was to focus the search on the wide range of available resources by debating, discussing and analysing the material with networks and relevant experts including: my formal community of practice (specialists working in relevant fields); informal networks (national and local); colleagues with academic and research expertise; and, acknowledged experts within relevant fields.

The final stage entailed taking a systematic approach to all the evidence collected. The material was synthesised by combining my tacit knowledge (Eraut, 2000) and considering Greenhalgh's (2001) advice on searching the literature and reviewing the research questions. Finally, a review of the quality of the journals was undertaken (<http://www.harzing.com>), and Greenhalgh's (1997b) guidance on the judgement of the methodological quality of a paper considered. This literature was integrated with other sources, for example, practice based evidence and grey literature such as policy documents, editorials and opinion papers (Eraut, 1997). Eraut (2000) advocates the importance of integrating multiple forms of knowledge, including non-formal learning. For example, tacit knowledge, which is less formalised, documented, and often unspoken, frequently forms the basis of how things actually happen within organisations and is therefore important to consider. An attempt was also made to achieve a balance between quantitative and qualitative literature as recommended by Mays and Pope (1995) and Greenhalgh and Taylor (1997). It is also important to recognise that the types of literature that are useful in change management may differ considerably from the scientific evidence that underpins clinical or technological knowledge growth. When researching change management, the research approaches should

capture the emergent nature and process of the change, rather than purely focussing on outcomes (Iles and Sutherland, 2001).

National Policy and Political Context

Policy documents from 1997 reveal that the first five years of the Labour government focussed on strengthening the command and control structure of the NHS (Klein, 2006a). This era also saw the beginning of the development of the modernisation agenda with the launch of the “NHS Plan” (DH, 2000). This raised ideas such as provision of Patient Choice and seamless care across organisational boundaries. During this period, there was also a growth in targets, National Service Frameworks and performance indicators. There was at the time a controversial perception that this would hinder quality and delivery of care, with the NHS Confederation (an influential national organisation) commenting that *‘there are too many targets that overburden the system and are set in a way that does not encourage local ownership and innovation’* (NHS Confederation, 2003b).

By 2002, policy had moved towards a decentralised and devolutionary model, with a focus on the power sitting locally and the development of collaborative partnerships and patient-led services (DH, 2001). In 2005, the DH (2005c), stated that incentives would replace commands, and a self-improving NHS would be driven by Patient Choice, money following the patient and competition amongst a diversity of providers. Klein (2006b) is critical of this, commenting that in reality, the NHS is now a combination of some remains of a command and control system, elements of devolution and local accountability, variable market competition and limited patient leadership.

In 2005, there was a shift to a focus on commissioning (DH, 2005a). The premise was that expert, imaginative and creative commissioning is central to the development of a patient-led NHS. Significant changes to the organisation of primary care trusts were central to the creation of this

vision. There is however, a fundamental flaw in the execution as stated by the NHS Confederation (2006). The policy defines the structures of organisations before defining their purpose. It is essential for the new Primary Care Trusts to be able to deliver adaptable, flexible services and functions. Defining the structures ultimately limits their ability to achieve the vision. It also inhibits the collaborations and partnership aspired to by many of the latest policy documents (DH, 2006b). This policy declares a focus on developing and promoting partnership working and on delivering effective health and social provision for the public across a whole patient pathway rather than within a single element thereof.

The policy context supporting the need for this study is apparent in the many documents. Latterly, the “Health Reform in England: Update and Commissioning Framework” clearly articulates the benefits of reform for staff by suggesting staff will have (DH, 2006a, p8):

‘a greater ability to work collaboratively across the clinical divides to construct care pathways around the individual needs of patients; and more scope for clinical leadership and engagement for nurses, midwives, GPs, consultants and other health professionals to shape services’.

Many policies claim to support increased collaboration and partnerships, thus suggesting an increased need for clinical inter-organisational working. However, there are tensions in the confused array of different approaches. This becomes evident when attempting implementation at a local level. Economically for example, the current implementation of payment by results (where money directly follows the patient) is in many cases a disincentive for acute hospitals to work in collaboration or partnership with their local primary care trusts (Jones, 2006). Patients require integrated care across organisational boundaries (DH, 2004) and in fact, Mann et al (2004) commented that partnership working has become a fundamental part of everyday work for many healthcare professions. However Klein (2006a) points out that reform has been more

complex than the government anticipated, the speed of improvement in performance is less than was anticipated from the enhanced investment in monetary terms, and the performance gap between good performers and poor performers is widening.

Conclusion - National Policy and Political Context

To summarise, Labour policy has attempted a move from a centralised command and control approach to a devolutionary style with a focus on partnership working and delivery of effective care across the whole patient pathway (DH, 2001). This move suggests the need for more inter-organisational clinical working, and is clear justification for this study.

It is also important to consider the apparent tension in current government policy. The contradictory nature of some policies may hinder or even act as positive disincentives to partnership working, collaborations and cross-organisational working, and even in some cases promoting inter-organisational competition (Jones, 2006). The result is a reduction in the incentives for inter-organisational working.

Clinical Leadership and Engagement

Clinical leadership and engagement are seen throughout the majority of the Department of Health's recent publications as central to the modernisation agenda (DH, 2006a). There also appears to be a growing literature base on clinical / medical leadership and engagement (Spurgeon, 2001). This is supported by experts such as Ham (2003) who see leadership by doctors and other clinical staff as vital if the performance of the NHS is to improve. Other authors also share the view of the positive association between effective clinical leadership and improved patient care (Shortell, 1998, Spurgeon, 2001, Ham, 2003). The literature reviewed pertained to all clinicians, but with a specific focus on doctors, as the focus of this study is on doctors as clinical leaders (Kenny and Adamson, 1992, Armstrong, 2002).

This raises the question of the meaning of leadership. Alimo-Metcalfe and Alban-Metcalfe's (2003, p1) define it as:

'about ensuring that high standards of performance are achieved, but that at the same time motivation, satisfaction and commitment are sustained'.

Kotter (1999) suggests that management is about dealing with complexity, whilst leadership is about managing change. The greater the rate of change, the more leadership is required, including setting a direction, aligning people, motivating, and inspiring others. In relation to clinical leadership, Malby (1998) commented that there was nothing particularly different about clinical leadership, except that the context in which it is being enacted is a clinical one. If taking this view, the clinical leadership role is like any other, incorporating expertise such as creating an impelling vision, inspiring others to follow, influencing, securing and managing resources, planning, and implementation. However, when leadership is considered through the framework of what clinical leaders are required to deliver, such as radically redesigned services, improving the efficiency of services, constructing care pathways around the individual needs of patients, as described by the DH (2006a), the challenges are quite significant and comprise a considerable extension to the traditional view of the leadership role.

In addition, there appear to be differing and contradictory views of what is expected of clinical leaders throughout the NHS. For example, Alimo-Metcalfe and Alban-Metcalfe (2004) postulate that an effective leader is self-aware, shows genuine concern for others and can negotiate well, and that most leaders and followers would see these as significant and important characteristics. However, this raises the question of whether clinical leaders are expected to be able to lead on more managerial tasks such as the creation of a business case, undertaking activity and financial modelling and working across organisational boundaries? Is this a

general management role or a clinical one? Harris (2006) debates whether the focus of clinical leadership should be on vision setting and leading the clinical process, or on more traditional management tasks and activities.

The main aim of the majority of current NHS reforms is to improve clinical service provision. According to Harris (2006), this implies clinical leaders need to extend their focus from solely clinical skills, to the development of a wider range of skills. These include financial management, service redesign and health care improvement skills as described by Ham (2003). This will require a significant change in the training of doctors at both undergraduate and postgraduate level (Harris, 2006, Ham, 2003). Ferlie (2005) states that the development of clinicians must be clearly based on research in order to have the desired effect. In turn, this will require greater integration between medical development and research departments. Spurgeon (2001) concurs with this premise, whilst also acknowledging that there is much congruence between managers' and clinicians' views of what the training should encompass. Shortell (2002) comments that to get individual as well as organisational benefits, the development must be focussed on organisational development and change for performance improvement, rather than individual career development. Whilst all these views make logical sense, they differ considerably from current approaches and offer significant challenges in delivery. The gap between the current and desired clinical leadership development is significant and will take considerable time to implement, however these changes are currently under discussion.

Engagement is a two-way process between two or more people. It involves feedback and disclosure between individuals and is frequently built on trust. Clinical engagement has been clearly recognised as a critical feature in radically redesigning the NHS. At the beginning of the national drive for modernisation, Bowns and McNulty (1999) demonstrated at the Leicester Royal Infirmary re-engineering project that clinical leadership and engagement was essential. Ham (2003) suggests

the goal of all redesign and improvement must be to create an improvement in the experience and outcomes for patients. To gain this benefit, a change in clinicians' everyday practice and behaviours is required, such as the involvement of patients in projects. It therefore is important to understand what motivates clinicians. Graham and Steele (2001) propose findings from across the UK that show that offering high standards of service in a timely and considerate way are the key motivators for the majority of clinicians. Ham (2003) suggests that engaging clinicians around these motivators will deliver greater results than top down control policies and dictates. Clinicians need to be supported to become engaged and thus to drive and lead the change. Ham (2003) also acknowledges that clinicians need to gain a better understanding and appreciation of the reality of the NHS, such as rising public expectations in the limited financial climate, and the need for a dramatic reduction in the variation of clinical practice and outcomes.

A key consideration when exploring clinical leadership is the power and autonomy historically invested in medical clinicians (Spurgeon, 2001, Armstrong, 2002). This has allowed doctors significant control over their own and others' actions (Ham, 2003), and has resulted in unique accountability features. In promoting the development of more clinical leadership and engagement in transformational change projects, there is a need to consider the relationship between management, policy and clinicians. Spurgeon (2001) remarks that there is a requirement to identify the added value clinical leaders can and should bring to the process. A central element of this added value is influence and peer pressure on other clinicians to expedite change in and across boundaries. Ham (2003) advocates the creation of a culture that offers incentives and motivators for clinicians, whilst also ensuring delivery of the reform agenda.

The literature suggests there is a strong link between leadership and successful transformational change. Leban and Zulauf (2004) suggest that transformational leaders of projects are constantly rated by followers as being more effective leaders, demonstrating greater organisational

performance and success. Gillespie and Mann (2004) postulate that a transformational leadership style and shared decision making promote greater trust within a team and with followers. Alimo-Metcalfe and Alban-Metcalfe (2000) state that the model of transformational leadership is as important for clinicians as it is for NHS managers. Empowering, supportive and facilitative leadership can allow people the space and time and give them the skills to become creative change managers, thus allowing the delivery of radical, second order change (Iles and Cranfield, 2004). Goldratt (1990) states that any improvement is a change, not every change is an improvement but we cannot improve anything unless we change it. He asserts that change can be, and often is, perceived as a security threat to individuals. This is significant for clinicians who may see a change in their status, income or research niche resulting from changes to service delivery. However, Bass (1985) noted that strong transformational leadership could support the emotional cost of this change.

Conclusion - Clinical Leadership and Engagement

Clearly clinical leadership and engagement are currently seen as important, as demonstrated by the increased focus within the policy arena and by the growth in literature demonstrating the positive impact of effective clinical leadership and engagement (Ham, 2003 and DH, 2006a). Clinical leadership is complex, with a diversity of views amongst authors of what is expected of clinical leaders, especially in relation to more managerial tasks. There is a clear focus within policy on improving clinical service provision, which seems to suggest a requirement for clinicians to develop a more diverse skill set to be able to deliver radical redesign of the patient pathway and cross-organisational change (Harris, 2006). This is, however, a challenge, as it requires significant change to the philosophy and delivery of medical training.

Understanding and aligning incentives for clinicians is vital for successful engagement. This theme is fundamental to this study, as the evidence

indicates that clinicians do want to modernise and redesign services, but within their control and in their own way. Power and autonomy are important to them (Ham, 2003). There is a need to identify the added value that they bring to increase the success rate of changes across organisational boundaries.

This focus on clinical leadership and engagement is important as the literature, discussion with experts, grey evidence and experience of working within this area imply that there is a need for clinical leadership and engagement to gain effective inter-organisational change. Furthermore, the increasing emphasis in health policy on partnership and collaborative working (DH 2006a), highlights the need to improve the understanding within a healthcare context of exactly what constitutes effective cross-organisational working. The NHS system is not made up of simple linear cause and effect interactions, but of complex networks of interrelationships (Senge, 1990b). If the knowledge base of clinical leadership and engagement in this area is enhanced, patient experience and quality of care may improve as described by the DH (2004).

Consideration of the Patient Pathway and Journey

A fundamental issue in healthcare is the co-ordination of care across the whole pathway (Gittell et al. 2005). This is seen as a concern to clinicians, patients and their carers and families. Kenagy et al (1999) reveal how patients experience their medical journey from pre-diagnosis to treatment. Many highlight the existence of fragmented loosely connected and poorly communicating providers offering uncoordinated elements of the care. The Institute of Medicine published a report in 2003 clearly identifying poor co-ordination of healthcare as a weakness of healthcare systems. Audet et al (2005) also emphasise that the issues most frequently reported by clinicians as reducing the effectiveness of care are those that arise from problems with co-ordination.

Within the UK, healthcare has historically been provided by separate organisations and services, under the umbrella of the NHS. These organisations and services, and the individuals working within them, have been focussed on the particular part of the patient pathway or journey for which they are held accountable. Incentives, performance management, and targets have, until some recent policy changes, primarily focussed on delivery within a small element of the pathway, with limited consideration of the interconnections. Recent policies have sought to redress this (DH, 2005b and DH 2005d). In fact, the DH (2006a) claims the outcome will be increased opportunities for clinicians to work across organisational and clinical boundaries, thus producing care pathways based on individual patient's needs.

This move towards a patient pathway focus does have an impact on clinicians' work, behaviour and rewards. For example, redesign and reconfiguration of services may involve doctors having to give up elements of their work, responsibility and accountabilities, creating new professional and organisational boundaries, and accountabilities. The old historic boundaries and accountability infrastructures may have provided clinicians with security, status, and financial gain and essential research platforms and opportunities (Spurgeon, 2001, Ham, 2003). Graham and Steele (2001) however, comment that what primarily motivates clinicians is the aspiration to deliver a high quality, timely, efficient and considerate healthcare experience. Ham (2003) suggests that strategies that profit from these motivations are more likely to succeed. Additionally, allowing clinicians to drive the changes rather than being driven by others will hold a higher potential for success.

Conclusion - Consideration of the Patient Pathway and Journey

There is consensus across the literature from clinicians, patients and carers that effective co-ordination of care is fundamental to the provision of effective care. There is robust evidence of problems arising from uncoordinated care resulting in poor quality of care (Gittell et al. 2005).

The majority of recent policy initiatives have focussed on patient pathways and the connections between organisations (DH, 2005b, DH, 2005d). This suggests a need for a change in clinicians' work, behaviour, leadership and incentives. This change is, however, complex to achieve, and potentially means significant alterations to individuals' jobs and status. The literature concludes that there is a need to align the motivators and incentives for the changes to be successful (Ham, 2003).

The literature and recent policy directives (DH, 2005b, DH 2005d, DH 2006a) indicate that there is a need to consider the patient pathway and journey. However, there is little indication in the literature on how to achieve this successfully.

Inter-organisational Clinical Leadership, Collaborations and Partnerships

Vangen and Huxham (2003, p61) suggest that:

'a key policy driver for collaboration appears to be a perceived need for service provision to be co-ordinated, sometimes deriving from a focus on efficiency and sometimes from a concern to improve the seamlessness of the service to the citizen'.

They recommend that the development of inter-organisational clinical collaborative working should have the potential to improve the integration of care provision by enabling clinicians to identify the gaps and inefficiencies in services across NHS organisations as experienced by patients. The collaboration itself can be advantageous as outcomes can be achieved which would not be feasible by one individual or organisation alone (Vangen and Huxham 2003). Franz (2005) builds upon this thinking, stating that:

'partnerships can enhance individual and organisational success through more effective problem solving and improved adaptation to

change. Working in partnerships is difficult and often requires learning for successful collaborations’.

Despite these seemingly logical ideas, there are limited examples of clinicians working effectively across organisational boundaries, and the resultant outcomes.

The National Co-ordinating Centre for NHS Service Delivery and Organisation Research & Development (NCCSDO) report (2005b) offers various interesting insights into inter-organisational working. It states that highly centralised and bureaucratic organisational forms do not perform well in rapidly changing environments. With the volume and speed of change currently occurring in the NHS, inter-organisational working and networks potentially offer a new delivery model. The report highlights that professional engagement and leadership is critical if attempting to implement change and sustain the outcome. This resonates with Garside (1998), who comments on how individuals can, for many reasons, attempt to disrupt the sustainability of a change. These reasons include lack of engagement from the beginning of the change process, poor trust, a lack of understanding of the need for or benefits of the change or personal concerns driven by potential perceived losses. However, the NCCSDO (2005b) and Kamensky and Burlin (2004) strongly recommend that new ways of working in healthcare are needed.

Senge (1990b) suggests that for organisations and individuals to learn, there needs to be a new type of leadership, which entails new leadership skills. For example, building a shared vision by the bringing together of multiple stakeholder views; seeing interrelationships not just the processes; being interested in building new interrelationships and networks; being able to learn from mistakes and not to lay blame; and, focussing on areas which deliver high leverage. Combined with a clear focus on the desired result of improving the patient experience and outcomes, these new leadership skills are fundamentally different in character compared to the historic leader as a charismatic decision

maker. As Senge (1990b) postulates, they require a surfacing and rethinking of mental models and ways of doing things. In support of this, the evidence clearly shows that patients feel the current piecemeal approach to service and information provision is inadequate (Holmes, 2006).

Huxham and Vangen (2000) suggest that collaborations require honesty and openness, building of trust, development of mutual understandings and a belief in the development and delivery of joint goals. This suggests a transformational, emotionally intelligent leadership style. In support of this, Freshman and Rubino (2004) advocate the inclusion of emotional intelligence as described by Goleman (1999) within strategic training programmes. Their premise is that professional staff require these vital skills to develop robust and useful social networks within and across healthcare organisations.

Examining the evidence about inter-organisational change identifies practical elements for consideration. Kotter (1995) comments on the need to remove obstacles to promoting and implementing the new vision. These can be extremely diverse, such as narrow job roles, procedural barriers to getting decisions made, people personally blocking the change and ineffective communication. Porter (1980) postulates the need to understand the complexity of the environment, before potential options can be deliberated. All these issues need considered attention when undertaking cross-organisational and professional working. Building on this, Sirkin et al (2005) explored the concept of effort, claiming that if an individual's workload increases more than 10 per cent because of any change initiative, they are likely to experience difficulties. Most dedicated doctors are working beyond what is formally expected within their job description (Royal College of Physicians, 2004). It is imperative therefore, that for inter-organisational working to be successful, appropriate time and resources are provided, allowing clinicians to create the space in their current roles. The literature offers other potential solutions such as hybrid roles spanning clinical and managerial tasks and cross-

organisational operational issues (NCCSDO, 2006) and boundary spanning roles (Gittell et al. 2005). The NCCSDO report (2005a, p9) describes boundary spanners as '*individuals who work in the middle ground between different agencies holding an authorised role in managing inter-organisational relations*'. Both of these options offer potential bridging roles, co-ordinating information and building networks. There is still, however, limited evidence of these roles in action and the resultant outcomes.

Working across professional boundaries and inter-professional relationships are also key considerations of intra-organisational working. Ferlie et al (2005) commented that inter-professional relationships are hindered by social boundaries which are '*created by well developed professional roles, identities and traditional work practices*' and cognitive boundaries which are underpinned by different research traditions and knowledge bases. Reeves and Lewin's (2004) research concurs with this, describing inter-professional relationships as fragmented in terms of service provision, which adds to the sense of internal division and lack of co-ordination experienced by service users. Goodwin et al (2004) state that for mandated clinical networks to succeed in working across professional and organisational boundaries, the priorities, incentives and drivers need to align with the clinical professionals. They raise a possible danger, however, of clinical professionals especially doctors, potentially becoming so powerful that they use the network for their own ends and gain. To counter this, Bate and Robert (2002), who studied NHS collaboratives and networks, suggest that to be successful, it is fundamental that projects have the support of senior management and other senior clinical colleagues, and wider support across other organisational staff. Additionally, clear lines of management authority to support projects are required (Kamensky and Burlin, 2004).

Within the literature of collaborations, partnerships and cross-boundary working, the issue of dispersed leadership arises (Ray et al. 2004). The NCCSDO report (2006), comments on the increasing evidence base

suggesting that effective change projects in healthcare depend on collective or dispersed leadership. There is an implication that hierarchical leadership does not work in these settings, but flatter, networked, matrix and dispersed leadership models offer further potential and are more receptive and proactive in change projects. Whilst this is a laudable goal, the reality of the current situation in most change initiatives within the health service is that the individual clinicians or other healthcare professionals remain employed by their existing organisations and thus remain largely answerable to their existing hierarchies. There is little evidence of a change in managerial or formal accountability lines. Additionally, dispersed leadership can lead to confusion where a follower has more than one leader and has to decide on competing priorities. Members of staff being employed by different organisations further adds to this uncertainty. Oertig and Buergi (2006), add to the debate by suggesting that in cross-cultural teams there is a need to choose creative leaders, who can lead through a collaborative leadership style, exhibiting exceptional communications skills and an ability to influence rather than manage.

Conclusion - Inter-organisational Clinical Leadership, Collaborations and Partnerships

A key driver for collaborations and partnerships is the desire to improve the integration and co-ordination of service provision (Vengen and Huxham, 2003). There is, nonetheless, a dearth in the literature of concrete examples of how clinical collaborations and working in partnerships across organisational boundaries deliver effective change. This supports the setting of this study in a real world inter-organisational transformational project delivering actual effective changes.

Inter-organisational working and networks are seen as effective in delivering the changes needed in the NHS. Professional leadership and engagement are imperative to achieving and sustaining change. Adopting these approaches requires doctors to develop a new leadership style and

skills including emotional intelligence (Goleman, 1999). These skills are noted to be essential when working across organisational and professional boundaries (Gittell et al. 2005). This study gives an opportunity to test this thinking, and to attempt to identify what kind of leader is required to lead effective change across organisational and professional boundaries.

There are practical issues that key writers suggest require consideration when working across organisational boundaries (Porter, 1980, Kotter, 1995). New roles and models are offered as solutions, but there is a gap in the knowledge base regarding these roles in action and the results that have or can be achieved by having them (NCCSDO, 2006).

The literature suggests that inter-professional relationships are affected by social boundaries (Ferlie et al. 2005). Incentives and drivers should align to clinical professionals' motivators, but this is countered by the danger of powerful positions being abused. Finally, dispersed leadership as a new model with differing accountabilities is offered to promote inter-organisational working, offering flatter organisational structures with greater trust and democratic leadership (Ray et al. 2004). There is, however, no evidence of actual changes in managerial or formal accountability lines occurring. This leaves unanswered the question of whether it has an influence on the success of inter-organisational projects.

Team Effectiveness and Accountability

Wheelan (1999) stated that a work group becomes a team when shared goals and the methods to achieve those goals are in place. Therefore, all members of the team must understand the purpose of the team, the team's role and their own sphere of activity within it. Building on this, Stokes (1994) states that if the collective team and individual roles are ignored, and individuals take a single functional role, the team simply becomes a group of individuals working independently. Wheelan (1999)

concur by noting that members of high performing effective teams feel involved, committed and valued and they deliver results. Shortell et al (2004) shows that the optimal size of an effective team is 10 to 13 members, although this is not supported in other studies.

Effectiveness is how well a team achieves its purpose and is dependent on a number of dimensions. For example, Moxon (1993) claims the team's individual and collective attributes are fundamental to effectiveness. However, Blanchard et al (1990), describe the essential characteristics of a high performing team as purpose, empowerment, relationships, communication and flexibility. The majority of the literature supports Blanchard et al's (1990) premise that high performing teams are seen to be extremely effective. However, in relation to this study, it is important to note that some evidence suggests that to achieve effective teams, team commitment is essential (Maddox, 1998, Wheelan, 1999).

Belbin (2004) describes the characteristics of nine team roles and advocates that an effective team must contain a balance of all nine roles. His research shows that a team of people, whose strengths lie in difference rather than similarity, consistently outperform other teams. This is however, an approach based on ideal types. In reality, it is difficult to find and create the perfectly balanced team. Frequently teams are self-selected or are randomly created and individuals have to attempt to adapt in an effort to be effective. Additionally, in contemporary working life, people frequently belong to many different teams and membership is often transitory (Glanfield, 2006) and should be viewed as loosely connected networks rather than teams (Gittell et al. 2005).

Lave and Wenger (1991) warn there is a danger that some professional groupings which become communities, can become controlling and dysfunctional therefore creating substantial barriers to change. However, Wenger (1998) postulates that teams learn from social interaction and being part of a community. These communities create trust and understanding, which enable a team to be more effective. Eraut (2000)

comments that the socialisation process within teams or networks provides a rich environment to learn and gain new knowledge and this can influence behaviour.

Shortell et al (2004) identified a dearth of robust evidence of what made teams working in healthcare effective or highly performing. His study showed that three key features were evident in teams that are more effective. These were: the presence of a champion (an advocate who supports the cause); the proactive taking of more actions to improve care; and, having a focus on satisfying patients. It should be noted that the limitation of this study is that the teams volunteered to be part of the process. This suggests that the teams may have been more motivated to make the changes anyway. However, the focus on patients as a determinant of team effectiveness is supported by the Institute of Medicine (2003), which promotes patient centredness as a vital value of change teams. Patient centredness includes assessing patients' needs and expectations, using patient data to improve services and incorporating patients' expectations when designing new services. These studies do not however address the issue of whether healthcare teams are purely motivated by the focus on patients or other rewards or incentives.

Collins (1991) comments that reward systems are important to attract and motivate individuals, and to achieve team commitment and effectiveness. Kessler (1993) states that there is limited evidence of enhanced motivation or performance seen with group performance pay schemes. Chaix-Couturier et al (2000) observe that financial incentives can be used to improve individual clinician's behaviours and thus outcomes. There is however, a scarcity of evidence of what motivates groups of clinicians to work effectively in teams. Other factors that may be responsible for motivating clinicians are status, the patient voice, healthy rivalry, inter-organisational or inter-speciality competition and wider system incentives (Ham, 2003).

Accountability is also relevant to both team effectiveness and leadership behaviour. Connors and Smith (1999) offer a model considering four different levels of an organisation's workings. These levels are results, actions, beliefs and experiences. They argue that unless the experience is changed, the results stay the same. The premise is that by aligning experience and beliefs with the desired action, personal and organisational effectiveness is increased. This change can be achieved by creating a culture of accountability. Connors et al (2004, p47) define accountability as:

'a personal choice to rise above one's circumstances and demonstrate the ownership necessary for achieving desired results – to see it, to own it, solve it and do it'

This demonstrates the need to consider the link between accountability and the alignment of incentives in relation to inter-organisational working.

The issue of accountability in relation to doctors is unique. Spurgeon (2001) and Ham (2003) both comment that when analysing clinical leadership, the power and autonomy historically invested in doctors has resulted in them having significant control over their own and others' actions. This has considerable accountability implications. Spurgeon (2001) comments that doctors frequently enjoy a high status, are seen as experts and have a significant degree of autonomy, which is frequently endorsed and legitimised by the public. He also refers to how many changes to policy and practice have attempted to level the balance with healthcare managers and other professionals. A recent policy example is the "Consultant Contract" (DH, 2003a). Ham (2003) adds to this thinking suggesting that there is a need to create equilibrium between autonomy and accountability. There is currently no clarity regarding doctors' professional accountability, and if and how this could be changed in cross-organisational working. With the recent use in the public domain of clinical performance data, there has been an evident growth in peer and self-accountability. The literature fails to reach consensus on the following

question: if an attempt were to be made to change accountability, what would be the incentives and motivators for doctors? What holds doctors to account? There is currently a multitude of potential options such as the comparative use of patient data, but little evidence offering definitive answers. Ham (2003) also highlights the paucity of evidence connecting clinical accountability to managerial and organisational accountability. A final uncertainty in the literature is what constitutes the link for clinicians between accountability, identity and status?

Conclusion – Team Effectiveness and Accountability

The evidence concerning what constitutes a highly performing team is relatively uncontentious (Stokes, 1994, Wheelan, 1999). In relation to team effectiveness, however the evidence is less clear (Blanchard et al. 1990, Moxham, 2003). For this study, it is important to consider the characteristics of highly performing teams, team commitment and optimal size.

There is little in the literature indicating what makes teams effective in healthcare, or what specific rewards may motivate clinical teams (Shortell et al. 2004). A clear focus on the patient is one area where there is agreement between authors (Institute of Medicine, 2003, Shortell et al. 2004). This consensus supports the consideration of the theme of user involvement, engagement and empowerment within the literature review and the consideration of patients as research participants within the study.

Understanding accountability, autonomy and status, especially of clinicians, is seen as key to inter-organisational working and the evidence suggests the need to consider accountability in the alignment of incentives (Ham, 2003). However, the literature contains limited explanation of how such understanding can be achieved, or of what would constitute effective incentives for clinicians. The identification of

this gap was an important influence on the development of the design and methods of data collection.

User Involvement, Engagement and Empowerment

The final theme for consideration is patient involvement, engagement and empowerment. As Shortell et al's (2004) study and the Institute of Medicine (2003) report confirms, making patient centredness a critical value of change teams promotes effective outcomes. Historically, the majority of theoretical work about user involvement in the development and implementation of policy has been dominated by Arnstein's (1969) model of a 'ladder of participation' (Appendix 2). The ladder represents nine different levels of citizens' power from 'manipulation' by the policy makers offering no power at all, through 'therapy', 'informing', 'consultation', 'placation' and 'partnership' to 'delegated power' and 'citizen control'. This model is contested by Tritter and McCallum (2006), suggesting it is static and one-dimensional because it is based on the single concept of power and the extent to which that power is shared. Tritter and McCallum (2006) and the Care Services Improvement Partnership (2006) concur that user involvement projects must reflect modern healthcare policy, for example: the complex nature of power in reality; the heterogeneous nature of communities and service users' different priorities, diverse illnesses and risks; users' groups (different levels of engagement, differing circumstances); and, the dynamic and evolving nature of policymaking. They argue against any particular preferred model of service user involvement, and advocate a mixture of schemes negotiated with user groups and appropriately integrated with one another. This suggests that there is no single, correct model of service user involvement, but instead that the model is dependent on the patient group, the setting, the relevant policy driver, etc. This does not, however, negate the clear evidence of the powerful beneficial effect user involvement can generate. The Care Services Improvement Partnership (2006, p5) comment:

'the ultimate effectiveness of services relies on active and appropriate participation by people who use the services. Put in its simplest terms, people will get the most from services, if those services make sense to them and meet their needs'.

Since the 1990s, there have been numerous policies placing an increased emphasis on involving patients (Care Services Improvement Partnership, 2006). Despite this emphasis, clinicians are frequently nervous and sceptical about asking service users for feedback, let alone involving and engaging them as evidenced by Fletcher and Bradburn (2001). Building on this thinking, the NCCSDO report (2002) clearly states that healthcare staff will need to offer support including extra time and information to coach service users. However, counter to this, Rutter et al (2001) in their review of the literature talk about the reluctance of healthcare professionals to embrace service user driven changes, as they have been unconsciously trained to be sceptical of their value. This raises a significant tension. For meaningful user involvement to occur, a significant change in mind-set by healthcare professionals is required. This may also lead to a dramatic change in power and accountability between service users and providers. Investment in training of both professionals and service users will be required. There is a dearth of literature on the subject of how the shift could occur whereby a doctor agrees to a significant transfer of power and accountability through patient involvement and empowerment. This is made even more complex when the doctor has to contribute to facilitating a growth in the service users' healthcare knowledge to realise true empowerment.

Conclusion - User Involvement, Engagement and Empowerment

There is clear evidence of the value of patient centredness in promoting effective team outcomes (Shortell et al. 2004). There is, however, a diversity of thinking about how this can be enacted effectively. The latest thinking suggests that a dynamic model of user involvement should be used dependent on the patient group, setting, etc (Care Services

Improvement Partnership, 2006). This supports the approach of this study, comparing two change teams working in different settings, with different patient groups and policy drivers.

There is significant evidence highlighting the difficulties of involving clinicians in patient engagement (Fletcher and Bradburn, 2001). However, there is also strong evidence that achieving patient empowerment is critical to realising the true benefits of involving patients (NCCSDO, 2002). Conversely, there is limited indication in the literature regarding how to create the mind-set shift for clinicians to empower patients, and thus relinquish some of their own power and authority. There is also limited evidence of what incentives would support moving to this new mind-set. Both the literature supporting patient centredness and the dearth of literature on achieving the change have influenced the design of the study, for example, the inclusion of a patient to undertake one of the semi-structured interviews and the design of the focus group and semi-structured interview topic guides.

Conclusions – Literature Review

In conclusion, Gittell et al (2005) comment that within clinical networks there is limited evidence of what creates effective cross-boundary working. This literature review has appraised the available existing knowledge, but found little defined evidence or agreement of what constitutes effective clinical leadership and engagement when working across traditional organisational boundaries. This may be due to the focus of cross-boundary working, collaborations and partnership working within the delivery of national and local healthcare being relatively novel, although there is clear evidence of a recent growth within the policy literature.

To explore the research questions and objectives, a wide diversity of interrelated themes has been considered within this literature review. These themes have influenced the thinking behind the development of

the design and methodology of the study. They offer a justification of the approaches taken, by both using the available knowledge base and considering the gaps or areas of lack of consensus in the literature.

Chapter 3

Inter-Organisational Clinical Leadership and Engagement - Methodology and Methods Employed

Theoretical Framework – Justification of Research Intentions and Design

This study was located in the real world, which is complex, messy, political, and constantly changing, for example NHS re-structures, new policy targets, and multiple differing organisational cultures. Consequently, the research intentions and design had to reflect this epistemological stance. Epistemology is '*the theory of knowledge embedded in the theoretical perspective and thereby in the methodology*' (Crotty, 2003, p3). Weldon (2002, p7) defines epistemology as '*the branch of philosophy that studies the nature of knowledge and the process by which the knowledge is acquired and validated*'. In simplistic terms, it is how we understand the world. To take account of the inherent complexity of the study, a pragmatic approach was used, incorporating an action research approach, using a single case study design. This methodological approach acknowledged the multifaceted nature of the research area, and the flexible design allowed a multi-method approach to data collection and analysis.

The theoretical perspective is interpretivism. Interpretive perspectives emphasise the meaningful nature of people's interactions in social and cultural life, with a focus on the meanings people bestow on their own and others' actions. This perspective contests the claim that a positivist scientific perspective adequately provides valuable insight into the complexity of society, relationships and human responses and actions (Walliman, 2001). It argues that a positivist perspective does not take account of the fact that individuals have a unique view on which their

actions are based. With an interpretive perspective, an attempt is made to understand and explain human and social reality. People are considered to have conscious ideas about the world, to attach meaning to these ideas and their consequent behaviour is dependent on these ideas and meaning (Crotty, 2003).

Walliman (2001) states that the interpretive researcher is bound into the human situation being studied, and as such must recognise the perspective from which they will make their observations. This study was based on human activity, and included quantitative and qualitative research methods.

In quantitative research, knowledge is gained from testable and verifiable data collection. A quantitative method was used to compare the effectiveness of two teams allowing new understanding to be gained via testable and verifiable data collection. A team effectiveness questionnaire was used with two of the change teams, including the key doctors driving the changes. This allowed an analysis of the relative effectiveness of the teams.

Walliman (2001) describes qualitative research methods as measuring and evaluating qualities. Qualitative methods were used to analyse the clinical leadership and engagement across organisational boundaries. For this element, the ontology was idealism. Idealism is related to ideas and thoughts not real matter. The epistemology was subjectivism, which is exploring the nature and meaning of ideas (Crotty, 2003). The two different methods of data collection, focus groups and semi-structured interviews within an action research framework were used to capture the experiences of the doctors and the learning.

The intention was to use a flexible design allowing a multi-method approach to data collection and analysis. There has been a debate within the research community over the last three decades about how valid and convincing multi-method approaches are (Crotty, 2003). However, within

real world settings this is becoming more acceptable and Murphy et al (1998) describe it as a pragmatic approach, based on its appropriateness for the purposes of the study. Data triangulation is used to enhance the rigour of the research (Meyer and Spilsbury, 2000).

The area studied has a limited evidence base as demonstrated through the literature review. An inductive constructive stance was therefore taken. In addition, in creating the approach, consideration of the value and meaning for the study's audience was required. The inductive nature of action research, focus groups and semi-structured interviews met these requirements.

Study Approach and Development of the Design

The framework below (figure 3.1) identifies the intended different stages of the study through the application of action research. The first action research stage occurring between January and December 2005 was planning the study. The second stage, which occurred between January and September 2006, entailed multiple action research cycles to identify crucial factors. Three methods of data collection were used, and the study activity and analysis was undertaken. The final stage incorporated the final analysis, writing and completion of the study, and took place between July 2006 and July 2007.

Throughout this study, multiple iterative action research cycles were undertaken. For example, each data collection method entailed several iterative cycles, such as investigation, piloting, adoption, design, development and analysis. The reflection, analysis, and changes made in practice from the team effectiveness tool influenced the design and the development of the focus groups and semi-structured interviews, with the focus groups similarly influencing the design and development of the semi-structured interviews (Winter and Munn-Giddings, 2001). The whole process was iterative and sequential, as each stage relied on data

collection and analysis from the previous stages. (A detailed review of each of the iterative cycles undertaken for the team effectiveness tool is presented in table 4.1).

Application of Action Research – Overview of Intended Stages

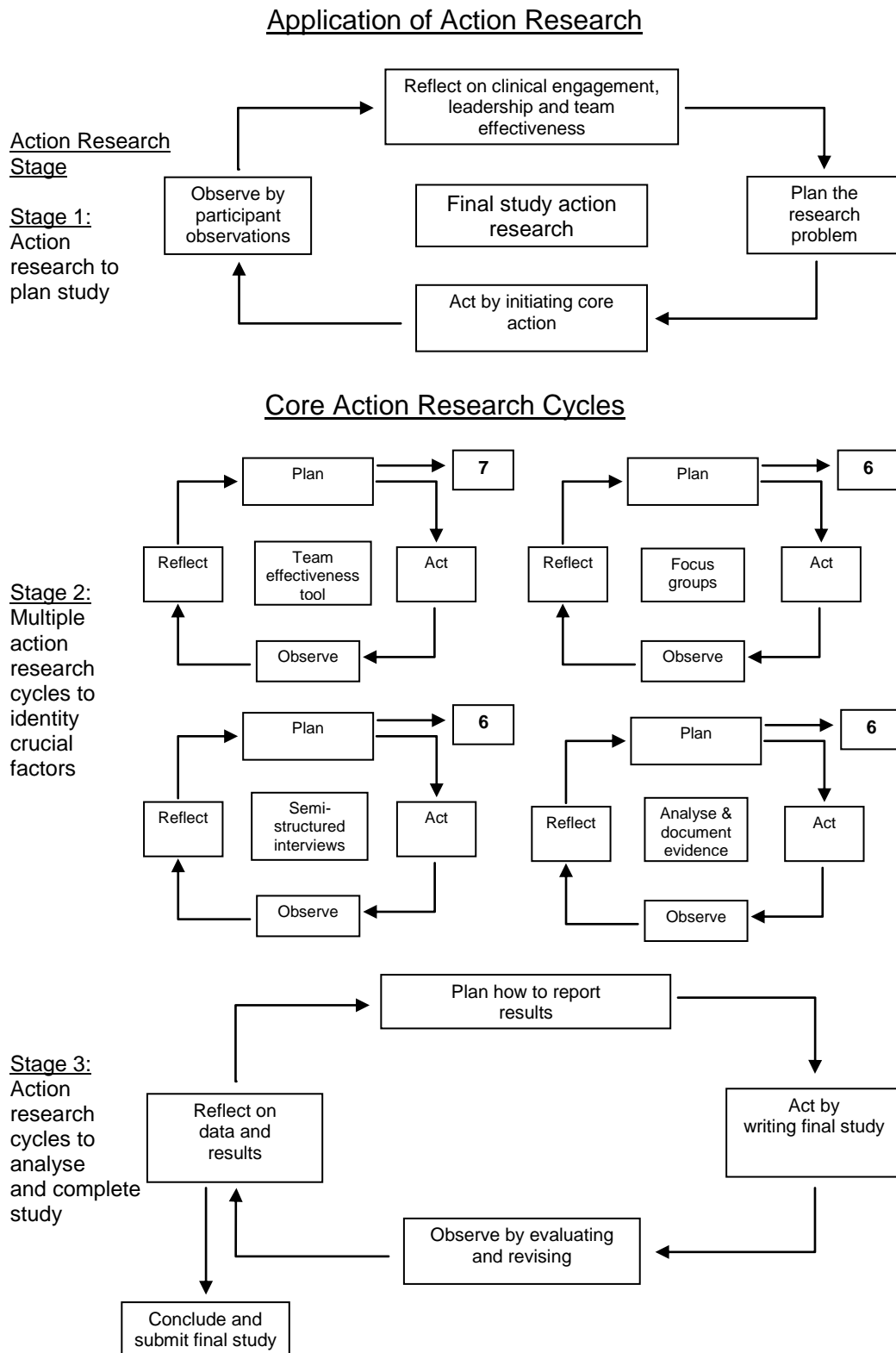


Figure 3.1 Overview of Intended Stages

Action Research Approach

An action research approach was employed for this study for the following reasons. Action research is described by Coghlan and Brannick (2001, p3-4) as:

'research which is based on a collaborative problem solving relationship between researcher and client, which aims at solving a problem and generating new knowledge'.

This was a good fit with both my research plans and my role as Director of the whole change project. A key objective of my role was to effect change, whilst also contributing to knowledge and understanding about the characteristics and impact of effective clinical leadership and engagement.

Waterman et al (2001) and Mitchell (2000) offer further descriptions of action research that support this decision. Action research focuses on change and improvement, areas that are highly relevant to the whole change project and the focus of the study. It explicitly and proactively involves participants in the research process. This was highly appropriate as the study was attempting to determine the characteristics of successful cross-organisational working, and to analyse doctors who were attempting to create change in real time. This created a rich research environment conducive to the action research approach. It was educational for all involved, which additionally offered benefit for my work, and synergistically improved both the research study and my work outcomes. The study was based in reality and action research looks at questions that arise from practice. Consequently, the research questions and objectives were pragmatic and sought real world solutions, therefore justifying this as an appropriate method to adopt (Waterman et al. 2001).

Action research involves a cyclical process of collecting, feeding back and reflecting on data to effect change (Coghlan and Brannick, 2001).

The stages comprise planning, acting, observing and reflecting. Within each stage of the study and the phases of data collection, many iterative cycles were undertaken from investigation and scoping, through piloting, adapting, designing and development. The reflections and learning from each stage influenced the next (Figure 3.1). For example, the design, analysis and building understanding stages of the team effectiveness tool, influenced the design and development of the focus groups and semi-structured interviews. The focus groups similarly influenced the semi-structured interview design and development. In addition, the knowledge and learning influenced the change project as the study was being undertaken. For example, the use of plain and clear English (DH, 2003c) is now policy for all documents the change project produces, and the management groups now have a new system of allocating and monitoring agreed actions within a clear timeframe, thus enhancing delivery. The action research cycle was highly suitable for the context, and the achievements of the objectives of the study and the change project.

The decision to use action research was influenced by the work of Hart and Bond (1998), as it offers an opportunity to improve health and social care through the involvement of service users and professionals who deliver this care. It allowed for the differences in what may be perceived as improvements from clinicians' and service users' perspectives to be acknowledged. Although the focus of the study was on inter-organisational clinical leadership and engagement, the outcome of the clinical leadership and engagement was to improve the quality and experience for service users. Using an action research approach in which service users could be involved in elements of the process was fundamental.

The main difference of action research from other approaches is that the researcher fully participates in the research study and is part of the research setting, therefore not observing or accessing the data from a neutral, detached standpoint. This involved me designing, running and

participating in all stages of the research. As I led the change project, although in reality not the day-to-day activities, it justified and made sense of the choice of approach. This did however introduce the concept of the insider researcher (Walliman, 2001) and its potential hazards, which are addressed later in this chapter.

As with any research approach, it was important to consider the limitations. In action research there is minimal endeavour to separate the issues studied from the context or environment. Action research is therefore mainly based on observation and behaviours identified (Coghlan and Brannick, 2001), which in this study was highly appropriate and important rather than a concern. Action research may be considered less rigorous in terms of generalisability, as there is limited control over variables. Meyer (2000, p179), states:

'to some extent reports of action research studies rely on readers to underwrite the account of the research by drawing on their own knowledge of human situations'.

Therefore, transferability and potential reliability are more appropriately sought. As suggested by Meyer and Spilsbury (2000) this can be achieved by describing the context and conditions of the study and thus providing transferable learning. Possible further limitations were the potential for the approach to be inward looking and lacking in the use of systematic methods.

On balance, action research was a logical choice and was fit for purpose. The environments in which the findings are likely to be used will also be relatively similar. By using multiple data sources and data triangulation, the impact of these limitations was minimised.

Case Study Design

A single case study design was used. Robson (2002, p178) describes a case study as:

'a well established research strategy where the focus is on the case (which is interpreted very widely to include the study of an individual person, a group, a setting, an organisation, etc.) in its own right and taking its context into account. Typically involves multiple methods of data collection. Can include quantitative data, though qualitative data are almost invariably collected'.

Yin (2003, p4) states *'the case study is the method of choice when the phenomenon under study is not readily distinguishable from its context'*. This supports the fact that the lead doctors who were working within the change projects were studied. An examination of two change projects was undertaken to explore the characteristics and impact of good clinical leadership and engagement across organisations. This design allowed the utilisation of multiple sources of data collection in real time. It also allowed for an emergent process, which aligns with the study approach and the continuous quality improvement methodology being used within the whole change project.

It is important to acknowledge that one argument for the use of the single case study is largely dependent on the assumption that understanding one case will add to the understanding of a different case and may ultimately produce transferable learning. The argument is not just that a case study has value within its own right, but additionally that with an adequately / richly described environmental setting, contextual learning can be gained (Keen and Packwood, 2000). Case studies can provide insights into possible cause and effect relationships. Yin (2003, p69) states: *'in the absence of the ability to conduct true experiments, such clues may be the best that can be attained'*. Guba and Lincoln (1989) suggest that a more informed and sophisticated approach is required to

move beyond pure science to include the myriad of human, political, social, cultural, and contextual elements that are involved.

The potential limitations of using this design were considered, especially the issue of how much transferable learning can be gained (Gill and Johnson, 1997). As much context as possible was included to help make sense of the learning. Despite the potential shortcomings, the tricky reality of the context in which this research study was placed, made it the most appropriate design to use. The benefits and limitations of case studies were compared to other designs such as ethnogenic or comparative (Walliman, 2001), but on balance a single case study design was deemed the most appropriate.

Methods of Data Collection

The scope was defined by the aim of the study (Pope and Mays, 1995), which was to identify the characteristics and impact of high-quality clinical leadership, engagement and team effectiveness across organisational and professional boundaries. The focus was on clinical leadership and engagement, the whole patient pathway, and the interface between different organisational settings such as primary care, secondary care and the voluntary and private sectors.

The term 'population', as used in research *'is used to denote all those who fall into the category of concern'* (Oppenheim, 1992, p38). For this study, the population was the staff and patients (those who are directly involved in the project work) within the three change projects.

A purposive sampling method was selected described by Robson (2002, p265) as follows:

'the principle of selection in purposive sampling is the researcher's judgement as to typicality or interest. A sample is built up which enables the researcher to satisfy her specific needs in a project'.

The rationale was that this methodology suited the flexible multi-method approach, and allowed the study to focus on a sample which should answer the research questions in a meaningful way through real world experience. Other sampling methods were considered and discounted. For example, random sampling was considered inappropriate because the change projects have fixed participants and quota sampling because representation of the population was not appropriate for the research questions or setting (Oppenheim, 1992).

The focus was on two of the three change project teams that I lead. This was to ensure the scope was manageable and feasible within the time available, and because the two projects selected had actually delivered demonstrable cross-organisational change. In addition, there was some concern regarding the progress of the third project, and the project's acceptance of improvement methodology as valid. A judgement was made that it was too politically sensitive to include this project, because it could have affected the change project. In terms of transferable learning, the relatively small sample size was validated by the in-depth analysis of all three data sources undertaken by data triangulation.

Phase 1 - Team Effectiveness Tool

Phase 1 of the study was measuring the perceived individual effectiveness of the project management groups. The rationale for using a team effectiveness tool was the importance of analysing the doctors' impact on the management group. By influencing their management group, the doctors could access resources and be empowered to lead cross-organisational projects. The effectiveness of the group would also correlate to the overall impact of the doctors in cross-organisational working, as demonstrated by the change project's work to date. By

influencing and leading the group, they could potentially demonstrate the characteristics of successful working across organisational boundaries.

Development Process

The phenomenon to be measured was the individuals within the management groups' perception of their own management group. The project management group comprised doctors, managers, service users and project management staff. The role of the management group was to design the strategy of the change projects, lead specific work streams and be accountable for the whole project. The two groups were approximately equivalent in terms of the nature and scope of their work. The management groups were created on an ad hoc basis, with members selected from a combination of: interested individuals (thus self-selecting); a required representational focus (specific organisation or service); availability; and, those working full time on the project. There was no formal management structure, the chairs were chosen randomly to suit the specific project and the terms of reference (Appendix 3) were focussed on the delivery of the change project.

Selection

The team effectiveness tool used was an evidence based tool (Bolster, 2006), consisting of a four point Likert type scale. The tool was originally designed and validated by the NHS Learning Alliance and has been used in comparable research projects (Bolster, 2006). It is based on Connors and Smith's work on accountability. They postulate that to enhance performance and deliver better results, alignment of organisational and individual accountability and organisational culture is required (Connors and Smith, 1999, Connors et al. 2004).

This particular tool gave an opportunity to explore the issues related to the perceived effectiveness of the management teams. For doctors to work across organisational boundaries there is a need for them to work

effectively in groups with multiple stakeholders, such as their management group. These groups were deliberately set up to run cross-organisational projects with members coming from different individual organisations. The questions used within this tool allowed analysis of the perceived effectiveness of elements of team working within the management group. It allowed examination of how well the group came together on cross-organisational projects, and moved away from their own individual accountabilities to their own employing organisations. This is a key issue with doctors leading and engaging in projects beyond their normal organisational accountability.

A systematic cyclical approach was taken in choosing this tool by reviewing the study's research questions and aims and considering several tools (Oppenheim, 1992). It was concluded that this tool was the most appropriate because it measured all the required parameters by answering the key questions about the effectiveness of a change management board, which was set up for a limited time and had diverse stakeholders. It also had a resonance with the creativity approach to change management being taken by each management group (NHS Modernisation Agency, 2005). Most other team effectiveness tools considered (Borrill et al. 2002), were focussed on stable (not time limited) internal teams within a department or organisation, did not consider creativity and had limited analysis of accountability within and across organisations. These were the critical issues within this study.

The design and development of each of the stages of the team effectiveness tool followed an iterative action research cycle (further details are presented table 4.1). This phase influenced the development of the focus groups and the semi-structured interviews.

Strengths and Weaknesses

The strengths of the tool were that it had been validated and used in similar research projects (Bolster, 2006). It had offered useful insights into teams that are from different organisations or have a diversity of membership. It had been demonstrated to be simple and easy to use, and therefore had limited user error. It could be used confidentially, which helped the accuracy of response, as participants were not worried about their views being personally attributable (Oppenheim, 1992).

A weakness inherent in the design of this tool was that it focused on individual perspectives and perceptions. Members of the project management groups attended the bi-monthly meetings with differing frequency and contributed at varying levels. They may therefore have had different perspectives of the effectiveness of the team.

The question arises as to whether a management group, which was so diverse and time limited, could be considered a team or was more akin to a loose network (Gittell et al. 2005). Whilst the teams undoubtedly differed in both composition and operational duration from the conventional intra-organisation team, the reasons justifying these differences have been established, and the differences themselves do not contradict the definitions of “team” offered in the literature review (Wheelan, 1999). It must also be recognised that each of the management groups worked and were run slightly differently (despite the nature and scope of the work being the same), which potentially affected the perceived team effectiveness. This was not completely captured in this tool. All these issues were considered in undertaking the analysis and offering any conclusions. Despite noting all of the above concerns, for the purposes of this study, this tool was considered appropriate.

Phase 2 - Focus Groups

A focus group method was used in the second phase of data collection. Originally used in the marketing and advertising fields, its use in healthcare has been developing over the last ten years, and it is now used extensively and is slowly gaining more credibility (Kitzinger, 1999). Robson (2002) defines a focus group as a group interview focussed on a particular subject area. In this study, the subject was clinical engagement and leadership, with the focus on doctors leading inter-organisational change. Two focus groups were undertaken with six doctors in each. The understandings and insights from the analysis of the team effectiveness tool influenced the focus group development, for example influencing the inclusion of a question regarding accountability and responsibility.

Focus groups provided an efficient and inexpensive way of collecting a large amount and wide range of data in one event (Oppenheim, 1992). This was appropriate as the doctors involved in the focus groups already provide extra commitment to the change project. The group processes and dynamics between the participants provided some check as to what was acceptable and realistic, and extreme views could be challenged by the group. The doctors were interested in successful cross-organisational working so it was hoped that the group dynamics would ensure the group concentrated on important issues. Open debate and the presence of several perspectives in one room, ensured consistent and agreed views were gained (Senge, 2000). As discussed by Morgan and Krenger (1998), it was necessary for the questions and debate to interest the participants and empower them to contribute fully, thus stimulating areas of discussion, creating insights and revealing hidden meanings which would not have emerged in an individual exercise (Kitzinger, 1999). Also, the raising of taboo and difficult areas could be encouraged by the perceived safety of the group. The homogeneity of the group allowed capitalisation on the doctors' collective shared experiences, an important issue for this study. The process additionally revealed relevant cultural

values or group norms. Finally, as an experienced group facilitator, I was able to bring my skill and expertise to the process (Oppenheim, 1992).

Despite the significant advantages of using focus groups, there were also significant disadvantages, which were important to consider. The significant disadvantages, as described by Oppenheim (1992), were that the time available was limited thus restricting the number of questions raised. My facilitation style and approach potentially may have limited some individuals' responses and engagement. One or more strong individuals might have tried to dominate the group, and this could have led to extreme views being debated, or group norms silencing some individuals. There may have been personality conflicts and power struggles within the group. The groups' composition in terms of age, gender and culture may have affected the outputs. Confidentiality concerns may have resulted in some participants not being completely open or fully engaged. Finally, for the results to be easily transferable, there was a need for the local context and environmental variations to be described.

The alternative approaches of using written postal questionnaires and undertaking semi-structured interviews for all the doctors was considered. The disadvantages of both of these approaches outweighed the concerns about using focus groups. For example, as Walliman (2001) suggests, postal questionnaires would have given only one perspective, would lack the group dynamic to drive new thinking and perspectives and may affect response rates. Undertaking semi-structured interviews would have been a huge demand on the doctors' and my own time and would lack the benefits provided by group interaction (Oppenheim, 1992). Despite the limitations, focus groups were the appropriate method to use, but in order to ensure the rigour of analysis, due consideration was given to the issues.

Phase 3 - Semi-structured Interviews

Phase 3 consisted of semi-structured interviews. Britten (1995) describes semi-structured interviews as a qualitative method of collecting data. A loose structure was used within a defined scope, and predetermined, open-ended questions were employed. The team effectiveness tool and the focus group learning and insights influenced the development and design of the semi-structured interviews. For example, the value of using an independent observer within the focus groups influenced the use for this phase. The aim was to discover the participants' frames and meanings, so a deliberate attempt was made to avoid creating an overly tight structure, which may have inhibited full exploration. Three semi-structured interviews were undertaken with two doctors and one service user.

The advantages of semi-structured interviews were that they were flexible, easy to use and inexpensive. Their broad focus gives sufficient flexibility that new concepts and ideas can emerge (Britten, 1995). Non-verbal cues can also offer new insights. They provide an excellent method of collecting rich, diverse and insightful data. Guba and Lincoln (1989) comment that the advantages of this approach are that it empowers stakeholders, whilst still defining a course to be followed. These advantages demonstrate why semi-structured interviews were an appropriate method for this study.

The disadvantages were that the outcomes were not easily generalisable and therefore there could be concerns about reliability and rigour and the application to shared learning. To counter this, it is important to understand that a skilfully applied inductive approach will elicit the meanings perceived by the research participants and gain an understanding of their ways of sense making, thus providing transferable learning (which is more applicable for this type of study). The interviews can be time consuming and the volume of data collected immense. The interviewer must possess a sufficient level of skill to facilitate the

production of useful, good quality output from a semi-structured interview (Oppenheim, 1992). These disadvantages were addressed during the analysis of the interviews, and the development of the findings and conclusions of the study, and by my facilitation skills.

Semi-structured interviews were chosen over other methods such as structured interviews and postal interviews as they offer a way of framing a clear area for discussion, but still have the flexibility through their use of open questions to obtain a diversity and richness of data and to open up the debating area (Oppenheim, 1992). They also allowed direct interaction with the participant and thus an opportunity to consider non-verbal cues (Britten, 1995). It should be noted that due to the size of this study this method allowed analysis to the required depth.

Reliability, Validity, Rigour and Authenticity

Reliability, validity, rigour and authenticity are key considerations for any research project, although in their purest forms they can be more appropriate for positivist scientific approaches (Morrison and Lilford, 2001). For a scientific approach, Robson (2002, p101) describes reliability as '*the stability or consistency with which we measure something*'. However, with action research, achieving absolute reliability is challenging. Waterman et al (2001) suggest assessing action research by considering the interrelationship between the process, the participative nature, the management of change and the reflection cycles.

When studying a real world project, the essential qualities of human experience and the understanding of complex social situations must be considered (Winter and Munn-Giddings, 2001). Validity from a pure positivist stance will not allow for this complexity. One alternative approach used was the consideration of potential threats to validity (Robson, 2002). For example, the ability to provide a valid description of all aspects of the data collection process, and providing a valid and

rigorous interpretation through analysis which is demonstrably free from the influence of prior frameworks, models or theories.

Morton-Cooper (2000) states that the key to attaining reliability and validity in action research is related to cultural validity. An attempt was made to uphold all aspects of cultural reliability whilst undertaking the study. These included that the researcher provided a trustworthy and likely account of the situation and that another professional in similar circumstances could recognise the findings and conclusions as congruent with their own experience.

Walliman (2001) offers alternative issues that may have potentially affected validity and reliability of this study. Steps were taken to ensure that all these factors were considered:

These included:

- The accuracy of recording data – all qualitative data was transcribed and there was an independent observer at all times. Data was collected and analysed in a transparent manner.
- Insider researcher – Consideration was given to my mind-set and preconceptions at all times, and peers and expert advice were used to challenge the findings and detect any predetermined views. The independent observer also continuously provided feedback and learning throughout the data collection process.
- Memory issues - all qualitative data was recorded and transcribed
- Different conditions – all focus groups and interviews were held at neutral venues away from the work place. All other environmental differences were reduced to a minimum.

In addition to ensuring validity, member checking / respondent validation was undertaken, which supplemented data triangulation by increasing confidence in the validity of the findings (Silverman, 2005). The data was checked with research participants to verify the accuracy of the account

and to reduce bias and reactivity (my presence as researcher interfering in the setting or influencing the behaviour of the research participants). A clear audit trail was kept of all processes executed and data collected, with justification of all assumptions made.

The final approach to validity and reliability was consideration of the rigour of the research from an interpretivist standpoint, using alternative criteria. This approach suggests that criteria, which have been created for a positivist approach, should be completely rejected in favour of criteria more consistent with an interpretivist epistemology. For example, Symon and Cassell (1998) offer authenticity criteria:

- Resonance – the extent to which the research process reflects the underlying paradigm. The research process reflected the research questions and the paradigm chosen
- Rhetoric - the strength of the argument presented. A strong argument for the methodological approach and methods used is offered and validates the results
- Empowerment – the extent to which the findings enable the readers to take action. The environment, research setting and study activities were described in detail thus enabling the learning to be applied
- Applicability – the extent to which the readers can apply the findings to their own contexts. An attempt was made to ensure applicability by providing richness in detail, consistency and transparency.

Reliability and validity are important concerns within this study as an action research approach was undertaken, with one site as a case study. However, although it is one site, it should be noted that it is a complex site comprising four statutory NHS organisations and numerous voluntary and private sector providers

Data Triangulation

In order to address the limitations of the design of the study, the combining of the multiple data sources was used to enhance the rigour of the research by data triangulation (Meyer and Spilsbury, 2000). Gill and Johnson (1997) suggest triangulation as a way of combining qualitative and quantitative data to help to promote the validity of a study by helping to reduce reactivity, respondent and researcher bias. Data triangulation compares results from multiple data sources to look for patterns of convergence or contrast, to develop the overall interpretation (Whitmore and McKee, 2001). It is a method that helps to ensure the comprehensiveness of findings and can increase confidence in findings. Data triangulation was used to collectively analyse all three data sources. The process sought to identify recurring themes and concepts across all the data sources thus promoting validity.

Ethical, Moral and Legal Issues

Walliman (2001) describes two different aspects to consider when dealing with ethical issues. The first concerns the researcher's values of honesty, frankness and personal integrity or ethical behaviour. The second concerns the responsibility to the participants of research, including privacy, confidentiality and courtesy. This approach can also be described as research best practice through every aspect of the process (design, reporting and dissemination), and the need to comply with legal and professional requirements such as Ethics Committee Approval, Data Protection and professional codes of practice.

Ethical approval was gained as part of an existing ethics process. The change project had ethical approval for both the change project and the academic evaluation that the Charity (the funder of the change project) commissioned. Ethical approval for this study was achieved via a 'Notice of Substantial Amendment' to the evaluation of the change project. This

was secured from Bromley Local Research Ethics Committee (Appendix 4). This approach was taken as the study was aligned to the evaluation of the whole of the change project. The evaluation team was not considering clinical leadership, engagement and team effectiveness across organisational boundaries. They were using similar methodologies in terms of ensuring all ethical aspects were adhered to, offering significant synergy in approach.

In terms of the moral and ethical responsibilities, all potential research participants were written to, explaining the aims, rationale and objectives of the study and seeking to gain their written consent. Within this letter, all relevant issues were addressed such as privacy, confidentiality, courtesy, feedback mechanisms and how the data protection requirements were met. It is important to note that within action research, researchers need to explicitly agree an ethical code of practice with all participants (Meyer, 2000). This helps both to ensure their participation in the research (a fundamental part of action research) and to deal with the difficulties that arise if the change becomes difficult or threatening. A transparent and consistent code of practice was put in place. This sought to ensure all participants were safe and their rights maintained at all times. An attempt was made to guarantee no individual's professional code of practice was ever compromised.

Signed informed consent was gained from all research participants (Appendix 5). This was in written form and at least 48 hours were given for consideration of participation. This ensured voluntary consent was gained and gave time for a participant to decline. Participants were also informed that they could opt out of the study at any time should they wish to. A reflective conversation was offered to any participants who chose to opt out.

All potential participants were briefed on what would happen to all the information / data collected. All participants were clearly advised that transcribed data from the focus groups and semi-structured interviews

could be reviewed. All research participants were clearly notified that the final audience for the research report was Middlesex University and that within the report all information would be anonymous. Additionally, all participants were informed that the product 'Practical Recommendations' would be in the form of a general guide with recommendations not specific research findings.

The ethical approach aimed to ensure that the study did not interfere with the progress of the change project or cause significant turbulence within the groups studied. Considerable recourse was made to the leadership skills portrayed in Emotional Intelligence (EI) as described by Goleman (1999) to monitor the impact on the change project and reduce any identified risks. Goleman (1999, pxiii) said:

'Emotional Intelligence: being able, for example to rein in emotional impulse; to read another's innermost feelings; to handle relationships smoothly.'

Elements of EI such as self-awareness of my actions and intentions, integrated with excellent relationship skills helped to ensure ethical procedures were implemented appropriately. Contingency plans were consistently incorporated in case either the whole change project was in serious difficulties and there was an impact on the study, or the study caused issues with the change project or did not work.

As I was accountable for the change project in which the study was based, the issue of insider researcher needs consideration. There are advantages and disadvantages to being an insider researcher, as stated by Waterman et al (2001) and Robson (2002). The advantages include: the efficiencies of working and researching in the same setting; the in-depth knowledge of the research environment and relevant politics; an understanding of who to involve; established credibility; and, an increased commitment to the study. Conversely the disadvantages include: the difficulties of forming a research rapport alongside existing hierarchal,

peer or line manager relationships (or a dependence relationship) impacting on the research outputs; issues of confidential information which may have significant status or meaning to the organisation; the impact of making mistakes and the bearing on researcher's credibility in the longer term; lack of time due to competing commitments; lack of research expertise; and, lack of confidence. The most important issue however was how objectivity was maintained given the existing history and relationships (Waterman et al. 2001). Despite all these issues, the advantages outweighed the disadvantages. Additionally, Coghlan and Brannick (2001) highlight that the insider researcher will gain significant new skills, understanding and knowledge about research undertakings and advantage is gained when this is shared with colleagues. Strategies were put into place to overcome the disadvantages such as accessing advice from experts in research; creating support mechanisms; allocating protected time; and using member checking to enhance objectivity. My objectivity was also closely monitored as suggested by Coghlan and Brannick (2001), and mechanisms used to prevent subjective judgements (these are discussed further in Chapter 4).

Each of the three methods used offered different ethical challenges. With the team effectiveness tool, meeting all the wider stakeholder group's needs was required, for example service users. This involved the use of appropriate clear and plain English as recommended in a "Tool-kit for Producing Patient Information" (DH, 2003c), the provision of support in filling in the tool, and postal as well as electronic distribution. With both the focus groups and the semi-structured interviews, there was a need to consider the timing so as not to disadvantage or inconvenience people. All individuals' inputs were monitored and all individuals encouraged to speak and put their views across. The environment and atmosphere were observed and interventions would have been considered if difficulties had arisen. Throughout the whole study consideration was given to ensuring that the two teams did not see any stage of the process as raising any undue concerns, causing competition between them, or creating any other disruption.

All information was held in a secure location and was anonymous. Full responsibility was taken to ensure complete privacy and confidentiality of all participants and of meeting the “Data Protection Act” (Department of Constitutional Affairs, 1998).

Approval was secured to undertake this study from the Chair of the Project Board. No legal issues arose and my employing organisation covered the study for indemnity purposes.

Chapter 4

Study Activity

This chapter describes the study activity. It illustrates the sample used, the methods of data collection employed, the study activity and analysis. The design of the study was complicated due to the complexity of the study focus and setting. Due to this, the multiple action research cycles undertaken were interrelated, reflecting the complexity of real life. Within this chapter, consideration is given both to issues which aided and to issues which hindered the study activity.

The methods of data collection used comprise a team effectiveness tool, two focus groups and three semi-structured interviews. These methods were used sequentially, with the findings from one method influencing the design of the next (Winter and Munn-Giddings, 2001). Figure 4.1 demonstrates how each action research cycle informed the next stage of the study activity. Each phase of data collection involved several iterative action research cycles (Coghlan and Brannick, 2001) for example: investigation and scoping; design and development; analysis; and, the creation of new understanding and insights that created modifications of the change project during the research study (as was presented figure 3.1, p56). The study influenced the activity to disseminate the practical recommendations. Two of the three change project teams were used, the sexual health and kidney management teams, since they were identified as offering potential learning.

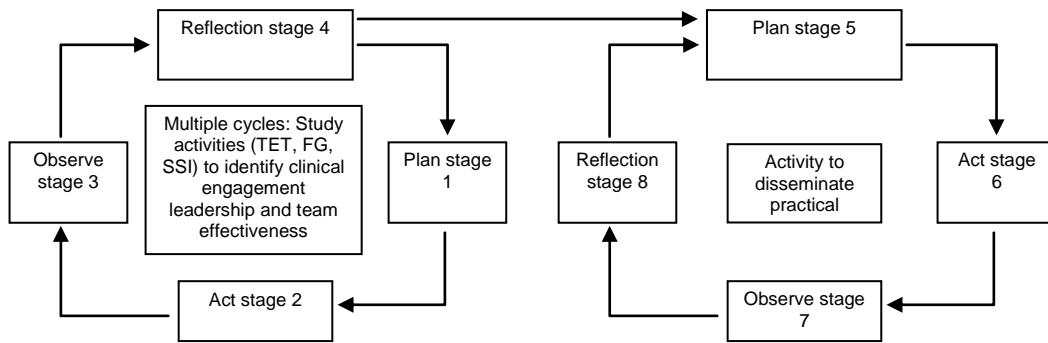


Figure 4.1 – Study Activity

Table 4.1 demonstrates in detail the team effectiveness tool action research cycles. The table demonstrates the cycles, the building of further understanding and the influence the process had on the focus groups and the semi-structured interviews. In addition, it shows the changes, which occurred within the change project because of the study activity.

Table 4.1 Team Effectiveness Tool (TET) Iterative Action Research Cycles

Method	Plan	Act	Evaluate	Reflection
TET	Investigation and scope - use of a quantitative tool	Literature review and discussion with experts	Options - types of tool	On my tacit knowledge and experience in relation to potential different tools
TET	Tool chosen - considered adaptations required	Made adaptations	Effect of adaptations	On any further adaptations required
TET	Adaptations and pilot stage	Made adaptations and piloted tool	Impact and issues arising from pilot	On adaptations and pilot for TET and learning for FG and SSI
TET	Final adaptations and implementation	Final adaptations made, sent out TET and follow up reminders	Response rates and implementation process	On process and learning for FG and SSI
TET	Analysis	Framework analysis – (further cyclical process throughout analysis)	Themes, understanding, insights and changes	On themes, understanding, insights and changes
TET	Reviewed implications, learning and influence on FG and SSI	Process learning and analysis of TET fed into investigation, scoping, design and development of FG and SSI	Thematic review of analysis of TET, FG and SSI via data triangulation	On analysis and learning from data collection methods – what changes have been or need to be made in change project
TET	Reviewed implications, learning and influence on change project	Made specific changes, e.g. policy for use of clear and plain English, increased accountability within management groups for actions, influencing future national medical training, etc.	Impact of changes made	On impact of changes made and on future research activity and projects

Phase 1 – Team Effectiveness Tool

The instrument of measurement for Phase 1 of the study activity was a team effectiveness tool, which was an attitudinal scale measuring individuals' perceptions of the effectiveness of their management group. The tool was a 4-point Likert type scale (Barnett, 1991) with all questions positively directed with responses varying from good, satisfactory, need to improve to poor. A 4-point scale was used because scales with an even number of points allow some variation, but do not have a midpoint and in that sense force a choice and avoid clustering around a mid-point (Oppenheim, 1992). Further adaptation and piloting was required to make it appropriate and fit for the purpose of this study.

Adaptation

In order to determine the perceived effectiveness of the management groups, the tool required adapting to attempt to ensure its complete applicability to this research study (Appendix 6). The adaptations were driven by reviewing the question design literature (Oppenheim, 1992, Walliman, 2001), considering issues such as what variables needed to be measured, the use of clear unambiguous language, simplicity to enhance the response rate and layout for processing of the information. My tacit knowledge and discussions with experts were used to ensure the right questions were being asked and the language was appropriate for service users. The adaptations included the addition of questions which allowed identification of which management group the participants came from. The instructions and some of the questions were simplified as the management groups included service users. The standards of plain and simple language (DH, 2003c) were met. The tool was reformatted so it could be circulated electronically or by post. This met the needs of all of the research participants.

Piloting

The tool was piloted with two members of each project management group to ensure ease of use and to review any issues arising. As a result of this exercise, the questionnaire was reformatted including adding tick boxes in the electronic version to reduce the time for completion. The above approaches were taken to enhance validity and reliability and to encourage the highest response rate possible.

Population

The population consisted of the sexual health and kidney management teams, incorporating clinicians, managers and service users who designed the strategy for the change projects and led specific work streams. Each team was responsible for the governance and accountability of the whole work programme. The management teams were chosen as the population because they provided the strategic direction and approved the funding for projects. As a result, the success of clinicians, specifically doctors, in influencing and leading the teams was critical. The functioning of the clinicians influenced the effectiveness of these teams. Issues and tensions within the teams could have inhibited the effectiveness with which the clinicians performed their roles and thus affected the outcome of projects.

The sexual health population comprised four men and twelve women. Their roles and healthcare setting are summarised in the table below.

Table 4.2 - Sexual Health Management Team Population (n = 16)

Job Role / Remit	Total	Acute Hospital Setting	Primary Care Setting	Voluntary or Independent Sector	Cross-organisational Role
Hospital Consultant	2	2			
General Practitioner / Community Doctor	4		4		
Manager	7	1	4	2	
Change Agent / Improvement Facilitator	3				3
Patient / Service User	0				

The kidney management team population comprised nine men and five women. Their roles and healthcare setting are summarised in the table below.

Table 4.3 - Kidney Management Team Population (n = 14)

Job Role / Remit	Total	Acute Hospital Setting	Primary Care Setting	Cross-organisational Role
Hospital Consultant	4	4		
General Practitioner / Community Doctor	2		2	
Manager	2	1	1	
Change Agent / Improvement Facilitator / Evaluator	2			2
Patient / Service User	4			4

The sexual health and kidney management team members were employed thus worked for either one of the four NHS organisations or the voluntary sector, within inner city London. The two hospital providers are Foundation Trusts, offering secondary and tertiary healthcare, both to the local population as well as attracting patients from outside the immediate geographical area. The two primary care trusts have the complexity of undertaking dual roles as providers and commissioners. The voluntary sector consists of charities who are commissioned to provide specific services, targeting certain sections of the community. The strategic health authority is NHS London, which has a substantial performance management role. The population of approximately 500,000, is culturally diverse, and has extreme deprivation alongside immense wealth, resulting in significant health inequalities.

This environment offers many challenges to effective work across organisational boundaries. For example, there are diverse cultures, values and incentives within each of the organisations and also different financial limitations on each organisation. Care is delivered across each of the individual organisations in different ways and settings. National policy impacts locally in erratic ways, for example by sometimes causing perverse incentives (such as the way the finances flow through the NHS with payment by results). This frequently results in different individual organisational and clinician's key priorities, and can cause tensions and competition across the health economy.

In terms of the study population, a higher number of clinicians within the sexual health management team worked in general practice or community settings, compared to the clinicians within the kidney management team, who primarily worked within hospital settings. This reflected the nature of the service provision in these areas at the time of the study.

The management teams and specifically the doctors had to have influence across organisational and professional boundaries to deliver

successful project outcomes. This is more challenging than working within one organisation or service, where individuals may have some formal power or influence. The complexity of the setting including multiple stakeholders with differing priorities made this a complex task.

Activity

The team effectiveness tool (Appendix 6) was sent out to all members of the sexual health and kidney management teams. The information sent out included a covering letter with clear instructions on how to complete the tool (Appendix 7). The tool was in Word format and was simple, quick and easy to use. Within the consent process, the option was offered to use either email or the postal service. All NHS staff requested the tool to be sent by email, whilst two of the four patients requested the postal method. Support in filling out the tool was offered, but none was requested.

Non-response can be an issue with questionnaires sent out via email and post and can potentially bias the results. An attempt was made to reduce the non-response rate by clear communication, using a simple, quick and easy questionnaire, providing adequate time for people to return the questionnaire, and undertaking two follow-up mail-outs (Oppenheim, 1992). On reflection, sending the tool out during the height of the summer holiday period resulted in having to undertake two follow-up reminders. To preserve anonymity, it was not known who had not returned the tool. All chaser mail-outs therefore had to go to all group members, with the potential risk of irritating the participants who had responded early. With hindsight, it would have been beneficial to delay the mail out until the main summer break had finished and to use an anonymised coding system to enable the tracking of responses.

Analysis

All responses were entered into an Access database using a bespoke Access form (Appendix 8). Anonymity was assured by a data analyst saving all of the questionnaires on the database with no link to source. This form had an extra option 5, not present in the tool, to record when no answer was given to a question. Structured Query Language (SQL) statements were written to extract information from the database about the two management groups for detailed analysis. SQL is a mechanism for querying relational databases, such as Access. Due to the small sample size (n=26) it would not have been statistically valid to generate confidence intervals around the results and therefore descriptive statistics have been used to compare the returns from the two study groups (Robson, 2002). The trends and totals can be seen through the number of responses and the use of percentages. Built-in Access functions were employed to present the data graphically. The analysis of the findings influenced the design and development of the focus groups and semi-structured interviews.

Phase 2 - Focus Groups

Focus groups were the method employed for Phase 2 of the project activity. Two focus groups were undertaken and the learning from the team effectiveness tool influenced the design and development.

The resources employed in the creation of a topic guide for the focus groups were the literature regarding focus groups (Oppenheim, 1992) and the reading and literature used in the literature review. The learning from the team effectiveness tool process, analysis and the new insights and understanding were also instrumental. For instance, in one action research cycle, the team effectiveness tool analysis and findings were presented to each of the management teams individually and discussed with the evaluation team (which works with the change project). This process initiated significant debate and learning, resulting in further action

research cycles, which facilitated the learning influencing the future design of the study. For example, the debate with the management group highlighted the need to ensure the focus groups and semi-structured interviews focussed specifically on patient involvement as a key topic area as, on reflection, the team effectiveness tool had not offered any illuminations in this area. In addition, accountability was debated as both an inhibitor and enhancer. This resulted in a specific question on accountability being included within the topic guides.

The synthesis of my experience and thinking to create the themes was also a vital developmental stage. My views and suggestions, reinforced by discussion with experts, were used to attempt to ensure results with a high degree of validity and reliability. The creation of the topic guide (Appendix 9) and questions therefore followed an inductive process.

Sample

Focus groups consisting of the twelve leading doctors working within the management teams were chosen to give a specific focus on clinical leadership. Using all the doctors on both of the management teams at this stage allowed access to many differing perspectives, but maintained a clear focus on practising clinicians. This offered a varied range of information and data and diverse emergent themes were used in the development of the topic guide for the semi-structured interviews.

The sexual health Focus Group sample comprised six doctors, five women and one man. Two of the sample were acute hospital consultants, two general practitioners, one community sexual health consultant and one public health consultant. The kidney Focus Group sample comprised six doctors, consisting of five men and one woman. The sample included four acute hospital consultants, one general practitioner and one public health consultant, giving a total sample of twelve doctors. The contrast in the gender composition of these two groups were noted and considered further during the analysis.

Activity

All twelve doctors invited from both management teams participated. My personal assistant negotiated a mutually convenient time and located a neutral venue away from the workplace. The two management team focus groups were held separately so any differences in opinions and mind-sets between the two groups of doctors could be identified.

I facilitated both of the focus groups and ensured all individuals could freely express their views. No difficulties requiring intervention arose. I attempted to be mindful of my potential bias as an insider researcher (Waterman et al. 2001) and of the potential impact of my role within the project. An independent observer was used to document the interactions between participants, non-verbal behaviours of the group and my role (Kitzinger, 1999). The independent observer noted in their field notes:

'The team were not led at all in the discussion by the facilitator. The body language reflected a group who knew each other well and who were comfortable talking about change. There were times when the discussion grew more passionate, but there was always respect shown for individual opinions'.

The focus groups ran for one and a half hours, in comfortable, quiet neutral settings. Kitzinger (1999) notes that there can be problems associated with interpretation of notes. Consequently, consent was obtained for the session to be recorded and the tapes transcribed. However, the non-verbal behaviour noted and observed by the facilitator and observer added to the quality and reliability of the data (Walliman, 2001).

Phase 3 - Semi-structured Interviews

Phase 3 of the study consisted of semi-structured interviews. Three interviews were held with two doctors and one service user. The learning

from the team effectiveness tool and the focus groups influenced the design and development. The final topic guide was created by using open-ended questions (Oppenheim, 1992) providing a loose structure to define the areas to be covered (Appendix 10). An inductive process was used to define the areas to be explored. The topic guide design emerged from the analysis of the findings of the team effectiveness tool and the focus groups. Several action research cycles were undertaken throughout the process of data synthesis. In one action research cycle, the team effectiveness tool was debated and discussed with both of the management teams and the evaluation team. In another cycle, the focus group analysis was checked through individual member checking to increase confidence in validity, but was also discussed informally with the clinicians and the project change team to elicit the learning for the study and the change project. An impetus for change for the study resulting from the action research cycles undertaken was the realisation that the study data would be enhanced if a semi-structured interview were undertaken with a patient as well as two clinicians. This significantly changed the focus of the semi-structured interviews. In addition, from the discussion of the analysis of the focus groups, another action research cycle identified the emerging theme of what personal skills and qualities were required by clinicians to work across boundaries, which thus influenced the development of the semi-structured topic guide. Finally, the use of an independent observer for the focus groups was noted to be advantageous and was therefore used for the semi-structured interviews. This illustrates the cyclical action research approach, allowing for data collected from one method or source to inform the next stage. The findings were synthesised with semi-structured interview literature (Britten, 1995), literature from the study's literature review and my experience. In order to promote validity and reliability, the questions were checked through debate and discussion with relevant experts.

Sample

For the three semi-structured interviews, one doctor from each management team and one service user were interviewed. The doctors were selected as they had actually delivered significant changes across organisational boundaries. The doctor from the sexual health management team was an acute hospital consultant and the kidney doctor was a general practitioner. The use of doctors from both management teams, who work within fundamentally different environments and contexts, enabled a diversity of data to be collected. The service user who was selected was an integral part of the kidney management team. This person chaired the management team and was involved in several of the change projects across the whole pathway. A service user was not used from the sexual health management team, as there are more complex confidentiality issues with sexual health service users. A service user was selected for their ability to offer fundamental insights into the understanding of the context, and the influence and effect of having service users involved. Service users view the success of the projects from a different perspective than doctors. This important insight added to the richness of data collected (Shortell et al. 2004). Three semi-structured interviews were undertaken to ensure the size of the study was manageable and feasible within the timeframe, but still ensuring in-depth analysis.

Activity

The three semi-structured interviews were organised at times and venues convenient to each person. I facilitated the semi-structured interviews with a consistent consideration of my potential bias as an insider researcher.

Analysis – Focus Groups and Semi-structured Interviews

A transparent process was used for the data collection and analysis stages. The focus group and semi-structured interview data was analysed using Ritchie and Spencer's (1993) Framework Analysis. The stages were iterative and are represented in table 4.4 below. The sexual health and kidney management teams' focus group data was analysed together. The original idea was to analyse the data separately to gain comparisons. In reality, whilst undertaking the analysis no difference was seen so the data was analysed co-jointly. The three semi-structured interviews were also analysed simultaneously.

Table 4.4 - Framework Analysis

Familiarisation – immersion in all data
Identification of a thematic framework – these arose from emergent themes as well as from the original research questions and objectives
Indexing or coding - of all the data against the thematic framework
Charting – pulling together of thematic themes
Mapping and interpretation – making sense, creating the concepts and theories

The familiarisation stage involved reading the transcribed raw data to gain an overview of its range and diversity and to start the initial consideration of key ideas and recurrent themes across the data sets. The next stage of identifying a framework entailed distinguishing key issues, concepts and themes. The framework drew upon a priori issues, questions derived from the research questions, study aims and objectives, emergent themes raised by the respondents and analytical themes arising from emerging patterns in the data. All raw data was examined, referenced and indexed according to the framework created. This was undertaken manually using materials such as flip chart paper and different coloured post-it notes.

The indexing stage involved applying the framework systematically to all the raw data using numerical codes. The charting stage required assigning the data to the appropriate part of the framework, and then forming charts. This allowed the whole dataset to be easily read across its breadth. The charts were themed on each key subject area, drawing together all themes across the whole dataset and highlighting single and repeating themes. The final stage was mapping and interpretation, using the charts to define concepts (for example leadership), mapping the range and nature of patterns and trends, finding associations between themes (such as patient involvement), explaining the findings and developing strategies. This final stage was influenced by the original research questions, study aims and objectives, the learning from the team effectiveness tool and, as appropriate, the focus groups and the themes that emerged from the data. The whole process was one of iteration, revisiting and reviewing the data in an attempt to ensure all findings were considered. As recommended by Silverman (2005), questions and themes holding high value in the analysis were included in the write up of the results to help increase reliability. Peer review and expert advice helped throughout the process to validate both my approach and analysis of the findings. This attempted to ensure that the process was not influenced by prior frameworks, models or theories.

Project Management

I led and managed the overall study. I have extensive healthcare knowledge and experience in many different arenas: clinical, managerial, operational and strategic, and in many different roles: facilitator, change agent and consultant. Through my work, I have developed an extensive network of public and private sector relationships, which were critical to the delivery of this study.

As a senior leader of a large change project, I have the authority, knowledge and experience to undertake this study. I have a team of service improvement practitioners and a senior information analyst who

offered me support and capacity whilst undertaking the study. The activity and data were my responsibility to define and collect. Throughout the process, I was mindful of the potential pitfalls of my dual role as researcher and leader of the overall change project (insider researcher). Whilst I acknowledge the limitations of my research experience, the use of many experts in research, academia and evaluation helped to overcome any issues.

Study Reliability, Validity, Rigour and Authenticity

Issues of reliability, validity, rigour and authenticity were considered throughout this study. Walliman (2001) states that the researcher should provide a reliable and clear account of all activities. I have achieved this by:

- Ensuring the data was recorded accurately by using a transcriber and an independent observer. This also eliminated any issues with memory reliability
- Articulating clearly how data was collected and analysed.
- Ensuring all the focus groups and semi-structured interviews were held in a neutral environment at the participants' request, and at a mutually convenient time
- Using member checking to reduce the potential of insider researcher bias and reactivity
- Documenting a clear audit trail of all activities and data collection processes
- Data triangulation – all three data sources were compared and contrasted to identify recurrent themes, thus enhancing reliability, validity, rigour and authenticity

Ethical, Moral and Legal issues

Throughout the process, an attempt was made to uphold the values of honesty, frankness, personal integrity and ethical behaviour (Walliman,

2001). All prospective research participants were contacted personally with full information about the planned study. Written informed consent was gained from all participants. The freedom to opt out of the research at any time was offered, but was not accepted by any participant.

All participants were ensured full privacy, confidentiality and courteous treatment. Feedback mechanisms were consistently in place and the “Data Protection Act” (Department of Constitutional Affairs, 1998) was fully met, and all data was anonymous.

Throughout the study I was mindful of ensuring the two teams did not perceive any issues of competition or disadvantage as arising from the processes, or have any other concerns, which may have compromised the change project. This was not an issue at any time.

A Reflective Practitioner

I am a member of two action learning sets, where my fellow participants act as critical friends and offer advice, we learn from our own and others’ problems and gain insights into our patterns of behaviour (McGill and Beaty, 1992, Pedler, 1997). During this study, engaging in critical debate with peers enabled me to safely explore the complex issues of undertaking research and to learn (Schon, 1991, Brockbank et al. 2002). Edmonstone (2003) espouses the importance of reflection on critical issues and the exploration of preferred styles and preferences through action learning sets. These sets provided the time and space to reflect and learn.

Additionally, over my doctoral journey I have kept a reflective diary (Pedler et al. 1986). As Senge (1990a) states, I required a surfacing and rethinking of new mental models and ways of doing things, for example considering the fundamental issue of whether a clinical leader currently means a doctor. This diary has been enhanced by my interactions and critical debates with my doctorate peer support group, the module peer

group, my two action learning sets and my coach. Being a reflective practitioner (Schön, 1991) has had profound implications on my role as insider researcher, as I had to analyse my assumptions throughout the process. In an effort to enhance my objectivity, I needed to ensure I was constantly striving to broaden my horizons and challenge my own mind-sets and assumptions through debate and interactions (Edmonstone, 2003). For example, the blending of my managerial and clinical mind-sets allowed me to consider and use both aspects effectively. The action learning sets and reflective diary provided mechanisms to facilitate this. They also influenced the study activity, helping me to address issues and concerns as they arose (for example the level of patient involvement), thus providing additional insights into other cultural change initiatives similar to my change project.

Chapter 5

Study Findings and Analysis

This chapter presents the study findings and analysis including the team effectiveness tool response rates, findings, and analysis. The qualitative methods of focus groups and semi-structured interviews findings are interpreted and an analysis offered.

Team Effectiveness Tool - Response Rates

The tool was sent out to a population of sixteen people within the sexual health management team, with fifteen questionnaires returned, giving a response rate of 93.75%. Fourteen questionnaires were sent out to the kidney management team, with eleven responses returned, presenting a response rate of 78.57%. Three service users formed part of this sample. There were nine responses sent back via the postal service, with the remaining seventeen being sent by email. The individual team and total response rates are shown in table 5.1 below.

Table 5.1 - Team Effectiveness Tool Response Rates

Management Team	Number of Questionnaires sent out	Number of Questionnaires returned	Response Rate %
Sexual Health	16	15	93.75%
Kidney	14	11	78.57%
Total	30	26	86.67%

Out of a total population of thirty, n=26 answered the questionnaire tool giving an overall response rate of 86.67%. There are differing views on what constitutes an acceptable response rate. Robson (2002) claims that 70% is normally quoted, but he also notes simulation techniques have suggested that a response rate of about 90% is required if bias is to be

avoided. Bowling (1997) suggests that a response of over 60% is necessary to ensure an accurate picture of the population chosen. However, Armstrong and Ashworth (2000) noted in their studies of GP questionnaire responses that the important point is not to assume the non-responders' views will be the same as those of the responders. I believe the response rates were acceptable. No particular reason can be offered for the slightly lower kidney management team response.

Whilst user involvement was a central tenet to this study, the complex issues of confidentiality in relation to sexual health service users resulted in none being involved. The service users' participation therefore was solely from the kidney management group, comprising 27.3% of the kidney sample and 11.5% of the total sample.

Findings

The positively directed perception response options to questions posed in the tool were: *poor, need to improve, satisfactory, good or not answered*. Due to the small sample size (n=26), descriptive statistics were used to compare the two study groups. All raw data can be found in Appendix 11, and a detailed analysis is provided in Appendix 12.

Analysis - Combination of 'Satisfactory' and 'Good' Perception Response Scores

The following tables offer a comparative summary of the sexual health management team, the kidney management team and the combined team perception response scores. Table 5.2 combines 'satisfactory' and 'good' perception response scores to illuminate those areas where the research suggests that effective team working was occurring. These areas are indicated by the relevant questions having scores above 85% and such scores have been highlighted in bold.

Table 5.2 - Combination of 'Satisfactory' and 'Good' Effectiveness Perception Scores

Combination of 'Satisfactory' and 'Good' Effectiveness Perception Scores						
	Sexual Health		Kidney		Combination of all Responses	
Question	Number of Responses (Total =15)	%	Number of Responses (Total =11)	%	Number of Responses (Total =26)	%
Q1	14	93.33	11	100.00	25	96.15
Q2	12	80.00	11	100.00	23	88.46
Q3	12	80.00	9	81.82	21	80.77
Q4	12	80.00	9	81.82	21	80.77
Q5	11	73.33	8	72.73	19	73.08
Q6	9	60.00	8	72.73	17	65.38
Q7	11	73.33	7	63.64	18	69.23
Q8	10	66.67	10	90.91	20	76.92
Q9	11	73.33	8	72.73	19	73.08
Q10	10	66.67	9	81.82	19	73.08
Q11	14	93.33	9	81.82	23	88.46
Q12	11	73.33	11	100.00	22	84.62
Q13	11	73.33	6	54.55	17	65.38
Q14	10	66.67	8	72.73	18	69.23
Q15	12	80.00	8	72.73	20	76.92
Q16	13	86.67	9	81.82	22	84.62

This table demonstrates that question 1 had the joint highest percentage score for the sexual health management team of 93.33%, the joint highest percentage score for kidney management team of 100% and the highest combined perception response score of 96.15%. These results suggest that both teams believed that their teams were highly effective in accepting the views both of other team members and of people outside the immediate team.

The sexual health management team rated themselves at 93.33% (with a combined perception response rate of 88.46%) for question 11. This

indicates the sexual health management team believed they were highly successful at effectively working creatively with problems. The sexual health management team also scored 86.67% for question 16, indicating perceived effectiveness at measuring their own progress in relation to the care and services they gave.

The kidney management team scored 100% for question 2 (with the combined score of all perception responses being 88.46%). This result suggests that the kidney management team judged themselves highly effective at communicating openly and honestly. The kidney management team also scored themselves at 90.91% for question 8, suggesting they considered themselves effective in achieving their own personal objectives and in achieving the wider team objectives. In answer to question 12, the kidney management team scored themselves at 100% suggesting they estimated they were highly effective at ensuring that problems were solved and results were achieved.

The lowest combined '*satisfactory*' and '*good*' scores were 60% for the sexual health management team for question 6 suggesting low effectiveness in team members accepting personal responsibility for problems. For the kidney management team the lowest score was 54.55% for question 13, indicating low effectiveness for reporting and discussing potential problems before they become real problems.

Analysis - Combination of '*Poor*' and '*Need to Improve*' Perception Response Scores

Conversely, table 5.3 combines '*poor*' and '*need to improve*' perception response scores to illuminate those areas where the tool suggests that the teams were less effective. These areas are indicated by the relevant questions having relatively high scores (above 25%) and such scores have been highlighted in bold.

Table 5.3 - Combination of 'Poor' and 'Need to Improve' Effectiveness Perception Scores

Combination of 'Poor' and 'Need to Improve' Effectiveness Perception Scores						
	Sexual Health		Kidney		Combination of all Responses	
Question	Number of Responses (Total =15)	%	Number of Responses (Total =11)	%	Number of Responses (Total =26)	%
Q1	1	6.67	0	0	1	3.85
Q2	3	20.00	0	0	3	11.54
Q3	3	20.00	2	18.18	5	19.23
Q4	3	20.00	2	18.18	5	19.23
Q5	2	13.33	3	27.27	5	19.23
Q6	6	40.00	3	27.27	9	34.62
Q7	3	20.00	4	36.36	7	26.92
Q8	4	26.67	1	9.09	5	19.23
Q9	4	26.67	3	27.27	7	26.92
Q10	5	33.33	1	9.09	6	23.08
Q11	1	6.67	2	18.18	3	11.54
Q12	4	26.67	0	0	4	15.38
Q13	4	26.67	5	45.45	9	34.62
Q14	5	33.33	3	27.27	8	30.77
Q15	3	20.00	3	27.27	6	23.08
Q16	2	13.33	2	18.18	4	15.38

This table illustrates that question 6 scored the highest for the sexual health management team at 40%. This correlates with the low score when combining 'satisfactory' and 'good', showing that the sexual health management team's least effective area was that of team members accepting personal responsibility for problems. The kidney management team had their third highest score for this question at 27.27%, with a combined perception response score from both teams of 34.62%, suggesting this was an issue across both management teams.

The next highest response for the sexual health management team was 33.33% for both questions 10 and 14. This indicates low effectiveness amongst this team in working with other teams when problems require it and in ensuring agreed actions were followed up and delivered. Additionally, questions 8, 9, 12 and 13 score 26.67%, demonstrating areas of reduced effectiveness for this team.

The kidney management team's highest score was 45.45% for question 13. This correlates with the lowest score for this team combining 'satisfactory' and 'good' perception responses. It shows that the most ineffective team working was occurring for the kidney management team in reporting and discussing potential problems before they became real problems. The next highest score for the kidney management team was question 7, scoring 36.36%. This suggests that this team was less effective in creating understanding of and answers to the problems experienced by the team. Both of these scores are interesting in contrast to the team estimating they were also highly effective at ensuring that problems were solved and results were achieved and at communicating openly and honestly. Questions 5, 6, 9, 14 and 15 score 27.27% also demonstrating areas of less effective team working for the kidney management team.

Question 14 has high scores when comparing the results from both teams (33.33% for the sexual health team, 27.27% for the kidney team and a combined response score of 30.77%). This demonstrates low effectiveness across both teams in ensuring agreed actions were followed up and delivered.

Summary of Team Effectiveness Tool Findings

The following tables summarise the findings of the team effectiveness tool and demonstrate areas of more effective and less effective team working. The findings suggest that both teams were open and accepting of other views both inside and outside the teams, able to communicate

openly and honestly, and work creatively with problems. However, in contrast less effective handling of problems was a recurrent theme across both teams. There were also some contrasts across the teams in relation to less effective team working (these are discussed further in Chapter 6). Insights or learning about patient centredness were not gained through the analysis of this tool. This omission influenced the development of the topic guides for the focus groups and semi-structured interviews.

The process of undertaking a team effectiveness tool influenced the overall change project. Both management teams debated the team effectiveness tool analysis and findings. Several changes resulted from the process of completing the tool and debating the findings. For example, each of the management teams reviewed their accountability arrangements, both for individual members and as a management team. This has resulted in clearer allocation of tasks and activities, and more effective reporting of governance and accountability within the management team. It also raised the issue of the relationship between accountability and delivery of successful outcomes. The other key impact on the change project from this process is a new policy for the use of clear and plain English.

Table 5.4 - Sexual Health Team Effectiveness Tool Findings Summary

Highly Effective Team Working	Less Effective Team Working
Accepting the views of other team members and people outside the immediate team	Accepting personal responsibility for problems
Working creatively with problems	Achieving own personal objectives and also achieving the wider team objectives
Measuring their own progress in relation to the care and services they give.	As individuals constantly offering help with problems with the team
	Working with other teams when problems require it
	Ensuring that problems are solved and results are achieved
	Reporting and discussing problems before they become real problems
	Ensuring agreed actions are followed up and delivered.

Table 5.5 - Kidney Team Effectiveness Tool Findings Summary

Highly Effective Team Working	Less Effective Team Working
Accepting the views of other team members and people outside the immediate team	Owning problems associated with the care the team delivers
Communicating openly and honestly	Accepting personal responsibility for problems
Achieving their own personal objectives and also achieving the wider team objectives	Creating understanding of and answers to the problems experienced by the team
Ensuring that problems are solved and results are achieved	As individuals constantly offering help with problems with the team
	Reporting and discussing potential problems before they become real problems
	Ensuring agreed actions are followed up and delivered
	Doing the things which have been agreed and that individuals have said they will deliver

Table 5.6 - Sexual Health and Kidney Combined Team Effectiveness Tool Findings Summary

Highly Effective Team Working	Less Effective Team Working
Accepting the views of other team members and people outside the immediate team	Accepting personal responsibility for problems
Communicating openly and honestly	Creating understanding of and answers to the problems experienced by the team
Working creatively with problems	As individuals constantly offering help with problems with the team
	Reporting and discussing potential problems before they become real problems
	Ensuring agreed actions are followed up and delivered

Focus Groups Analysis

The interpretation of the analysis from the two focus groups is provided below. The analysis is of the two discussions which ranged through a variety of topics. The analysis generated nine core thematic areas, each containing additional sub-themes and patterns as seen below. As suggested by Ritchie and Spencer (1993), some of these thematic areas could be developed into strategies for change (this is considered further in Chapter 6). Quotes from the original transcribed text are provided, to further highlight the context of the study, applicability (Symon and Cassell, 1998) and transferable learning. These quotes are representative of typical responses to demonstrate a particular theme, or several themes which are embedded in one sentence, demonstrating the multiplicity of the themes.

The interpretation of the analysis provides comprehensive insights into the original research questions by identifying the characteristics and impact of effective clinical leadership and engagement when working across the organisational and professional boundaries. In addition, this analysis was fundamental in the development of the 'Practical Recommendations'.

1. The Need for a Forum or Focus to Initiate Inter-Organisational Working

The necessity to get to know other clinicians and gain an understanding of different perspectives, working environments, cultures, conditions, pressures and issues was perceived as essential to facilitating inter-organisational working.

"It's partly about appreciating the different ways and the different limitations that people have to work within, that makes you more aware of, you know, how, how people are working."

The requirement for a setting or forum to be neutral, not owned or dominated by one organisation was considered important. The promotion of equal ownership of the forum through early and equal stakeholder engagement was noted. The need to have a reason for working across the pathway, and thus across organisational boundaries, was highlighted as essential.

“You need to identify all your potential stakeholders very early so that you include them very early. And even if effectively one organisation does drive the beginning, you’ve got to have everyone there at the beginning, so that they can all contribute, and therefore they all have a sense of ownership.”

The use of roles that span organisations was noted as helping facilitate cross-organisational working.

“X is talking to lots of them, and X is not seen as being from a practice, you know, but X has been sort of enabling practices and encouraging practices to get more involved in Sexual Health. Yes, and X, who works for X PCT, has brought providers of services together, GPs and people from X Service, over really clinical issues. Again, because X is seen as neutral.”

Teams visiting other teams or services to see good practice was seen as fundamental to appreciating one another’s perspectives, as well as seeing new and different practices.

“And I think things like the X trip actually, I mean we all laugh about it, but actually six of us sitting down together for a week, I came back understanding so much more about what primary care did. And also about thinking about what X did at X from an equal – you know, I’d been a registrar at X but that’s a very particular perspective, it’s not about how does another hospital interact in my sector?”

This allows teams to learn from good practice and offers a benchmark for current practice, whilst also subtly gaining invaluable team building.

2. Clinical Leadership, Engagement and Team Effectiveness

Many different factors were suggested as facilitating clinical leadership and engagement across organisational boundaries. One of the key factors was that within the change project (the study setting), clinicians had self-selected through passion and interest.

“I was just thinking about, there’s an element of I think, perhaps in our groups, of self selection. So, I mean, so in the sense that there are other people in the sector that could have been involved in the change project, but the people that want to do.”

A degree of seniority with demonstrable experience, which generates respect and credibility, was noted as helpful to effect change within and across organisations. The ability to generate and build trust was also seen as important. Possession of the skill of influencing was seen as essential for those not in a senior position.

“How you influence people is around what they think of you, and the level of respect, because actually I don’t have any levers on whether someone in general practice does something or not.”

The need to work closely and effectively with the appropriate level of management was articulated as imperative to delivering change. Clinicians were also seen to be the historical memory of an organisation or service, as there was a view that managers may move more frequently.

“And I, for many years, have felt very strongly that the way you get really radical change, is by working properly managers and clinicians together.”

The personal skills of political awareness and team working were raised as imperative for clinicians to work successfully across organisational boundaries. The issue was raised, however, of traditional medical training not teaching, or preparing doctors to acquire, these skills and behaviours.

“Nowhere in your training is there development of team working skills and behaviours and also they talk about teams in clinical care, but it’s always like the doctors that are supposed to be leading the team.”

The power of using data to create peer review and competition was acknowledged as a key lever for change.

3. The Power of the Patient’s Voice, Involvement and Leadership

Service user and patient data was seen as extremely powerful in stimulating and driving change. Involvement of service users was noted to be critical as they brought a perspective which could be used to view services and the gap between services in a unique way and to challenge deeply held assumptions. Getting patients involved early was acknowledged to be important.

“Getting the patients involved really early, because although they have some loyalty to their unit and, or to their satellite or particular things, essentially they want the system to work well, and that’s very powerful.”

The patient’s voice and their evidence and stories were considered a key lever for influencing other clinical colleagues to buy into the change process.

“Well the one lever I think we have over colleagues who don’t particularly want it, if you go back and say, ‘That is what the patients want.’ It is incredibly powerful. No doctor would want to do something that is bad for patients.”

For patient involvement to be meaningful, it was deemed essential that clinicians have to take notice of and act on patient feedback and suggestions. It was noted that this is the difference between token involvement and real patient engagement.

“But they wouldn’t have learnt unless they’d seen what they said made a difference. And I think that’s really important, that if we go – it’s not token ... - if we get patients involved, then it’s our duty, as clinicians, to work really hard to do the things that they want us to do.”

It was stressed as key to identify patients who had the skills required for any particular change project or activity, and to provide feedback on how their skills had influenced the project and what difference their input made. By involving patients throughout the whole process, and enabling ongoing feedback, real learning can occur and empowerment can be seen.

“I’ve really noticed in our meetings that the first meeting we had in the October two years ago now, the patients were very anxious, they didn’t really understand what the deal was. By the time they came back 18 months to the inpatients, they understood how the system worked and you couldn’t stop the talking. You know, they’d learnt how to do the meetings. And so that they were on a learning curve.”

The concerns around the skills required by both clinicians and service users to work together meaningfully to improve services was raised.

“My experience is that users are very good at identifying the problems with the service, and that we’ve had a lot of, we’ve not managed to put in enough input to help them to identify the solutions, because you have to know quite a lot about what the potential solutions are, what the system can accommodate..”

The issue of payment to service users arose, especially in relation to sexual health.

“Users are expected to contribute their time for free and everybody else is being paid, and not users. The users now are paid. It’s an important step, a very first step along a pathway towards a, some sort of genuinely collaborative approach.”

It was acknowledged that paying patients may change the dynamic of the relationship and thus the accountability.

4. Barriers and Risks to Inter-Organisational Working

There were many sub-themes raised about barriers to inter-organisational working. The main areas were not having full senior management and corporate support for the project, with a further consideration being the

extremely hierarchal nature of some organisations, especially the acute trusts. It was stated that the current competitive market and current financial systems combine to render practical working across organisational boundaries extremely difficult, despite it being a policy imperative. Gaining alignment of clinical, financial and managerial perspectives was also seen as important.

“I mean everybody in your organisation being signed up to it. You know, I mean, you know, you might get certain people involved and other people just don’t want to know.”

Bureaucracy was highlighted as a key inhibitor especially when trying to work beyond just one organisation. Specific examples were given demonstrating how bureaucracy can severely delay or derail changes which would benefit patient pathways. Finding mechanisms to bypass the systems was seen as fundamental to success. Information flowing freely across all organisations involved was seen as a key driver for successful inter-organisational working.

“And there’s so much bureaucracy as well, isn’t there? You know, you’ve got, you know, within your own organisation as well, you have to get through it. And get through in everyone else’s organisations.”

Suggested ways to reduce the barriers included people working across organisational boundaries and using patient stories and improvements to the patient journey to inspire and encourage support of changes and cross-organisational working.

“And I think it would be really good to have people across sites and things like that, wouldn’t it? I mean that would really get engagement with different services.”

It was also noted that money is not central to driving change and sometimes a different approach or perspective can be more effective.

5. The Use of Incentives

Incentives within and across the healthcare systems were highlighted as fundamental drivers to initiate and sustain change. Whilst these were identified as critical drivers to change practice for the benefit of the patients by improving their journeys along the pathway, a lack of cross-organisational drivers was acknowledged, despite many policies citing cross-organisational working as fundamental for modernisation and radical redesign.

“In terms of other areas other than Sexual Health, the QOF (quality outcomes framework) – GPs receiving payment for certain activities) money has been an immense driver for things like, you know, the cardio vascular guidelines. And that, that has involved dialogue between primary and secondary care.”

The incentive of improving the patient experience and desire to enhance patient pathways were considered essential. The reality of patients' experiences of care passing between services and organisations was highlighted.

“In terms of the patient, the care is shared between two providers, but there's absolutely no linking between the GP side and the hospital side.”

Personal learning and development were emphasised as a clear incentive for clinicians to get involved.

“It's given me a very useful, very good and strong focus at an early stage in my consultant career, to allow me to develop myself and to develop more broadly, I think, than I would have done without it. You know, much stronger sense of working with patients, and for patients in a positive way, not just the individual patient, but actually the patient population. And I think I have a much better sense of what happens in general practice ...”

It was noted that a key motivator was ensuring people personally benefit from partaking in any project or initiative. Junior medical staff noted that their involvement had dramatically widened their perspective both of the

health service and of working with patients and the local population, providing significant career benefits.

6. Accountability...to What and to Whom?

The themes concerning to whom respondents were accountable were extremely varied, for example: patients; the employing organisation; the locality director; the General Medical Council; their practice; their medical director; and, themselves (personal accountability). This demonstrated the reality of the complexity of accountability within healthcare. The pattern of the impact of these responses raised vital issues, for example being employed by different trusts was considered an inhibitor to inter-organisational working, as allegiances are seen to be to individual organisations.

“I think that is critical, because for as long as people are employed by different Trusts, then obviously their, you know, your allegiance primarily has got to be to the person who pays your salary.”

A clear theme also arose regarding not feeling accountable to senior management. In addition, the high status of clinicians was raised together with a need to reconsider the relationship and status balance between managers and clinicians.

“Clinicians were higher up the pecking order than the managers in PCGs. And in some ways you ask, I don’t think it’s going to change until there’s a change in that relationship.”

In relation to the change project, a different type of accountability was described, as a wider accountability to the patient pathway and the patient population.

7. Service improvement approaches versus randomised controlled trials (RCT)

The issues of the importance of service improvement approaches versus RCT were raised. Medical training is clearly focussed on RCT having a much greater emphasis than service improvement or modernisation approaches. It was noted, however, that RCT do not necessarily facilitate innovation and creativity, and take much longer to deliver results. Additionally, the issue of RCT not answering the complexities of the real world was raised. A pattern of concerns was highlighted regarding the risks of the change project pushing the boundaries of what is currently deemed as clinically acceptable, and how it is imperative to gain adequate support for these changes.

“And that cultural phenomenon of the randomised controlled trial is so embedded, so completely and utterly, unquestionably embedded in all medical training and in every aspect of our lives, that it is very, very difficult to dislodge.”

“We’re going to push the boundaries in terms of what is clinically acceptable. And, you know, and that might be, I mean that would carry some risk.”

The starting point of change for service improvement was to consider patient evidence and focus on improving the quality of care.

“So we’ve not started with, ‘We need to do serious research here, but what we’ve done is we’ve started with, ‘We need to just improve quality of care.’ And the right way to do that is to just do it.”

This attitude was seen both as fundamental to successful service improvement and as different from the normal academic mind-set. The greater speed with which improvements to patients’ experiences are delivered by service improvement projects as compared to RCT was also considered an advantage.

8. Personal Risk of Inter-Organisational Working

When redesigning the whole patient pathway across organisational boundaries, the desired outcome is a transformed pathway providing better quality of care. This analysis acknowledges that this holds many personal risks. It may entail some of the individuals involved having an uncertain future, being managed by or working in a different setting, potentially losing their jobs or experiencing significant changes to their role. At a wider level it may also entail destabilisation of services.

“I think, I mean I think it’s quite risky for X, because I think, obviously X% of us are going to lose our jobs, I would say, potentially. That’s the sort of worst outcome for us, I suppose.”

It was also acknowledged that the unknown feels very risky, which can reduce collaboration and cross-organisational working.

“A lot of people feel, you know, that their jobs are much less stable than they were, which tends to mitigate against being collaborative and kind of, in general, more of a bunker mentality isn’t it.”

However, a clear theme was that to be involved and to have influence over the future creates huge personal and work opportunities.

“And it’s one of those things that’s a sort of an opportunity as well as a threat, isn’t it, because, you know, we’ve got opportunities to provide a really good service, have a new, you know, work in a different way, you know.”

Overall the benefits were deemed to outweigh the risks, but this needs to be considered alongside the self-selection of the clinicians involved.

9. Time Out and the Space to Undertake Service Improvement Work

It was acknowledged that having ‘head space’ and time allowed to undertake service improvement was invaluable for clinicians. This was seen to not be available in the current NHS climate.

“But it’s actually having my head space time that’s been really important for me.”

Additionally, the willingness to take a risk and a long-term view was seen as fundamental to success. However, frequent changing policy imperatives and organisational priorities were seen at times to counter this.

“And there’s lots of things in all sorts of areas that we do and we don’t change – because there’s a risk mentality. ‘This might cost, there is a risk associated, maybe we need to get somebody to champion it for six months.’ ‘Well we can’t, maybe next financial year,’ and that sort of thing, whereas in fact, you know, some of these things are relatively straightforward to do if you, a small degree of risk but a large potential benefit.”

It was highlighted that often the potential cost prevents creative innovation, when in reality the risk is relatively minimal.

Summary of Focus Group Analysis

Table 5.7 summarises the nine core thematic areas elicited from the analysis of the focus groups. These themes are diverse in nature and cover: environmental conditions; contextual factors; personal skills and behaviours; patient involvement; and, methodological approaches. No differences in findings were seen between the sexual health and kidney clinicians. The power of the patient voice, involvement and leadership was a very strong theme with clinicians stating this was one of the most important drivers to cross-organisational working.

Table 5.7 - Focus Group Analysis Summary

Focus Group themes
▪ The need for a forum or focus to initiate inter-organisational working
▪ Clinical leadership, engagement and team effectiveness
▪ The power of the patient's voice, involvement and leadership
▪ Barriers and risks to inter-organisational working
▪ The use of incentives
▪ Accountability...to what and to whom?
▪ Service improvement approaches versus randomised controlled trials
▪ Personal risk of inter-organisational working
▪ Time out and the space to undertake service improvement work

Within the change project, the process of analysis and feedback from the focus groups provided further impetus for change. The findings and analysis of the focus groups were discussed with all of the clinicians, the evaluation team and the senior management team of the change project. One of the key resulting changes was a re-framing of the use of trips. Prior to undertaking this debate, trips especially with just clinicians, were often seen as a bit of a “waste of time” and not value for money. The focus groups’ findings, alongside the subsequent debates and discussions surfaced the significant hidden value of these trips. These benefits included team building, raising of awareness of differences in perspectives, priorities and approaches between team members, capturing best practice alongside benchmarking current local services. This benchmarking had the additional benefit of highlighting excellent local practice, which was very motivational and helped promote further change. These trips overall had helped create understandings and relationships which promoted effective cross-organisational learning. These trips are now seen as a crucial part of team building resulting in effective cross-organisational working.

Semi-structured Interview Analysis

The analysis of the three semi-structured interviews generated seven core thematic areas. Several sub-themes and patterns were evident within the core areas, and some of the thematic areas could be developed into strategies for change (as recommended in Chapter 6). Further themes were identified in the semi-structured interviews which did not arise in the focus groups, such as the advantages and opportunities of inter-organisational working, and senior management and corporate engagement. These additional themes reflect the value of this method of data collection and provide a depth and rigour to the study. These new themes perhaps reflect the extensive experience of the two clinicians and the service user in delivering effective change across organisational boundaries.

Quotes from the original transcribed text of all three interviews are adduced to the thematic areas described below. These quotes are representative of characteristic responses supporting specific themes. As with the focus groups, the findings provide further illumination of the original research questions.

1. The Advantages of Inter-Organisational Working

The gains to patients, the health services and communities of working across organisational boundaries were acknowledged and seen to be valuable.

“There are significantly more upsides by working across communities and particularly primary and secondary.”

The benefit and inspiration of gaining different perspectives from working with colleagues across organisational boundaries were seen as important. Without this insight, clinicians could become focussed on a limited part of the whole patient pathway. The development of an

understanding of different perspectives from different parts of the health service and patient pathway was considered fundamental to working more collaboratively and improving patient care.

“So I’ve learnt a huge amount about how hospitals work and kidney doctors and nurses and kidney patients. And I’d like to think that they’ve learnt something about the primary care perspective. So it’s not just we get to understand each other’s perspective across, say, primary and secondary care, the very act of working together means we change patient care.”

It was perceived as fundamental to focus on the whole patient pathway, taking into consideration the impact on patients’ quality of life, regardless of the stage of their personal journey. The creation of connections between the historically separate areas of secondary and primary care provision had in some examples resulted in a coherent package of care which benefited the patient and also in some instances the state, as patients could return to work, thus became economically independent.

“And it meant engaging with Job Centre Plus. But you could argue, and I would say that a lot of the people in the acute sector may well argue that actually jobs are not anything to do with successful dialysis or not.”

The accelerated speed of achievement was acknowledged as one of the advantages of inter-organisational working. This was seen to be a result of working in a collaborative coherent way.

“I think that we’ve achieved things in a shorter period of time that we would have, that we would have taken a lot longer to achieve without making it a bit more joined up.”

The significance of having a collective vision, involving all stakeholders from the beginning and agreeing methods of working was recognised as important.

“So I argued passionately from the very start, that it shouldn’t be about patient experience, which, in a nutshell for me, was literally just about the experience that patients experience as they pass through the healthcare system. I felt that that was, that, for example, on dialysis, you pass through the healthcare system for only 7% of

your time. But you're suffering the consequences of the disease for 93% of the time. And this, as a good example, is a case where there are profound things. For example, symptom management etc., self care, where change can be introduced which will have a profound impact, in other words, within the pathway, not at home, not in the community."

The value of the patients' experience being at the centre of this vision was seen to reduce some of the barriers of inter-organisational working.

2. Clinical Leadership and Engagement

The degree of seniority and the respect other colleagues hold was seen as essential to leading successful inter-organisational change. Within the change project, respect between colleagues was recognised as important. It was clearly noted that there was a need to be respected to be able to influence peers outside the project to change their practice.

"A part of it is also about the level of respect you have for the people you're working with, and they have for you."

Being seen as honest, impartial and transparent was considered as a vital leadership skill. This encompassed the skill to be able to work beyond the individual's own organisation's perspective, boundaries or thinking.

"As modernisers we have to be totally impartial and fair and honest, that this is not about X organisation – and we have to champion, it doesn't matter, if it's right that someone from X should be involved – they should be."

The necessity to set a clear and inspirational vision to facilitate engagement and focus was seen as key for clinical leaders of inter-organisational projects. The vital importance of patients being at the centre of this vision was noted. It was stated that significant results could be achieved when clinicians get to a point where their whole perspective is driven by the patient.

“I think getting a common vision that pulls everyone together, not just clinicians, but doctors, managers, patients, in particular patients, carers, is profoundly important. And I think, pushing at the edge of what the vision is, something that inspires, it’s not just, let’s say, conventional – is important.”

However, it was considered that at times of significant uncertainty or ambiguity, there was a need as a clinical leader to provide a clear sense of direction within the vision.

“I think the leadership already feels more like we need to be a lot more directive. So I think because there’s a lot of uncertainty about, where it’s really going, what it’s going to look like, what it’s going to do, how it’s going to be funded, where it fits in with everything else etc. And so that feels like – which is a personal challenge to me, because I’ve never been in that situation that, well we, I think that we need to be a lot more directive and actually we’re kind of going round and consulting to get people’s ideas. But I think we need to write a paper, present a direction.”

Reminding people constantly of what they have achieved and early promotion of some quick wins were also considered key actions for clinical leaders working across organisational boundaries.

“And so I think the other thing is about giving out a real sense of, you know, that celebrating quick wins thing which I really believe in, you know, it could be one of the biggest motivators. It’s actually reminding people of all the things that we’ve achieved already.”

It was also felt that clinical leaders needed to be seen as challenging the status quo and assertively promoting new ways of working.

“But I think, as an individual, you make a decision early on in the modernisation process, that actually your head being above the parapet, which basically means that you can be criticised by your peers for what, to them, seems to be unconventional work, because you have that power of conviction that actually improves the quality of life.”

It was noted, however, that this sometimes meant ‘raising your head above the parapet’, as successful leaders of inter-organisational change need to have real conviction about what they are doing and to be able to see that the gains outweigh the risk.

3. The Skills Required by Clinicians to Lead Inter-Organisational Change

The multitude of skills required by clinicians when leading inter-organisational change was raised. Having excellent interpersonal skills was considered vital to being successful. This included an ability to alter the approach taken depending on the situation.

"I mean, what's the right word, I mean they are personable. You need to be able to get on with people initially."

Having strong and effective influencing skills was noted as essential for clinicians to lead inter-organisational change. This involved being seen to be enthusiastic and passionate, having a 'can-do' attitude, demonstrating commitment and being well informed and prepared. The requirement to be trusted and seen as competent was suggested as fundamental in gaining influence. Negotiation and conflict management skills, empathy, and an understanding of structure and process were also seen to be essential.

"I think, you know, it's because you need to be able to behave appropriately, influence when you need to negotiate, when you need to understand where other people are coming from, manage conflict, have a strategy, you know, think a little bit about structure and process and how you deliver that, so all of those things are essential."

Being able to see others' perspectives and demonstrate empathy by temporarily putting one's own interests aside was cited as a fundamental skill. It was commented that this requires individual self-awareness of working styles and approaches to differing interactions and situations.

"I'm interested in different perspectives on the same problem. And that's what you get when you work across boundaries. So it's not that my perspective is right, and everyone else is wrong. It's that my perspective is different. And I would like to know what someone else's perspective is."

“So I think, and also you need to have a, you know, a better awareness of how you work and how you interact.”

A strong ability to understand diversity and cultural issues and change, and be population focussed was also considered a critical skill in effecting successful inter-organisational change. It was seen to be of additional benefit to continue to maintain close clinical contact.

“I think another issue for me is that I still see patients regularly and for me that’s terribly important. So that when I’m talking about the patient in a particular situation, it’s one that I understand and feel, rather than one I theoretically know about.”

Management skills were cited as important, but it was also acknowledged that gaining these skills was difficult as they were not currently part of standard medical education.

“I do think management skills are important. I mean I suppose I haven’t really started to learn that until I started being a consultant. I mean you don’t really get much management experience or training. I think it’s difficult to say, it’s difficult to kind of put that stuff into practice sometimes.”

In relation to this, the important skill of being able to admit to not knowing something was highlighted, and the ability to work outside the individual’s comfort or knowledge zone.

4. The Power of the Patient’s Voice, Involvement and Leadership

The important skill of being truly patient centred and using the patient’s voice and experience to drive the changes across organisational boundaries was seen as imperative in the delivery of genuinely beneficial changes. It was noted that clinicians who were truly motivated by the involvement and leadership of patients frequently fundamentally affect the quality of life of patients on the pathway. It was also understood that the journey is not always easy and listening and acting upon a strong patient voice can be extremely challenging. Being able to acknowledge patients’

perspectives, and not feel the professional view is always right, was cited as difficult but a fundamental skill.

“I view the world through patients’ eyes, I think, predominantly. I mean those would be – yes patient tinted spectacles I would wear, I think, I’m happy to rock the boat in terms of how we work and what we do because I feel, I believe there are benefits to patients.”

The importance of having patients involved at every stage and throughout the infrastructure was identified as being crucially important. For example: having patients represented on every level of the infrastructure thus keeping the voice of the patient central to the work; gaining patients’ views both on current service provision and on the introduction of new, innovative models of care; using patients to evaluate services (and paying them to do it); patients offering peer support to each other; patients as teachers of clinical staff; and, taking patients on good practice visits to gain the patient perspective as well as the clinical and managerial ones.

“So I think that was a forum in which the patient voice really got heard. I mean profoundly heard and got written up. And delivered outcomes.”

It was commented that significant change could be made when patients see what a difference their involvement has made. Feedback is imperative to ensure the impact is acknowledged.

“And I think for me as a patient that’s been the most important part in actually me feeling a genuine partner, and a genuine insider.”

In order to get real inter-organisational working, it was suggested that it is necessary to go beyond just attempting to improve healthcare provision and to consider what will fundamentally affect patients’ everyday quality of life.

“Something that captures people’s imagination and that really empowers patients to work towards that, to actually contribute in a meaningful way, and also helps the clinicians begin to see, perhaps, perhaps, I’m not saying it has, but begin to see

healthcare in just a slightly different way, and what we're really talking about actually is quality of life."

This was seen as extremely motivating to both patients and clinicians.

5. Barriers and Risks to Inter-Organisational Working

The first barrier to inter-organisational working was the potential personal risks that individual clinicians may have to take. For example, when significant redesign occurs, there may be an impact on individuals' roles, security and status or a risk to their local and national profile when championing a change that is seen to be challenging accepted current practice.

"So I suppose there's a disruption to your planned future, which is, which is, you know, which makes you feel a little bit nervous."

The risk of not being able to carry other staff forward with the change was recognised. This was linked to concerns raised about the risk averseness of some managers, and how this can affect the roll-out or sustainability of an inter-organisational change project.

"The first one is that I won't carry other members of, let's say the PCT, or general practice, with this work. And that, in part, is always something that you run the risk of when you've got projects."

It was acknowledged that there were potential logistical risks, but these could be easily mitigated with good planning and senior management support.

"But, from the patient perspective, a patient perspective, I think the risks are significantly less than the huge potential benefits."

The key theme was that the gains from inter-organisational working clearly outweighed the risks, particularly in relation to improving patient care.

6. Opportunities of Inter-Organisational Change Projects

Many opportunities arising from inter-organisational working were discussed. The individual exposure and visibility, especially as a new consultant, were seen as beneficial to career development. In addition, the personal and cross sector learning which would not occur without a cross-organisational focus was highlighted as a unique opportunity.

“So I mean, I guess that that’s meant I’ve perhaps been more visible than I might, as a new consultant in this department, than I might have been if I hadn’t. So I suppose perhaps that’s made me a little bit more visible.”

The constructive competition involved when working across organisational boundaries was identified as an important issue. By ensuring the patient is kept central to all changes, different organisations or services can benchmark against each other and compete to undertake more effective changes. This competition must however be constructive and is based on a collaborative honest relationship.

“I mean, I love the fact that if we do something that X haven’t done or we do better than them. I’m sure that there’s that slightly competitive thing. There’s that mentality of being slightly the poor relation down here, I think, that enables us to be a little bit bolder. And I think we gain the benefit.”

The ability to be able to make mistakes and learn constructive lessons from the mistakes was considered invaluable. Connected to this, having a safe environment where lessons learnt from mistakes can be used to create faster and better solutions, was highlighted as vital.

“And part of our success is that we have been given the flexibility to try new things out and fail.”

Finally, the impact of inter-organisational working, with the patient at the centre, is that issues such as quality of life can properly be identified and successful outcomes created.

“Community care, for example, take me, being given home dialysis, that’s an option, profoundly changed, not only my quality of life, but enabled me to contribute as a meaningful economic unit, rather than being unemployed.”

Focussing on the entirety of the patient journey or pathway, rather than merely on one element thereof, means that all of the patient’s needs can be considered, not just individual healthcare elements.

7. Senior Management / Corporate Engagement and Support

Senior management / corporate sign-up and engagement were highlighted as critical to promoting the changes and supporting the individuals driving the inter-organisational working. The significant challenge of changing healthcare delivery between and across organisational boundaries was seen to require the agreement of, and support from, the most senior management level.

“I think it’s essential. I mean I can’t think of any negatives because I think it feels like that top level buy-in has given us a lot of leverage in times when we’ve needed it. So, you know, knowing that, you know, X CEO goes to those meetings, is aware of all the stuff, you know, has, it’s about that kind of general sign up to the philosophy, you know.”

It was noted that, to gain senior management support, there was a need to ensure the changes would be viable. This is, however, countered with the concern that senior management may be focussed on key managerial agendas and lose sight of the fact that the driver for change management is pushing the boundaries of improving patient care. This offers some tension as some dramatic improvements to quality of patient care may not be financially or strategically viable to one of the involved organisations.

“So although the chief executives get together and the directors get together, I think that they mainly deal with, what I would describe as managerial issues. And they perhaps lose sight of what this game’s all about, which is improving patient care.”

There was clarity offered on what senior management could bring to inter-organisational working.

“I think it can provide advice about what’s sensible and what’s not sensible, what’s doable and what’s not doable. And they can certainly - in theory they view the system in a different way.”

The focus was largely around unblocking or removing obstacles both intra- and inter-organisationally. Additionally, senior management were seen to have a role in ensuring projects were realistic and achievable.

Summary of Semi-structured Interview Analysis

Table 5.8 summarises the seven core thematic areas arising from the analysis of the semi-structured interviews. Many of these themes build on the focus groups’ findings, with new themes also arising. The power of the patient’s voice, involvement and leadership was a strikingly strong theme, as were the behaviours and skills clinicians require to lead inter-organisational projects. These behaviours and skills reflect a transformational leadership style (Gillespie and Mann, 2004). For example: setting a vision and direction when necessary; facilitating engagement and involvement; having strong interpersonal skills; and, being an effective influencer. Additionally, the service user provided a different perspective, which has enriched and validated the findings.

Table 5.8 - Semi-structured Interview Analysis Summary

Semi-structured interview themes
▪ The advantages of inter-organisational working
▪ Clinical leadership and engagement
▪ The skills required by clinicians to lead inter-organisational change
▪ The power of the patient’s voice, involvement and leadership
▪ Barriers and risks to inter-organisational working
▪ Opportunities of inter-organisational change projects
▪ Senior management / corporate engagement and support

Following the analysis of the semi-structured interviews, the findings were debated and discussed with the clinicians and patient who had undertaken the interviews, the clinicians on the management group, the evaluation team and the senior management team for the change project. These debates (action research cycles) resulted in several actions. For example, the significant issue of accountability resulted in a review and consideration of using honorary contracts to enhance the cross-organisational focus for accountability. Whilst it was too late to implement this for the current change project, the learning has been fed into other local cross-organisational projects with good effect. The multitude of new or adapted skills highlighted as crucial for clinicians to work effectively across organisational boundaries and within large change projects also created a series of changes. For example, those clinicians on key committees within Royal Colleges presented the evidence to colleagues, the learning was sent to key policy makers and a local leadership course with mentoring was developed in an effort to enhance the skill base incrementally.

Chapter 6

Discussion

The purpose of this study was to identify the characteristics and impact of effective clinical leadership, clinical engagement and team effectiveness when working across organisational and professional boundaries, and to develop and disseminate 'Practical Recommendations'.

Effective Clinical Leadership, Engagement and Team Effectiveness?

A team effectiveness tool was used to ascertain the management groups' perceptions of effective team working. Many of the areas that illustrated perceived effective team working reinforce the conclusions in existing literature of what constitutes an effective team. For example, Wheelan's (1999) premise that there is a requirement to have shared goals, methods to achieve the goals and an understanding of the purpose of the team, is verified by the findings. However, recurrent themes also emerged about less effective team working, which also concur with the literature. One such theme was the handling of problems: taking responsibility for problems and working with other teams on problems. Blanchard et al (1990) suggest that a high performing team has certain essential characteristics such as purpose, empowerment and using communication to solve problems. A second theme was of a perceived weakness in agreeing actions and achieving deliverables, supporting Shortell et al's (2004) view that one of the key features of an effective team is proactively taking actions.

There are also some striking contrasts within the results. For example, the kidney management team perceived themselves less effective in creating understanding of and answers to the problems experienced by the team, and in reporting and discussing potential problems before they became real problems. In contrast, the team estimated they were highly

effective at ensuring that problems were solved and results were achieved, and at communicating openly and honestly. This contrast may be due to espoused theory, with teams responding to what they believe they should do, versus what they actually do (Argyris and Schön, 1978). Alternatively, the contrast may relate to the complexity of the problem being addressed, and individual versus collective problem solving approaches. Simple problems can be relatively easy to solve and may be solved by an individual alone, whilst more complex problems involving multiple stakeholders and team decision making may prove to be more difficult to work through and solve. Successful inter-organisational working requires effectiveness in solving complex multiple stakeholder problems. Additionally, the ad hoc nature of the team selection resulted in different perspectives and priorities, as some members self-selected whilst others attended through the need to ensure representation of their service or organisation. In addition, the attendance level at meetings was varied. These may have added to this contrast.

Whilst the results elucidate some of the features of an effective team, they also suggest that perhaps the management groups may at times be more of a group than a team (Wheelan, 1999), especially when undertaking more complex activities such as dealing with problems as a single entity and producing collective outcomes. Moreover, there was no indication of any particular type or balance of Belbin's team roles across the teams (Belbin, 2004). All members work within one of the partner organisations, but come together to deliver the change project. The individuals have a diversity of job roles and accountabilities, and come from a range of healthcare settings. Some of the members are there through passion for the work, whilst others have to attend to ensure their service or organisation's needs are protected. Together with doctors' strong sense of autonomy and personal accountability, these factors mitigate against the formation of a genuine and effective team (Spurgeon 2001, Ham 2003). This raises the issue that attention should be made to the composition of a team. However, this is often not feasible within a real

world setting. Consideration is therefore required of the potential problems that ad hoc compositions pose.

Shortell et al (2004) suggest that the optimal size of an effective team is 10 to 13, although this was not strongly supported by other literature (Blanchard et al. 1990). The sexual health team having 16 members and the kidney team 14 may have had an impact on team effectiveness. In creating future inter-organisational teams such tensions will have to be considered, and boundary-spanning roles may be required (Gittell et al. 2005, NCCSDO, 2005a) to help reduce the barriers to effective team working.

Two of three change project teams were used for this study. This was largely due to the time constraints and size of the study, but also to ensure the change project was not affected, as the third team experienced some considerable challenges. It is therefore important to note when considering the findings that the two teams used were largely enthusiasts, with the third team having more challenges and issues, resulting in a reluctance to embrace change. It would be beneficial to undertake a further study comparing these teams.

The literature suggests that patient centredness is a key factor in a healthcare team's achievement of effective outcomes (Shortell et al. 2004, Institute of Medicine, 2003). Patient centredness did not arise as an issue within the team effectiveness tool results. With hindsight, the tool was insufficiently sensitive to identify this issue. Additionally, patient representation was low due to the complex confidentiality issues within sexual health services. This would need to be taken into account if further studies were considered.

The focus groups and semi-structured interviews offer an illumination of the characteristics and impact of effective clinical leadership and engagement when working across organisational boundaries. The analysis of the findings also creates potential strategies for change

(Ritchie and Spencer, 1993), many of which are offered within the practical recommendations (Appendix 13).

The literature supports the premise that inter-organisational working facilitates the delivery of coordinated care across the whole pathway (Gittell et al. 2005, Kenagy et al. 1999, The Institute of Medicine, 2003). However, this study additionally highlights the need for inter-organisational working to have a clear focus and purpose for it to gain momentum. It also demonstrates the basic requirement for doctors to get to know one another, for example by undertaking joint visits to widen individual perspectives. This enables doctors to gain a deeper understanding of the whole pathway, which both results in better patient care and produces the desired outcomes of the relevant inter-organisational projects.

Some of the literature on patient involvement is focussed on different methods of patient engagement (Tritter and McCallum, 2006, Care Services Improvement Partnership, 2006). Currently, there is limited evidence that involving patients in pathway change projects results in those projects focussing on improving patients' quality of life. Furthermore, there is also little evidence that having this focus results in improving patients' quality of life. The study findings show that patient-centred change projects do indeed focus on patients' quality of life, and do result in significant improvements thereto. This study suggests encouraging a change in mind-set away from focussing on improving the delivery and quality of healthcare and towards focussing on improving the quality of life, which is patients' greatest concern, especially for those with long-term conditions. In addition to the obvious benefit for patients, improvements to their quality of life can also have significant economic benefits by allowing them to return to work.

The experience of paying patients for their time and interventions was viewed positively. This is a new way of working for the NHS and the required processes and governance can be complex to establish.

However, the change in dynamic of the relationship between the clinician and the patient and the potential shift in accountability can be an effective lever for change.

It is important to note that the number of patients involved in this project was small. The espoused theory (Argyris and Schön, 1978) was to include patients throughout the study. However, within the real world setting of this study, a value-based decision was made not to include sexual health service users due to the complexity of confidentiality issues. Methods to involve sexual health service users were being tested within the change project, but as these tests were at a critical stage, it was deemed too risky to use them in this study. Further studies would potentially benefit from additional patient inclusion.

This study supports the findings (documented in the literature) that leadership by doctors is important to improving the NHS (Ham, 2003), and that effective leadership promotes improved patient care (Shortell, 1998, Ham, 2003, Spurgeon, 2001). The study did not offer further insight into the definition of clinical leadership (James, 2007, Cook and Leathard, 2004), but supports the idea that context is significantly relevant to leadership - in this case working across organisational boundaries (Edmonstone, 2005, Pettigrew et al. 1991). Within the study, transformational leadership skills were seen as important ingredients to enable successful change. This belief concurs with the literature, supporting the link between transformational leadership and delivery of change within the NHS (Smith and Edmonstone, 2001, Edmonstone, 2005, Leban and Zulauf, 2004).

There is recognition in the literature that doctors require new skills to in order to enhance the effectiveness of clinical leadership and engagement within cross-organisational projects (Fitzgerald, 1990, Spurgeon, 2001, Shortell, 2002, Ham, 2003, Ferlie, 2005, Harris, 2006, Buchanan et al. 2007b). The study findings support this contention and determine what some of the new skills required are, for example: interpersonal and

communication skills; influencing; political awareness; team working; ability to use the patients' voice to generate peer pressure; ability to generate and build trust; honesty and impartiality; working effectively with management; being able to see and thus work beyond one's own perspective; and, other significant but fundamental management skills. The findings further concur with the literature that these skills are not currently taught (Spurgeon, 2001, Shortell, 2002, Ham, 2003, Ferlie, 2005, Harris, 2006). This will need further consideration within medical training fields if inter-organisational projects are to be successful in the long-term.

This study does not give insights into models of leadership beyond a resonance with transformational leadership. However, some of the leadership ingredients (seniority, experience and the ability to generate trust), which engender faith in followers to believe and follow in leaders were highlighted. The study shows that leadership, rather than management, is required to produce significant change (Alimo-Metcalfe, 1996, Edmonstone and Western, 2002). It's participants acknowledged that clinical leaders and champions require additional leadership skills and behaviours in order to work effectively across organisational boundaries. This counters Alimo-Metcalfe and Lawler's (2001) suggestion that at times of change old practices tend to get new labels, rather than giving way to new ways of working and skills. In addition, the study participants reported that most individuals can learn new leadership skills, so new training is required. This would support the contingency theory (Beech, 2002) and the rational–legal leader (Alimo-Metcalfe and Lawler, 2002), in which any individual given opportunities for learning can become an effective leader. However, it must be noted that this study did not specifically set out to compare different leadership theories, so further research is necessary.

Significant barriers and risks to inter-organisational working were raised such as threats to individual's status and security and the potential destabilisation of services. The current competitive market was noted by

participants to pose significant risks to the future of effective inter-organisational projects (Jones, 2006). The findings regarding senior corporate management engagement were aligned with the literature (Kotter, 1995, Bate and Roberts, 2002, Dopson et al. 2002, Fitzgerald, 2007), with a fundamental requirement for senior managers to remove significant barriers. There was also agreement with the literature that bureaucracy significantly limits inter-organisational working (NCCSDO, 2005).

The research participants of this study saw the use of incentives and rewards as essential components in promoting effective whole pathway transformation. This is also consistent with the literature (Collins, 1991, Spurgeon, 2001, Graham and Steele, 2001, Ham, 2003). However, the study found that despite the policy focus on cross-organisational working, not only is there a significant lack of incentives for doctors, there are in fact substantial disincentives. Some current financial policies for example in primary care (Quality Outcomes Framework), offer disincentives to cross-organisational working in the healthcare system, as doctors get financial gain to undertake work in one healthcare setting, irrespective of effectiveness or patient choice. Softer incentives were highlighted as important, such as the immense personal learning and development which can be gained and the widening of individual perspectives and experiences. In addition, considerable career development opportunities are presented by the exposure and visibility these projects offer doctors, especially new consultants. However, the incentives need to be balanced with the potential personal risks these projects pose. The literature suggests that reconfiguration of services can alter security, status, income and research opportunities (Spurgeon, 2001, Ham, 2003). This study shows how such considerations can dramatically reduce collaboration and therefore imperil success. However, it was also noted that if doctors and patients are involved from the outset, they can influence the future effects of the project, including the effects on themselves.

Accountability can be a considerable barrier to inter-organisational projects. Whilst literature exists describing the nature of accountability (Connors and Smith, 1990, Connors et al. 2004), there is little discussion of how to gain effective changes to lines of accountability, or of the tensions between doctors' accountability and management / organisational accountability (Ham, 2003), or of how to use accountability to align incentives (for example, a whole pathway focus can reduce clinical autonomy). This study supports the urgent need for new and innovative solutions. Participants were clear that employment by different organisations significantly inhibited cross-organisational working, and that there was an urgent need to reconsider the relationship between management and clinicians.

The change project's approach to change and its resultant sustainability support the findings of Fitzgerald et al. (2003), Buchanan et al. (2005) and Buchanan and Fitzgerald (2007a). The approaches and change methodologies were specific to the local context (Dopson et al. 2002, Fitzgerald et al, 2002). Whilst senior management was used occasionally to help remove barriers, the majority of changes were gained through clinical influence, persuasion and leadership. From the outset of the project, the success in embedding and mainstreaming the changes was directly linked to the high priority this agenda was given. This study also supports the premise that in order to generate change, a transformational approach to leadership is required, and that it should be continuous and not limited to a discrete period of time.

Reflection on the Methodological Approach

The methodological approach taken has strengths and weaknesses. With the quantitative approach, it is important to note that the team effectiveness tool recorded only the management group members' perceptions of their effectiveness as a team, and not the perceptions of others outside the team. In addition, due to the small sample size,

descriptive statistics were used to compare the returns from the two study groups (Robson, 2002). However, I am confident that taking this approach has provided valuable insights into the perceived effectiveness of the groups and informed the creation of the focus group and semi-structured interview topic guides.

In retrospect, the focus groups and semi-structured interviews provided a much richer data source than the team effectiveness tool. If further studies were to be considered, it may be beneficial to use a different tool that measures how those external to the team perceive its effectiveness, together with some objective outcome effectiveness scoring of the team's activities, patient centredness and results. Increasing the number of groups studied and / or the sample size may be worth considering (in the latter case, however, Shortell et al's (2004) determinations of the size of an effective team would also have to be taken into account).

The qualitative component of the research (Walliman, 2001) comprised focus groups and semi-structured interviews. It is important to note that the participants, both doctors and service user, were all enthusiastic about inter-organisational working, believing it to be the future for delivery of improved patient care. This raises the question of whether the study was limited by the choice of participants. The justification for this approach was my belief that fully answering the research questions required the examination of a project where the characteristics and impacts of effective inter-organisational clinical leadership, engagement and team effectiveness were present. In hindsight, it might have been better to include a comparison study of another group that had significant problems with inter-organisational working. However, I believe that such a group (for example, the third change project) would have raised many practical difficulties. The approach taken has produced rich in-depth insights into the views of some enthusiasts. Whilst it must not be assumed that surveying a more diverse range of participants would result in complete consensus, these findings still hold value (Robson, 2002).

The use of a service user, as well as doctors, for the semi-structured interviews proved valuable. It illuminated and, more importantly, helped to validate the doctors' perspectives. As service users are the recipients of the healthcare that this study is attempting to enhance, the alignment of theirs' and the doctors' views provides strong validation of the research findings. Additionally, the service user was the chair of the management group, which afforded some status and power. This was beneficial in delivering patient centred transformational change.

There were clear gender issues in the composition of the management groups used for the focus group and semi-structured interview sample. This may be due to several factors. The characteristics of the gender composition of clinical specialities may be evident, and the spread of the management group across the health sectors may have affected the composition. Additionally, the groups were largely self-selecting and this may have altered the composition. Despite this marked variation, the research indicated no obvious difference in the findings from the two areas. A further study may elicit some difference between what groups of men and women consider effective, although Jovic et al's (2006) study shows little difference in attitudes and behaviours across genders.

Walliman (2001) states that researchers using an interpretive approach are bound into the situation they are studying. I had to be constantly mindful of issues such as bias and influence. The concept of the insider researcher clearly influences the reliability and validity of the study (Waterman et al. 2001). Being an insider researcher had both advantages and challenges. The advantages were that I brought with me my wealth of knowledge and prior experience of this complex area. This allowed a rapid determination of, and focus on, key areas, and introduced some pragmatism to the study. I also brought a robust network of key national and international contacts that helped to shape and influence the study.

The challenges were significant and it was important for me to be mindful of any potential bias and to attempt to overcome it as robustly as

possible. I have considerable clinical experience in physiotherapy and as a change manager, which meant I came to the study with preconceived perceptions and social views created and influenced over years. The 'halo' effect had to be avoided. This is when the researcher interprets the results as they wish, frequently biased by prior knowledge, experience or a desire for a particular outcome (Coghlan and Brannick, 2001). Additionally, being the Director of the change project where the research was occurring brought with it a greater risk of causing reactivity and respondent bias than would be the case with a researcher who was independent of the project. To reduce this potential for bias, and to increase confidence in the validity of the findings, peer review and member / participant checking and data triangulation were used (Silverman, 2005). A reflective diary was kept over the period to test out any assumptions and reactions (Pedler et al. 1986). This diary and my participation in action learning sets helped me to consider my values, behaviours and position as a researcher practitioner, facilitated me being true and honest to the purpose of the study, and highlighted danger areas for me to debate with experts or peers (McGill and Beaty, 1992).

The Hawthorne Effect (Pope and May, 1995) describes how people react when they know they are participants of an experiment. This was a potential danger that was minimised by using strategies such as: briefing people on the purpose and desired outcome of the research study (emphasising that it was to create a learning product); gaining full informed consent; assuring participant anonymity at all stages; member checking; and, peer review. Emotional intelligence, especially self-awareness (Goleman, 1999) was used throughout the process. For example, I attempted to be aware of the participants' responses to the study, and I strove to ensure the study environment was as close to the change project as possible, thus not altering people's responses.

The quotes from the original transcribed text used in Chapter 5 were not attributed. This was due to the concerns regarding the potential impact it might have had at such a politically sensitive time within the change

project. It was judged to be potentially damaging to the project to do so. I also did not want to increase the tension or cause competition between the two teams. This is a demonstration of the ethical behaviour required in a real world situation.

An attempt has been made to provide a trustworthy account of the whole study from inception to completion. The triangulation of the three data sources (Gill and Johnson, 1997), identifying recurrent themes and concepts, has resulted in findings that are informative and valid. A clear audit trail of all of the activities, data collection processes and analysis has been provided. As an insider researcher, I attempted throughout the whole process to be objective, but acknowledge how difficult this is when I feel strongly about the topic, and have so many preconceived views (Waterman et al. 2001). This is, I believe, a reflection of the context in which the research was based (Robson, 2002).

The research intention and approach were successfully achieved. The change project was complex to set up, had to navigate the cultures and practices of four organisations and different professional groups, and deliver outcomes which were complex to embed, but needed to be sustainable. Robson (2002) describes the approach as a pragmatic approach in the real world. By taking this stance and employing data triangulation (Meyer and Spilsbury, 2000) for maximum validity, reliability and rigour of approach, I have demonstrated that the approach was valuable in terms of research outputs. Equally, as discussed previously, I would do some things differently if undertaking further studies.

The original research questions have been answered. However, overall the focus groups and semi-structured interviews provided a much richer data source than the team effectiveness tool. As this is an interesting area, it is worthy of further exploration (as discussed earlier in this chapter). This study has contributed to knowledge and understanding, whilst also raising new areas for consideration (discussed later in this chapter).

Personal Learning

Undertaking this study has been invaluable to me as a professional. Prior to this, I had worked and been interested in the arena of inter-organisational clinical leadership and engagement for the preceding six years. The experience and exposure during this time steadily increased my knowledge. I thought, naively, that I was an expert. However, undertaking this study has vastly widened my perspectives of both the available literature and the research process. I have also spoken to numerous experts within academic and practical fields, building extensive networks.

The rigour required in undertaking this study has caused me to explore concepts and evidence that I would have not previously have considered or valued. For example, the understanding of theoretical perspectives has helped me understand and value different types of evidence, and helped facilitate better communication with colleagues who view the world in alternative ways. My reflective diary, action learning sets and the process of undertaking this study have given me new insights into the many diverse cultural paradigms that exist, including professional, organisational, within patient groupings and those who oppose change. As a result, I now have a much broader and deeper understanding of different perspectives, knowledge and skill bases and an ability to understand, manage and analyse large volumes of diverse data. Whilst this has enabled me to undertake this study, the real value is in changing and improving my ability to function as an expert within the healthcare environment. I am, as a result, able to take different approaches to challenges. For example: I am much more confident in my ability to search and use the literature in a robust manner; I have enhanced my ability to analyse data methodically; I have access to an extensive network of experts interested in transformational change; and, I have developed my overall confidence. This allows me to offer to others a deeper insight and understanding of the complexity of this area.

I have significantly improved both my theoretical knowledge of the research process and my practical research skills and, together, these improvements have greatly increased my confidence in the research process. I have commissioned research projects in the past and have been involved on the fringes of projects. I now realise that my understanding, and therefore my competence, were quite limited. Having to undertake the whole process of this study has extensively enhanced my understanding of the rigour of research. By being an insider researcher, I have learnt of the conflicts and challenges this role involves. This is aligned to Coghlan and Brannick (2001), who suggest that the insider researcher will gain new insights and knowledge. In the future, my enhanced skills can be exploited in commissioning research and acting as a researcher-practitioner, an invaluable outcome for me personally and for my future work environments.

Impact and Dissemination of the Findings

The product of this study 'Practical Recommendations' (Appendix 13) has already been disseminated widely. The recommendations were produced from a synthesis of the research findings and literature. An iterative approach was used in creating the recommendations, with key peers and experts offering input through each stage of the development. The 'Practical Recommendations' are on the web-site of the change project, which has extensive internet traffic. It has been shared with key organisations and projects nationally and locally such as the DH, the Institute of Innovation and Improvement, NHS London, A Picture for Health (SE London sustainability project) and many Royal Colleges and associations. In the future, it will be promoted to the US Institute of Healthcare Improvement and the NHS Confederation. Dissemination will additionally take place in a less structured way through informal social networks.

There will be a wider dissemination over the coming months through the delivery of presentations at appropriate national and international healthcare conferences, and in relevant publications. Whilst a number of notable empirical studies already exist, this study has contributed significantly by the blending of existing knowledge with new understandings and insights delivered through the study and the 'Practical Recommendations'.

A key driver for me personally to conduct this research was to provide both evidence supporting the need for change in real life practice and practical assistance in achieving the change. It was of fundamental importance to me that the outcomes had value for the NHS practitioner. The design of the recommendations reflects this standpoint. The recommendations are being used by managerial and clinical NHS staff to change practice and approaches. This is very important to me, as it provides the confidence that my work is meeting the real world needs of relevant NHS staff. This is congruent with my personal aspiration that my research outcomes are firmly embedded in future practice.

Specific findings, such as the need to modify medical training, have been shared with the appropriate stakeholders. This has become an area of focus recently, and relevant stakeholders are using the findings of this study. It is important to note however that further research into this area is necessary to create the required significant change in mind-set. In addition, all the knowledge generated about patient involvement has been shared with key stakeholders, as this is currently an important agenda for the NHS.

Through the process of undertaking this study, and debating the findings with key experts and academics, many new conversations have been started. For example: how to develop leadership and engagement of other clinicians beyond doctors; incentives and accountability alignment; how to manage the risk of pushing the boundaries of what is clinically currently acceptable; and, the issues of clinical autonomy effecting new

leadership models. I consider that, whilst their effects are unquantifiable, these new debates and conversations are contributing significantly to the future thinking regarding inter-organisational clinical leadership, clinical engagement and team effectiveness. This may contribute to the creation of new knowledge or new research projects in the future.

It is important to remember the tension between the drive towards inter-organisational working to deliver high-quality care and the financial pressures and competition that individual NHS organisations are currently experiencing. Whilst the findings of this study have value in helping healthcare providers to work more closely together, there is a real need for further work to create robust managerial and financial evidence of the effectiveness of and gains from inter-organisational working, thereby demonstrating its value for money.

Further Areas for Exploration

This study has raised further areas for exploration. If this study were to be repeated or refined, suggested areas for consideration are:

- Compare and contrast a successful change project with one that has problems in order to demonstrate the different characteristics and impacts
- Team effectiveness – compare a team’s own perceptions of effectiveness with those of participants outside the team, including objective outcome effectiveness scoring based on activities, patient centredness and results of the team.

The study itself has illuminated some other fundamental areas for further exploration:

- Investigation of the relationship or potential interdependence between patient involvement in inter-organisational projects and a resultant improvement in quality of life

- What are the additional skills required by doctors to lead effectively and deliver inter-organisational projects?
- How may the additional skills be delivered through medical training?
- What changes are required to the current delivery of medical training?
- What are the additional skills required by other clinical professions to lead effectively and deliver inter-organisational projects?
- What new incentives are required to facilitate effective clinical leadership and engagement of inter-organisational projects and what is the mechanism to align them?
- What new accountability arrangements are required to facilitate effective clinical leadership and engagement of inter-organisational projects?
- How can robust managerial and financial evidence be created for the effectiveness of, and gains from, inter-organisational working, so demonstrating the benefits? This would entail a health economic focussed study to demonstrate value for money.

Chapter 7

Conclusions and Recommendations

In this final chapter, I reflect on my whole study in the context of the evidence identified and the contribution to knowledge and understanding. The majority of recent policy directives have acknowledged the importance of cross-boundary working in delivering effective patient centred care (DH, 2006b). There is also agreement that the role of clinicians is fundamental to delivering this agenda, as seen in both the policy and literature (Ham, 2003, DH, 2006a). However, there is a paucity of literature enumerating the key constituents of effective inter-organisational clinical leadership and engagement, and a lack of system incentives to drive it. This study has answered the research questions, and helped to fill this gap by contributing knowledge and understanding in a new context. It builds understanding and insights through this thesis and the 'Practical Recommendations', which have been disseminated widely throughout the NHS.

The study findings support the current move within the NHS towards cross-boundary working (DH, 2005b and DH, 2005d). They demonstrate that some clinicians, managers and service users feel passionately that this movement is important. They further show that it is central to the delivery of effective patient care. This study highlights, however, some fundamental issues which have to be resolved if effective inter-organisational working is to be realised more widely across the NHS (for example, changes to medical training and incentives and accountability alignment). Whilst the study demonstrates the complexity of transforming healthcare within a real world setting, with differing cultures and processes, it illustrates that such transformation can be achieved with considerable benefits.

This study is largely focussed on doctors' perspectives, whereas other clinicians or managers may wish to lead similar projects. Whilst other

clinicians may hold similar views, perspectives and skills, the unique clinical autonomy, status and power doctors hold should not be overlooked. Clinical autonomy has been in existence for a long time, and can in some instances alter perspectives and lead to significant power issues (Kenny and Adamson, 1992, Armstrong, 2002, Fitzgerald and Ferlie, 2000, Fitzgerald et al. 2002).

The ideal structure and composition of a team leading a cross-boundary project has arisen. This study does not offer any further illumination on how to form an effective team, but it has illustrated some of the potential problems with an ad hoc composition. It has demonstrated the impact of a service user as chair of a management group. This suggests that the patient voice is very powerful within this set-up, as was the case within this study.

The 'Practical Recommendations' offer new insights with practical guidance for clinicians and managers to consider at the start of an inter-organisational project, including the key elements which will facilitate success. It has already proven to be a useful source of information for healthcare professionals. I am pleased this work has enabled me to make a meaningful contribution to cross-boundary working, as I consider this fundamental to enhancing the quality of patient care. There is a lot of rhetoric regarding this agenda, but I am satisfied to have provided a valuable tool that can enhance the success of such projects. Also, by undertaking this study, I have drawn attention to this area as seen by the increasing numbers of requests for information and guidance on the subject. The dissemination of the recommendations will continue through presentations, publications and a focussed dissemination strategy.

As an insider researcher, I have undertaken a challenging journey, but one which has taught me much (Waterman et al. 2001). At the end of the journey, I am still of the opinion that this is a critical area, as the process has reinforced my view that patient care can be sub-optimal when the focus is not on the pathway. This study has given me new insights into

research processes, perspectives, cultural paradigms, and my personal views and perspectives of the world. The 'Practical Recommendations' in some way helps to embed my passion into practice, but there are still many more questions to be considered. This process has given me the insights and confidence to continue to strive to find more answers.

It may be beneficial to undertake a further study to compare a less successful change project with an effective one, and gain some external perspectives of the effectiveness of the relevant teams. Further examination of the study findings could be enriched by comparing them with the data resulting from this additional project. However, despite these reflections, this study in its current form has significantly contributed to the knowledge in this area.

Key Findings

A prerequisite to gaining effective cross-boundary working, as recognised and acknowledged by the study participants, was the need to make **significant changes to current medical training to enhance the development of new skills**. These new competencies and skills will equip clinicians to effectively participate in inter-organisational working. The new competences highlighted as essential were enhanced leadership, relevant managerial and service improvement skills. Whilst there are some national stakeholders who are working on this agenda, the changes to training are however yet to be realised. This creates an inherent tension. The Department of Health and other national bodies promote the importance of cross-boundary working to improve the quality of care provision. In addition, clinicians and patients within this study and other studies (Institute of Medicine, 2003) clearly believe the benefit of such working practices. But, there is a distinct theory practice gap, as these new skills are seen to be imperative to actually deliver the resultant higher quality of care from cross-boundary working. This study demonstrates when creating new policy and directives, there is a need to

rapidly provide the development and support to enable effective delivery. The findings of this study have been shared with key stakeholders who are reviewing the agenda. It is hoped that these skills can be developed before the policy direction is judged to be ineffective.

The power of the patients' voice has been seen to be growing throughout policy and the literature, but with little focus on how this affects patients' quality of life. The focus has largely been on how to involve patients in NHS processes and structures (Care Services Improvement Partnership, 2006). This study has highlighted **the necessity for change projects to aspire to a high degree of patient centredness**, as well as the **fundamental need to ensure that the focus of patient involvement is on improving the patients' quality of life** and not just on service improvements or redesign. In fact, the findings suggest that patients believe patient centeredness is about how their quality of life can be improved, rather than being involved in changes to services or re-design projects. It is within this novel frame that significant benefits for patients can be realised. The transferable learning from this study is that patient / service user involvement is complex and can be difficult to achieve as seen with the sexual health agenda, but is extremely worthwhile. Future studies would benefit from further inclusion of service users, to gain a better understanding of the relationship between patient involvement and a resultant improvement in quality of life.

This study has highlighted the issue of incentives. It suggests there is an **urgent need to achieve alignment of the drivers and incentives for inter-organisational working**. Incentives across the healthcare system are seen by the study participants as vital to achieving and sustaining change. The improvement of the quality and safety of patient care has been highlighted as a clear incentive for clinicians. However, the day-to-day complexities of actually attempting to work across organisational boundaries can diminish clinicians' motivation. The NHS is enduring an acute tension between the push towards cross-organisational working to deliver high quality effective care (with a clinical focus), and the financial

pressures and competition between individual NHS organisations (policy and organisational focus). There is a necessity to find the balance between or a solution to these opposing forces, and thus realise the benefits for patients. This study adds to the debate, whilst also suggesting additional research questions which will help to inform further deliberations. This is another example of how the implementation of centrally driven policies at a local level, can at times disable the system in delivering high quality of care. In addition, this study shows how some policies can in reality result as significant disincentives across the healthcare system (Fitzgerald et al. 2007).

The final finding relates to accountability. This study highlights that accountability is currently an inhibitor of effective cross-boundary working. For example, being employed by different organisations and the resultant spilt loyalties was seen as a barrier to effective inter-organisational working. This study suggests that for successful inter-organisational working to occur, a change in this culture is fundamental. **New innovative accountability mechanisms need to be sought** for the successful delivery of this way of working. This study demonstrates that to successfully implement this new policy direction, innovative human resource practice is also required. This could help to create new accountability mechanisms, reduce bureaucracy but still ensure all legal and statutory requirements are fulfilled. This would allow the flexible, agile working practices required to effectively deliver the high quality of care that inter-organisational working promises.

Recommendations

The tension between the evidence, the clear policy directives and the patients' voice supporting a pathway focus (and thus inter-organisational working) and the current financially stretched and competitive environment of the NHS requires further debate and consideration by policy makers, NHS lobbyists and professional bodies. There is a need to

gain agreement of the level at which NHS organisations can support inter-organisational working, and thus create the right environment for it to flourish. Within this debate, due consideration must be given to aligning appropriate incentives and creating novel innovative accountability lines. A project with a health economic focus would be hugely beneficial in identifying robust managerial and financial evidence for the effectiveness of and gains from inter-organisational working, thereby demonstrating its value for money.

Current training for doctors and other clinicians requires reviewing and updating to ensure that in the future it equips them for effective participation in inter-organisational working. This is already being considered by the DH, workforce experts, deaneries and professional bodies, and the findings of this study are being considered as part of the review. The revised training should be designed to build the fundamental skills and culture change required to enable effective clinical leadership and engagement as illustrated through this study. Additionally, consideration should be given to revising incentives and accountability to facilitate this change.

A dissemination strategy is required to ensure continued sharing of the 'Practical Recommendations' (discussed within Chapter 6).

Finally, this study has shown that the patients' voice is at its most powerful when it is facilitating the focussing of improvements on enhancing quality of life. These findings should be shared with the DH, lobbyists and key patient groups and associations, and this area is ripe for further exploration.

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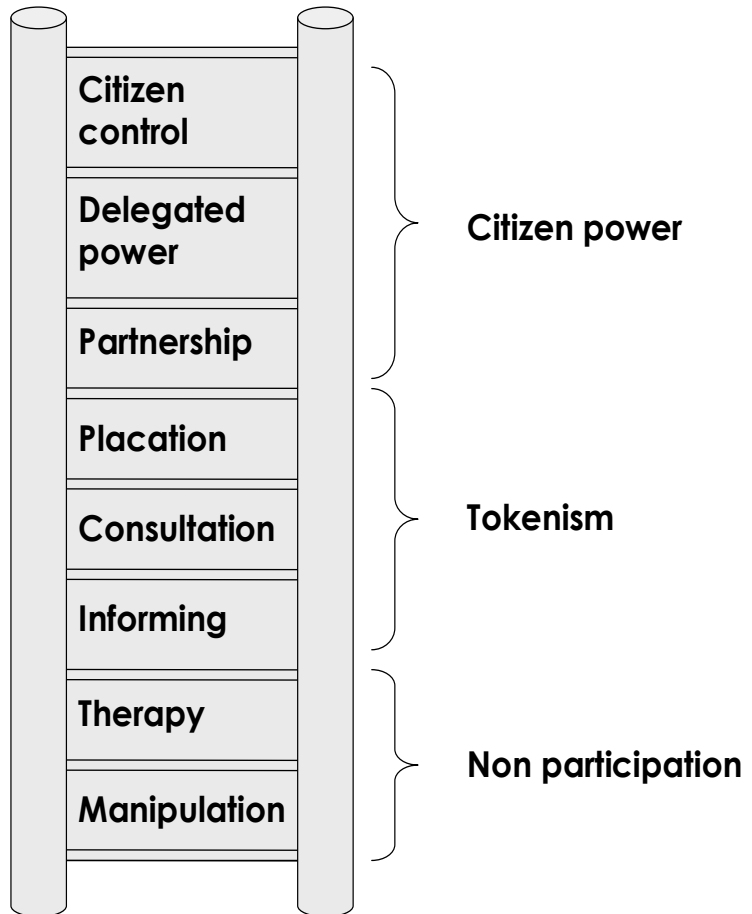
Appendices

Appendix 1 - Summary of Key Considerations and therefore Boundaries of the Study

The key considerations and therefore boundaries of the study are described below. These were influenced by the methodology and Robson's Framework for Research Design (2002, P81):

- Are the participants willing to be part of this study and if so why are they willing to share their time and experience when they have so many other commitments?
- There will be different styles of contribution. What impact will this have on the outcomes? How will this contribute to the emergent process?
- Does the research approach enable participants to engage with and contribute to the research activities? How do the design and study activities enable or inhibit the creation of knowledge and learning?
- Is the process sufficiently robust to capture knowledge and learning which can have future use?
- What impact does my leadership style and job role have on participation and the final knowledge and learning creation?
- How will the 'Practical Recommendations' contribute to increasing the knowledge and learning within the NHS? Will the recommendations encourage and facilitate enhanced understanding of the characteristics that make cross-organisational projects work and will it be used to increase the number and effectiveness of such projects?

Appendix 2 – Arnstein’s Ladder of Participation



Cited from: Arnstein, S. (1969). 'A Ladder of Citizen Participation'. Journal of the American Institute of Planners. 35, p216-224.

Appendix 3 – Management Group Terms of Reference

Terms of Reference – Kidney Management Group

Purpose

The management group is designed to ensure that the kidney disease XX is focused on preventing kidney failure and improving services living with kidney disease

Key Objectives

1. To ensure that the kidney disease XX focuses resources and efforts on improving the lives of people living with kidney disease in Lambeth and Southwark.
2. To be a fount of inspiration and ideas to support progress of the programme.
3. To remain focused on empowering patients and including and acting upon the views of patients, carers and professionals in the development of the programme.
4. To ensure that the process of improving services remains transparent and accountable to the Director of the XX, the XX Board and the patients.
5. To monitor progress against defined measures and identify and manage risks to ensure the success of the project.
6. To receive and review regular budget reports and ensure that the Initiative is using its resources in a timely and cost-effective manner. To be responsible for approving applications for further funding.
7. To be an information exchange and resource to ensure coordinated working across the working groups, and beyond the Initiative to other modernisation projects.
8. To ensure appropriate evaluation is conducted and learning is established at each stage and acted upon.
9. To communicate developments, successes and learning within the Initiative, with patients and carers, within the local health economy and beyond.
10. To ensure projects are embedded within the health economy and linked into other local objectives to ensure sustainability.

Appendix 4 - Ethical approval - Notice of Substantial Amendment

SL32 Favourable opinion of amendment
Version 2, October 2004

copy



Bromley Local Research Ethics Committee
Health Intelligence Unit
1st Floor, Templegate
115-123 High Street
Orpington
Kent BR6 0LG
Tel: 01689 865985
Fax: 01689 884074

E-mail: Janine.peters@bromleyhospitals.nhs.uk

16th June 2005

Professor Trisha Greenhalgh
Open Learning Unit
4th Floor
Holborn Union Building
Archway Campus
Highgate Hill
London N19 5LW

Dear Professor Greenhalgh,

Study title: *Guy's and St Thomas' Charitable Foundation Modernisation Initiative: A study of innovation in NHS services.*
REC reference: 04/Q0705/44
Protocol number: N/A
EudraCT number: N/A

Amendment number: 1
Amendment date: 09/06/2005

The above amendment was reviewed by a Sub-Committee of Bromley LREC on 10th June 2005.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

COREC Notice of Substantial Amendment form dated 09/06/2005
Information Sheet Version 1 dated 14/11/2005
Consent Form Version 1 dated 14/06/2005
CV for Fran Woodward dated 14/06/2005

Membership of the Committee

The members of the Sub-Committee who reviewed the amendment were Carol Jones (LREC Chair), Niall McCrae (Expert member) and Janet Paterson (Expert Member).

Management approval

All investigators and research collaborators in the NHS should notify the R&D Department for the relevant NHS care organisation of this amendment and check whether it affects local management approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

04/Q0705/44: Please quote this number on all correspondence

Yours sincerely,



Janine Peters
Committee Administrator

E-mail: Janine.peters@bromleyhospitals.nhs.uk

Appendix 5 - Signed Informed Consent Form, Covering Letter and Information Sheet

Participant Consent Form - Inter-Organisational Clinical Leadership and Engagement Study

	PARTICIPANT NAME:	YES	NO
1	I confirm that I have received information explaining the nature of the above study to me and I have had the opportunity to ask questions. I have read and understood the information sheet.		
2	I understand that my participation is voluntary and I am free to withdraw from the study at any time without having to give any reasons.		
3	I confirm that if I have been asked to be part of the Focus Groups and Semi-structured Interviews I have agreed to the group / interview discussion being tape-recorded as part of the above study.		
4	I understand that all interview data will be treated as strictly confidential and will not be seen by anyone other than the researcher Fran Woodard. Tapes and transcripts will be anonymised and stored within a locked filing cabinet. This will be in accordance with the Data Protection Act, 1998.		

5	I understand that the results of the study will be written up for submission to the Middlesex University as part of a doctoral submission and 'Practical Recommendations' will be published. The findings will be presented in general and anonymised terms. The researcher will consider all verbatim quotes in such publications for their sensitivity, appropriateness and fairness.		
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I confirm I am willing to be a participant in this Research study

Participant name and signature

Date

Researcher name and signature

Date

Ethics Covering Letter

Dear Colleagues,

DOCTORATE – LEADING INTER-ORGANISATIONAL CHANGE

As many of you may be aware, I am in the final stages of undertaking a doctorate. The title of my doctorate is 'Leading Inter-Organisational Change'. I am in the process of undertaking my final study entitled 'Inter-Organisational Clinical Leadership and Engagement'.

In the final study, I will be looking at whether there are different cultural and situational issues alongside team dynamics that either facilitate or hinder Inter-Organisational Clinical Engagement and Leadership. The aim is to gain a deeper understanding of what facilitates cross-boundary and cross-organisational working across the patient pathway.

I am writing to ask whether you would consider taking part in my final study by becoming one of my research participants. I have listed below what this will specifically entail for you, but I am more than happy to speak on the telephone or meet face-to-face to explain this in more detail. I also include a participant's information sheet providing additional information.

- A short team effectiveness questionnaire (takes approximately five minutes to fill in). I am asking all members of the management group to consider filling this in.
- Focus groups consisting of all doctors on the management group lasting approximately one and a half hours. The focus will be on determining the key components of cross-organisational working, engagement and leadership as well as establishing the barriers
- Semi-structured interviews with two key doctors and one service user heavily involved in the projects lasting approximately one and a half hours. The focus will be on the learning coming from the two stages described above.

All data collected will be strictly confidential and anonymous at all stages. I will ensure that iterative feedback is given throughout the course of the whole of my final study. I do have ethics approval to undertake this work, but want to reassure everyone that it is looking to highlight key learning to take to the future not looking to highlight problems.

I am writing all of you to all of you to ask for your consideration in partaking in this study. I enclose a consent form and I would be hugely appreciative if you could return it to me by 28th February 2006.

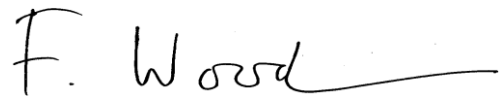
I wish to offer you full assurance if you do not wish to be involved or at any time wish to withdraw from the study, you will be able to do so immediately and without having to offer any reasons or rationale.

My proposed timetable is to do the team effectiveness questionnaire in March 2006, the focus groups in April/May 2006 and the semi-structured interviews in June/July 2006. I will be analysing and writing up over the end of the summer and autumn months for submission in 2007. The final study is submitted to the Middlesex University where I am undertaking my doctorate. As I write up and present any findings, I will ensure everybody has full access to all the learning.

I will also create a product (called 'Practical Recommendations') to help future modernisers create the best environment to promote inter-organisational and patient pathway change.

I really appreciate your consideration in supporting me in this piece of work, which is very important for me but also offers key learning for the X change study.

Many thanks in anticipation

A handwritten signature in black ink that reads "F. Wood" followed by a long horizontal flourish.

Fran Woodard
Director

Information Sheet

Doctoral Project - Inter-Organisational Clinical Leadership and Engagement Study

Participant Information Sheet

Leading Inter-Organisational Change

You are being invited to take part in a research study. Before you decide if you want to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If you would like further information please contact me:

Fran Woodard – fran.woodard@gstt.nhs.uk / 07789 653184

What is the purpose of the study?

The purpose of this study is to identify the characteristics and impact of good clinical leadership, engagement and team effectiveness across organisations and professions and to produce Practical Recommendations, which can be disseminated widely across the UK healthcare system. The study is the final project in my Doctorate entitled 'Leading Inter-Organisational Change'. It will be submitted to the Middlesex University on completion.

Why have I been chosen?

I am using two of the three Change Project projects because their patient pathways, ways of working and delivery of services are fundamentally different. This will give the study diversity and different operating contexts and environments to learn from.

Do I have to take part?

Taking part in the study is voluntary. If you decide to take part after you have considered this information sheet and the enclosed letter, you will need to sign and return the consent form by 28th February 2006. You can change your mind about participating at any point without giving a reason.

What will happen to me if I take part?

If you agree to take part, the nature of your involvement depends on your role within the MI. This is because the focus will narrow down as the study progresses focussing on clinicians specifically working across the pathway. There are three stages

- A short team effectiveness questionnaire (takes approximately five minutes to fill in). I am asking all members of the management group to consider filling this in.
- Focus groups consisting of all doctors on the management group lasting approximately one and a half hours. The focus will be on determining the key components of cross-organisational working,

engagement and leadership as well as establishing the barriers. The focus group will be tape-recorded and transcribed to allow for detailed analysis. There will be an independent observer of the group who will document any learning that is not picked up in the tape recordings. The independent observer will also facilitate my learning by giving insight into my interactions and role within the process.

- Semi-structured interviews with two key doctors and one service user heavily involved in the projects lasting for approximately one and a half hours. The focus will be building on the learning coming out of the two stages described above. The semi-structured interviews will be tape-recorded and transcribed to allow for detailed analysis. There will be an independent observer of the group who will document any learning that is not picked up in the tape recordings. The independent observer will also facilitate my learning by giving insight into my interactions and role within the process.

The letter you will have received with this information sheet will highlight the level of involvement I am requesting from you individually.

How is the Study Monitored?

This study has been submitted for ethics approval in order to ensure that it meets the required standards for research. The ongoing conduct of the research will be monitored by the Change Project governance structures, Middlesex University and my Doctoral Consultant John Clarke who works for the National Institute of Innovation and Improvement.

Thank you for reading this and considering supporting me in the research study

**Fran Woodard
Director**

Appendix 6 - Adapted Team Effectiveness Tool

Change Project X

Developing accountable, high performing teams

This rating tool was designed to help leaders and their teams to explore the effectiveness of the team. It contains questions about team effectiveness in 16 areas that you are asked to think about and then provide a rating for YOUR team. Your team is either the kidney disease management group or the sexual health management group. Please start by selecting the management group to which you belong.

Please rate your team based on the scale of 1 – 4 by placing a cross in the appropriate box:

- 1 – Poor
- 2 - Need to improve
- 3 – Satisfactory
- 4 – Good

Thank you for your assistance

Fran Woodard
Fran.woodard@gstt.nhs.uk
March 2006

Acknowledgment is made to the Learning Alliance

Please select the management group / steering group to which you belong		Sexual Health <input type="checkbox"/>	Kidney <input type="checkbox"/>		
Description of team behaviour		Rating			
		Poor	Need to improve	Satisfactory	Good
Q1	How effective is the team in relation to accepting the views of <u>all</u> team members and also people outside the immediate team?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q2	How effective are the team members at communicating openly and honestly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q3	How effective is the team in asking for and offering feedback to help with problem solving and improving the care to patients?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q4	How effective is the team in relation to listening to difficult and critical issues which relate to the team performance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q5	How effective are the team members and therefore the team as a whole, in owning problems associated with the care the team delivers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q6	How effective are the team members in accepting personal responsibility for problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q7	How effective is the team in creating understanding of and answers to the problems experienced by the team.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q8	How effective are the team members in achieving their own personal objectives and also achieving the wider team objectives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Description of team behaviour		Rating			
		Poor	Need to improve	Satisfactory	Good
Q9	How effective are the team members, as individuals, in constantly offering to help with problems within the team?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q10	How effective is the team at working with other teams, when problems require it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q11	How effective is the team at working creatively with problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q12	How effective is the team in ensuring that problems are solved and results are achieved?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q13	How effective is the team in reporting and discussing potential problems, before they become real problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q14	How effective is the team at ensuring that agreed actions are followed up and delivered?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q15	How effective are the team members at doing the things which have been agreed and that individuals have said they will deliver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q16	How effective are the team members at measuring their own progress, in relation to the care and services they give?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 7 - Team Effectiveness Covering Instructions Letter

April 13th 2006

Dear Colleagues,

RE: Doctorate – Leading Inter-organisational Change – Inter-Organisational Clinical Leadership and Engagement– Team Effectiveness Questionnaire.

I would like to extend my thanks to you all for agreeing to participate in my doctorate research project. I appreciate your time and support.

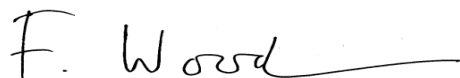
I attach a team effectiveness questionnaire which is the first stage of my research. It is a simple questionnaire which can be filled in as a word document, saved (please ensure you save it when filled in) and returned to me by email – fran.woodard@gstt.nhs.uk - or can be filled in as a hard copy and returned to me in the post at the above address.

The team effectiveness questionnaire relates to your perceptions and views of either the Kidney Steering Group or the Sexual Health Project Management Group as appropriate. Please fill it in quickly, using your initial responses to the questionnaire, being as honest as possible. If a question does not make complete sense please answer in the best way that you can. Please try to answer all the questions, but only give each question one score.

I would like to reiterate that the questionnaire is completely confidential. The responses will be anonymously analysed together and the results will be reviewed and reported in my doctorate study as a whole group not individually.

I really appreciate your time and support. I would appreciate the form being returned to be by Friday 19th May 2006 at the latest.

Many thanks for your support and help. I will feedback the results as appropriate to the Steering Group / Management Group and individuals if requested.



Fran Woodard
Director

Appendix 8 - Team Effectiveness Bespoke Access Form

The screenshot shows a web application window titled "Measuring effectiveness". At the top, there are navigation tabs: "Start", "Q1-4", "Q5-8", "Q9-12", and "Q13-16". The "Q1-4" tab is selected. Below the tabs, there are four questions, each followed by a five-point Likert scale labeled "Score Q1" through "Score Q4".

Question 1: How effective is the team in relation to accepting the views of all the team members and also people outside the immediate team? The scale shows "1" selected.

Question 2: How effective are the team members at communicating openly and honestly? The scale shows "1" selected.

Question 3: How effective is the team in asking for and offering feedback to help with problem solving and improving the care to patients? The scale shows "1" selected.

Question 4: How effective is the team in relation to listening to difficult and critical issues which relate to the team performance? The scale shows "1" selected.

Appendix 9 - Focus Group Topic Guide

Focus Group Questions / Areas of Debate

- What in your experience creates the environment, conditions and culture to facilitate and optimise clinical cross-organisational and / or whole patient pathway working?
- What has been in your experience the impact of service users, patients and carers on the facilitation and optimisation of cross-organisational and / or whole patient pathway working?
- What do you think clinical leadership and engagement looks and feels like in successful cross-organisational working?
- How do you get clinicians and managers to work effectively across organisational boundaries?
- What are the barriers to clinicians working effectively across organisational boundaries / whole patient pathway working?
- Do you, and if so how do you, deal with clinicians and other healthcare staff who are reluctant or resistant to cross-organisational and / or whole patient pathway working?
- Who are you accountable to?
- How do you build confidence and trust?
- Some clinicians focus primarily on RCT / level 1 research evidence to implement change. In this project, we are using improvement methodologies and service innovations as an approach. Why do you feel there is a difference in the “value” given to these approaches?

Other areas if not covered in debate

- What are the tangible benefits of facilitating and optimising clinical cross-organisational and / or whole patient pathway working?
- How do you as individuals work effectively within a cross-organisational team?
- What do you see as the measures of success in cross-organisational and / or whole patient pathway working?

- What do you think the personal skills and qualities are for clinicians to facilitate and optimise cross-organisational and / or whole patient pathway working?
- What are your anxieties about working in a different setting / domain?
- How do you influence effectively and how do you measure the success of your influencing?
- Do you understand the system you work within and if so, what is the importance of the understanding in terms of facilitating and optimising cross-organisational and / or whole patient pathway working?
- What are some of the practicalities which need to be considered?
- What, if any, are the key elements of senior strategic leadership required to facilitate and optimise cross-organisational and / or whole patient pathway working?
- What are the barriers to effective patient care?
- What is the relevance of different models of care in facilitating and optimising cross-organisational and / or whole patient pathway working?
- What is the importance of money to facilitate and optimise clinical cross-organisational and / or whole patient pathway working?
- Do you see improvement as part of role and if so how does this play out?
- How do you manage yourself as a clinician?
- What level and type of management skills do you think facilitate and optimise clinical cross-organisational and / or whole patient pathway working?
- What is the importance of empowerment to facilitate and optimise clinical cross-organisational and / or whole patient pathway working?
- What type of communication skills do you think facilitate and optimise clinical cross-organisational and / or whole patient pathway working?

- What type of cultural diversity and equality skills do you think facilitate and optimise clinical cross-organisational and / or whole patient pathway working?
- What are your aspirations of working across organisational boundaries / whole patient pathway working?
- In your roles as part of the MI, do you think you understand when to lead and when to follow?
- How do you view the world – through the service, professional, organisational or patient's eyes?

Appendix 10 - Semi-structured Interview Topic Guide for Doctors and Service User

Semi-structured Topic Guide – Doctors

- What are the tangible benefits of facilitating and optimising clinical cross-organisational and / or whole patient pathway working?
- How do you as an individual work effectively within a cross-organisational team?
- How do you champion clinical cross-organisational and / or whole patient pathway working?
- What do you think the personal skills and qualities are for clinicians to facilitate and optimise cross-organisational and / or whole patient pathway working?
- What are your anxieties or risks if any of working in a different setting / domain?
- What if any are the risks to you individually in undertaking cross-organisational and / or whole patient pathway working?
- How do you influence effectively and how do you measure the success of your influencing?
- Do you think it is important to understand the system you work within and if so why?
- What, if any, are the key elements (positive and negative) of senior strategic leadership required to facilitate and optimise cross-organisational and / or whole patient pathway working?
- Do you see improvement as part of role and if so how does this play out?
- What level and type of management skills do you think facilitate and optimise clinical cross-organisational and / or whole patient pathway working?
- What type of communication skills do you think facilitate and optimise clinical cross-organisational and / or whole patient pathway working?
- What are your aspirations of working across organisational boundaries / whole patient pathway working?

- How do you view the world – through the service, professional, organisational or patient's eyes?

Semi-structured Topic Guide – Service User

- What in your experience creates the environment, conditions and culture to facilitate and optimise clinical cross-organisational and / or whole patient pathway working?
- What are the tangible benefits of facilitating and optimising clinical cross-organisational and / or whole patient pathway working?
- What has been in your experience the impact of patients and carers on the facilitation and optimisation of cross-organisational and / or whole patient pathway working?
- How do you get clinicians and managers to work effectively across organisational boundaries?
- What are the barriers to clinicians working effectively across organisational boundaries / whole patient pathway working?
- What are the risks if any to clinicians working effectively across organisational boundaries / whole patient pathway working?
- What do you see as the measures of success in cross-organisational and / or whole patient pathway working?
- What, if any, are the key elements of senior strategic leadership required to facilitate and optimise cross-organisational and / or whole patient pathway working?

Appendix 11 – Team Effectiveness Tool Raw Data

Both group's responses to all questions.

Responses	q1	q2	q3	q4	q5	q6	q7	q8	q9	q10	q11	q12	q13	q14	q15	q16
Not answered	0	0	0	0	2	0	1	1	0	1	0	0	0	0	0	0
Poor	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0
Need to improve	1	3	5	5	5	9	7	5	7	5	3	4	9	7	5	4
Satisfactory	16	11	10	17	10	10	13	16	12	14	10	14	8	11	18	21
Good	9	12	11	4	9	7	5	4	7	5	13	8	9	7	2	1
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Sexual Health responses to all questions. (15 received)

Responses	q1	q2	q3	q4	q5	q6	q7	q8	q9	q10	q11	q12	q13	q14	q15	q16
Not answered	0	0	0	0	2	0	1	1	0	0	0	0	0	0	0	0
Poor	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	0
Need to improve	1	3	3	3	2	6	3	4	4	4	1	4	4	4	2	2
Satisfactory	10	7	5	11	6	6	8	7	7	8	5	7	5	6	11	13
Good	4	5	7	1	5	3	3	3	4	2	9	4	6	4	1	0
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Kidney responses to all questions. (11 received)

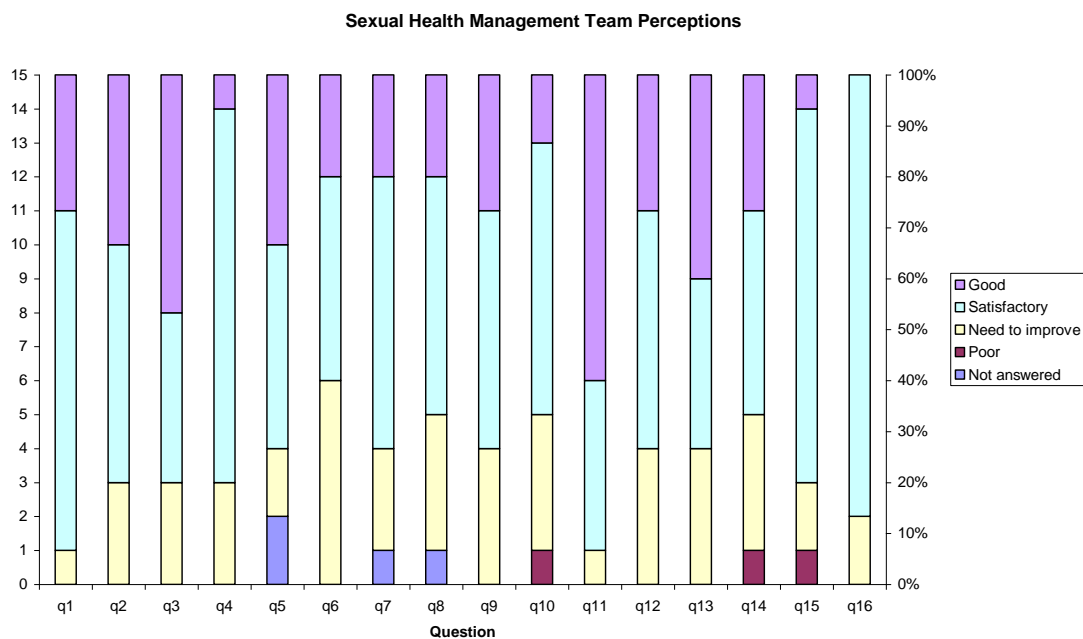
Responses	q1	q2	q3	q4	q5	q6	q7	q8	q9	q10	q11	q12	q13	q14	q15	q16
Not answered	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Poor	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Need to improve	0	0	2	2	3	3	4	1	3	1	2	0	5	3	3	2
Satisfactory	6	4	5	6	4	4	5	9	5	6	5	7	3	5	7	8
Good	5	7	4	3	4	4	2	1	3	3	4	4	3	3	1	1
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Appendix 12 – Team Effectiveness Tool - Detailed Analysis

The first two graphs below show the findings for the two management teams with the third graph illustrating the combined teams' findings. The axis on the left of the graph depicts the number of perception responses, with the axis on the right demonstrating the perception responses in percentages. The responses illustrate how effective the teams perceived themselves to be. All raw data can be found in Appendix 11.

Sexual Health Management Team

The graph below shows the sexual health management team effectiveness perceptions



The graph demonstrates for the 16 questions posed that there were three questions (numbers 10, 14 and 15) to which one respondent answered 'poor'. Conversely, questions 1 and 11 had no respondents answer 'poor' and only one respondent answer 'need to improve'. Questions 5, 15 and 16 had two respondents answer 'need to improve'. Three questions (numbers 6, 10 and 14) had the highest scores when combining 'poor' and 'need to improve', with question 6 being the highest.

In terms of 'satisfactory' perception responses, four of the questions (numbers 1, 4, 15 and 16) had the highest scores. The lowest scores for 'satisfactory' perception responses were questions 3, 11 and 13. The highest scores for 'good' perception responses were questions 3, 11 and 13, with the lowest scores seen in questions 4, 10 and 15.

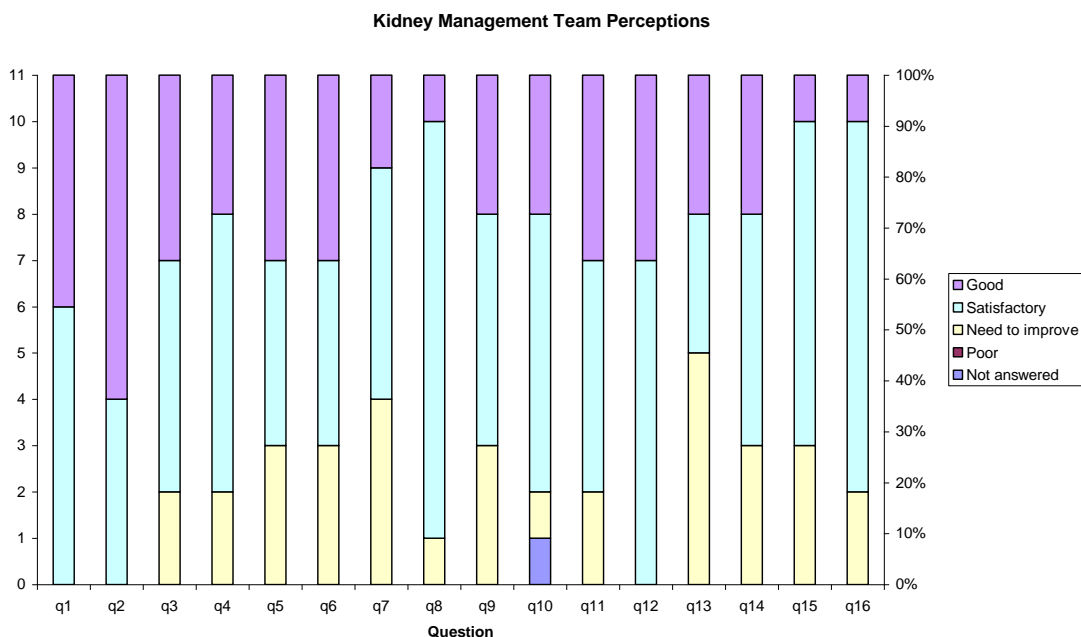
The highest combined 'satisfactory' and 'good' perception response scores were questions 1, 11 and 16, with the lowest being questions 6, 8, 10 and 14. There were three questions which had non-responses

comprising questions 7 and 8 each having one respondent not answering and question 5 having two respondents not answering.

Overall, questions 1 and 11 had a greater than 90% perception response of 'satisfactory' and 'good', with question 16 scoring greater than 80% and questions 2, 3, 4, 5, 7, 9, 12, 13 and 15 greater than 70%. In contrast, question 6 had a 60% perception response scores of 'satisfactory' and 'good', closely followed by questions 8, 10 and 14 with response scores of more than 65%.

Kidney Management Team

The kidney management team effectiveness perceptions are represented in the graph below.



The graph demonstrates for the 16 questions that there were no respondents who scored any of the questions 'poor'. Three of the questions (numbers 1, 2 and 12) had no perception response score for either 'poor' or 'need to improve'. Questions 8 and 10 had only one respondent each scoring 'need to improve'. The highest scores for 'need to improve' are question 7 with four perception response scores and question 13 with five perception response scores.

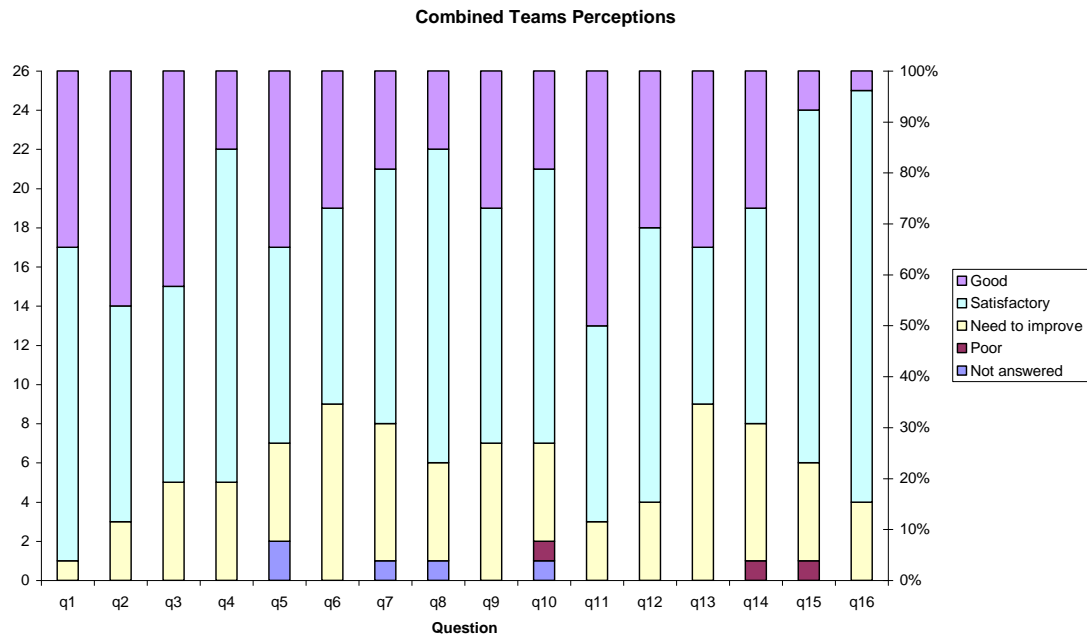
In relation to 'satisfactory' perception responses, four of the questions (numbers 8, 12, 15 and 16) held the highest scores. In comparison, the lowest scores for 'satisfactory' perception responses were found in four questions – 2, 5, 6 and 13. Questions 1 and 2 had the highest scores for 'good' perception responses, with questions 7, 8, 15 and 16 holding the lowest perception response scores. In combining the 'satisfactory' and 'good' perception responses, questions 1, 2 and 12 had the highest perception response rates, with questions 7 and 13 having the lowest

perception response scores. Only question 10 had one respondent who offered no response.

Questions 1, 2 and 12 had 100% 'satisfactory' and 'good' combined perception responses. Question 8 had a greater than 90% perception response rate of 'satisfactory' and 'good', with questions 3, 4 10, 11 and 16 all having an 80% or greater 'satisfactory' and 'good' perception response scores. In contrast, question 13 had less than 60% combined perception response scores of 'satisfactory' and 'good', with question 7 having just over 60%.

Combined Teams Effectiveness Perception Responses

The figure below represents the combination of both teams' perception responses to the team effectiveness tool.



On analysing the combined results, the following patterns can be seen in the graph. The highest combined perception response scores of over 30% for 'poor' and 'need to improve' were questions 6, 13 and 14. The highest 'satisfactory' scores were 4, 15 and 16, with question 16 having a greater than 80% response score for 'satisfactory'. In terms of 'good' perception response scores, questions 2, 3 and 11 held the highest scores, with question 11 having a 50% perception response score of 'good'. In combining 'satisfactory' and 'good' perception response scores, questions 1, 2 and 11 had the highest scores. Question 1 had a greater than 90% combined 'satisfactory' and 'good' perception response score.

Appendix 13 – How to Achieve Effective Clinical Engagement and Leadership when Working Across Organisational Boundaries - Practical Recommendations

Electronic copies can be found on: <http://www.modernisation-initiative.net/publications>