Exploring transformative engagement of managers, clinical staff and patients

A project submitted to Middlesex University in partial fulfilment of the requirements for the degree of Doctor of Professional Studies

Janine Cochrane

Student Number: **2436022**

Project Module: IPH5220

August 2014

Table of Contents

List of tables

List of figures

List of Appendices

Abstract

Policy directives and the new NHS constitution require managers and leaders to adopt strategies that motivate and encourage teams to work collaboratively with staff and patients. These innovative ways of working are seen as a means of improving the quality and coordination of patient care, thus impacting on the patients' experience.

Despite this focus, the evidence of what constitutes and therefore what can deliver effective collaboration between managers, staff and patients is sparse. This study identifies a conceptual model of effective management strategies and behaviours that will assist in achieving partnership and collaborative working.

This research is based in the real world which is complex and uncertain. The study uses an explorative framework and gains insight from a number of different perspectives. The methodological approach is a qualitative case study. Data was collected from an NHS Trust based in Wales and a District Health Board in New Zealand. Data was collected through document analysis and semi-structured interviews.

The findings support a move from a managerialist approach (where managers are target driven, transactional and administer activity) to a more reflexive, egalitarian, transformational approach that can be adapted to cope with complex environments and function successfully in the zone of chaos (where problems are ill defined and messy). The ability of a middle manager to interpret context and operate a balanced approach would appear to be key to navigating a constantly changing and negotiated environment. This study supports adoption of a servant leadership model and proposes guidance for middle managers undertaking change. The guidance proposed is a move away from the dominant doctrine of managerialism and describes the principles for working collaboratively with front-line staff in the NHS and the New Zealand health system.

Acknowledgements

I would like to sincerely thank a large number of people that have assisted me in completing this doctoral thesis. Without them I would be lost. I would like to thank the two teams of dedicated staff that I worked with in the National Health Service in Wales and in the New Zealand public health system. This includes dedicated and trusted line managers, all of the staff who implemented and assisted with data collection. To friends and colleagues in Wales – thank you for the support you gave to our family while we lived there.

To the staff at that large hospital in New Zealand, thank you for your support and tireless optimism. A special thanks to the line managers for allowing me to interview front-line staff and complete my work. Thank you also to the wonderful division of medicine who have supported me during this time in providing the inspiration and aspiration to carry on.

Special thanks to Professor Hemda Garelick and Dr Gordon Weller. They have provided me with rigor, confidence and direction to see this programme through.

Last but not least to my family. My lovely son Sebastian, who came along only a year into this epic event and who has delighted and distracted me ever since. My husband Allan Cumming whose unfaltering belief that I would finish this process has meant that I have indeed.

This is dedicated to my parents Lesley and Frank Cochrane.

Chapter 1

Introduction

Over the last decade, poor quality care and poor use of resources have been identified as a significant problem in the National Health Service (Keogh 2013), (Francis 2010). A major strategy to eliminate these problems has been to establish partnership between management and front line staff (Department of Health 2002) and this has become a major imperative for the NHS. Striving for true partnership where the NHS (manager) commits to:

> *"engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families (pledge)" (*Department of Health, 2014 p13)

This is seen as an ambition that will address many of the problems identified. Clinical and non-clinical managers have largely been held responsible for adopting a more collaborative approach to building partnership and improving services while ensuring the achievement of government goals and targets. The change from clinical to partnership accountability is illustrated by key investigations into poor clinical outcomes, the first in the 1990s with the Bristol Royal Infirmary investigation where there was a shift from holding clinical staff responsible for poor outcomes, to holding managers accountable for a failing healthcare system (Millburn 2001). In the 2000s the Stoke Manderville Hospital inquiry found that management failures were linked to patient deaths (HSE 2007) caused by *Clostridium difficile* outbreaks. Three enquires into clinical care at Mid-Staffordshire NHS Trust have all identified short comings how managers interacted and engaged with staff (Francis 2010). Managers were

reported to ignore concerns raised by staff. Staff reported being discouraged from speaking out.

In response to the need to work differently and more transparently, there has been an agenda to improve patient care in England, Wales, Scotland and Northern Ireland since the NHS Plan (Department of Health 2000). The setting up of the Modernisation Agency, the equivalent (Innovations in Care, Wales in 2001) and Centre for Change and Innovation Scotland resulted in hundreds of centrally funded programmes and publications. Despite significant investment, focus, research and the passing of ten years, major public failings continue to be exposed suggesting that the work undertaken had not addressed all of the issues everywhere. The more recent examples moved more of the responsibility for the failings to managers. In March of 2009 reporters in the Telegraph wrote of problems with Mid Staffordshire NHS Trust.

> *"It is not clear how many patients died as a direct result of the failures but the Commission found that mortality rates in emergency care were between 27 per cent and 45 per cent higher than would be expected, equating to between 400 and 1,200 excess deaths"* (Smith and Bingham 2009; online source)

The article in the Telegraph went on to suggest that;

> *"…The trust was more concerned with hitting targets, gaining Foundation Trust status and marketing and had 'lost sight' of its responsibilities for patient care, the report said."* (Smith and Bingham 2009; online source)

In November 2009, Basildon and Thurrock University NHS Hospital was exposed…

> *"The Care Quality Commission (CQC) found that poor nursing, filthy wards and lack of leadership at Basildon and Thurrock University NHS Hospitals Foundation Trust contributed to 400 avoidable deaths in a*

year.

> *Among the worst failings were a lack of basic nursing skills, curtains spattered with blood on wards, mold in vital equipment and patients being left in A and E for up to 10 hours."* (Smith and Bingham 2009; online source)

Exposure of these two trusts to public scrutiny (Trusts which appeared to be functioning well according to NHS league tables), provided a situation where different types of measures came to conflicting conclusions. Were the measures (targets) or the way they were collected erroneous? Or were the patients and staff spoken to wrong or misguided? Does one need to be wrong in order for the other to be correct, or do we need to recognise the existence of two conflicting states in any organisation at any one time?

It is proposed that the largely managerialist form of health organisations co-exists with the messiness of working in social hierarchies - where individual experiences and the narrative (of staff and patients) carry significant influence on how work gets done. Managerialist is described in many ways and will:

> '*help to identify and eliminate waste, to concentrate resources where benefits can be seen to be greatest, and give a clearer display of how the money is spent'* Cnmd 9058 (1983, pg3)

Managerialism ideology assumes that:

> *"the world should be a place where objectives are clear, where staff are highly motivated to achieve them, where close attention is given to monetary costs, where bureaucracy and red tape are eliminated."* (Pollitt 1993, p7)

Trayner asserts that the roots of mangeralism lie in the 'scientific management' advocated by FW Taylor (Trayner 1999, p13). In my

experience in the public health service the target driven approach is often seen by front-line staff as peripheral to their day-to-day work. Middle managers appear to be the 'buffer' between front-line staff and senior management in that they understand managerialism (targets, goals, efficiency) and at the same time they work with the complexity and messiness of influencing front-line staff. This analogy has been described in both the area of higher education (Gleeson and Shain 1999, p462) and in the health sector (McConville and Holden 1999, p406).

Middle managers are sometimes viewed by senior managers as 'captured' by the clinicians in the clinical world (siding with clinicians). Front line staff may view middle managers as having 'gone to the other side' and become more aligned to their senior counterpart. Middle managers are caught between worlds and could be seen to have two masters. Front-line staff are their masters because front-line staff cooperation and engagement is necessary the moment a change is required. Achieving new targets is dependent upon engaging effectively with front line staff. Senior management are also the masters of middle managers as they determine salary, role and function. The terms and conditions for middle managers are in many ways, more vulnerable than for front line staff (who often have collective bargaining powers). In my view both masters need to be kept satisfied and the middle manager has to navigate their way through conflicting states and views of the world.

Kirkpatrick challenges the extent to which managerialism (and the manager) is able to influence and change the practices of front-line professional staff. In social services he proposes that the: *'… capacity of these groups (of professionals) to negotiate or 'capture' change in ways that minimise disturbance to their day-today activities should not be under-estimated.' (*Kirkpatrick (2006). The second point Kirkpatrick makes relates to the discretionary effort made by health professionals and the potentially negative impact that managerialism has on this aspect of followership (Kirkpatrick, 2006)

A collaborative approach to change has not specifically focussed upon the role and function of middle managers, or what Buchanan (2010) has described as the '*other front-line staff'*. Middle management would appear to be key to the instigation of a collaborative approach by reason of their position in the hierarchy – i.e. their greater or lesser engagement with the complex social structures and their knowledge of the managerialist world' (Birken, Lee et al. 2012, p5). It could be said that in order to succeed middle managers have to work collaboratively with staff whilst appearing to maintain the managerialist façade that is expected and vice versa. Haslam, Reicher et al. propose that there are four principles in the new psychology of leadership; a leader 1) is one of us, 2) does it for us, 3) crafts a sense of us and 4) makes us matter (Haslam, Reicher et al. 2001, pxxii). The term 'us' for a middle manager is from either side – the front-line staff and the senior management/politicians – thus reinforcing the need for a strong overlap to front-line staff and senior management.

The utopia of achieving partnership working between managers and front-line staff is a difficult aspiration that has not been recognised as having been achieved on a widespread scale. Despite the Lord Darzi report (2008) and subsequent NHS Constitution (2008); there remain instances where managers have not protected patients in cases of poor practice (as in breast cancer operations) (Buchdahl , 2013) and

> "*the imbalance that exists around the use of transparency for the purpose of accountability and blame rather than support and improvement*" Keogh (2013, p5)

In other words, the processes that managers have traditionally utilised, for example in the Human Resources (HR) department, and measuring data are not achieving the goals aspired to. Kirkpatrick asserts that

> '.. *there is very limited evidence of change in orientations and values within this sector (social services). For most professionals engagement with management ideas and priorities is at best*

pragmatic.' (Kirkpatrick, 2006, p20)

This study sits within the complexity of the Welsh NHS and New Zealand public health system, both systems are characterised by frequently changing environments, ambitious organisational targets and increasing expectations from politicians, patients, staff and managers for higher quality care and coordination. This study provides an opportunity to answer research questions utilising multiple change strategies, teams and countries thus providing a rich study area and data collection. Both countries health care systems are similarly characterised by offering healthcare free at the point of deliver with similar expenditure and outcomes (Davis, Schoen et al. 2007, pviii).

The programme of work has focussed upon perceptions of patients, front-line staff and managers. The research uses the unique multiple positions held by myself as a middle manager and insider researcher. A number of managerialist approaches are examined. How these are perceived by front-line staff and patients is explored.

In the context of a managerialist approach, this study explores the intentions and the behaviours of managers and how they were perceived by both frontline staff and patients. It investigates the views that managers held while they were implementing change. This research explores core principles of ethical behaviour, openness, integrity, honesty and respect as well as the aspects of unconscious behaviour that may not have been recognised and to which participants remained ignorant of (the shadow side). Egan described the shadow side as the "*covert, un-discussed, and un-discussable things that drive your organisation*" (Egan 1994, p3). Fox describes the shadow side as the 'hidden' side of the organisation that is more difficult to view and evaluate as an outsider (Fox et al. 2007, p60).

My interest in seeking how to work more collaboratively and develop engagement with front line staff has been one of self-preservation and

pragmatism. I am a middle manager working between the two worlds of managerialism and the complex nature of social organisation. I have watched strategies work well in one area but fail when transferred to another area, often with the conclusion that failure was due to the organisation or department culture, the personality of individual staff, or the type of team involved, but with no real knowledge to apply other than it was just bad luck. This research programme is an attempt to provide some of the missing ingredients that may help to explain the complex behaviours occurring between health managers and front-line staff. It is my hope that this study will provide new knowledge for middle managers enabling them to navigate their way to the utopia of partnership while accepting the premise that it is complex.

My capacity for fulfilling my own needs is integral to the findings of this work. I have long been interested in the art of applying tools and techniques but find that I now use them less and less in my day-to-day life. I feel guilty about this because the dominant hegemony of managerialism would suggest that the tools are important for achieving results. This research programme has provided me with an opportunity to explore changes I need to make to be effective in my new front-line role i.e. middle management. The one that involves closer working with the real front-line staff with many more opportunities to make errors and do the opposite of what I intended. There is some benefit to front-line staff in having distant, heroic leaders – there is perhaps less opportunity to make an error and the managers don't interfere too much with the front line work. The requirements of new leadership models would appear to be that middle managers need to work even closer with the people doing the real clinical work.

A key driver for this study was an apparent lack of willingness of health middle managers to undertake quality improvement. In my roles as middle manager I have observed an acceptance of poor care systems by middle managers (and in some circumstances front-line staff). I have observed too

much reliance on external stimuli such as targets and inspection, with lost opportunities to identify and improve services from within. I have observed active avoidance of change because of fear of failure. I have observed an over reliance on technical approaches without consideration for the human factors of change. I have observed people at all levels of the organisation appearing to be over-whelmed by the thought of making changes and therefore descending into battle weary negativity, which few strategies could break through. And finally I have observed managers and staff losing patience with each other resulting in stress taking a physical and emotional toll. This was type of behaviour was exemplified in the analysis of the problems and abuse uncovered in the Mid Staffordshire hospital inquiry (Francis Report, 2013).

My reason for undertaking this work is to provide better guidance for the people that I work with in the organisations I work in. A key component of this work is the complexity both from the uncertainty associated with cause and effect and the types of problems to be solved. I see the guidance as less of a street map and more of an ordnance survey map - where the terrain, altitude and valleys become important to determine how you are going to get somewhere. The three dimensional nature of the ordnance survey map provides a better understanding of the journey than a street map. Developing guidance that will increase certainty of successful change processes, across many different contexts and terrains, is an important outcome both for the organisations I work in and for myself as a manager.

Each of the portfolios I have worked in while undertaking this research has involved undertaking support for staff doing quality improvement work. This has meant that I support staff who work outside of my usual operational responsibility. The organisations have used me as a resource in this way and in return, they have provided me with support (financial, time and access to participants). In the first two years, the cost of my research programme was fully paid by the trust at case study one. The second case study hospital paid a contribution to my fees. Overall, I have personally

funded half of my fees and contributed approximately 3 months of annual leave over the last 6 years. When I have requested to present information to wider groups of staff as part of the study, this has been fully supported by the organisation. Whilst there is no specific planned educational programme of work to roll out to the current organisation I work in, there is an expectation with the organisational wide campaigns I am leading that the findings of this research will be utilised. I fully expect to publish my findings in collaboration with my supervisory team for other practitioners of change to view and critique.

Overview

Chapter two outlines the terms of reference for this project and sets out the context in which I was practicing in the NHS in Wales and in the New Zealand healthcare system. It articulates the key research questions concerning manager led strategies and provides a review of the literature, which has influenced the design, and nature of the study – both in terms of what change strategies were implemented and how data was analysed in this programme.

Chapter three provides the justification for the development and implementation of the strategies and for the data gathering approach. It demonstrates how my unique position contributed to the research because of the level of participation undertaken, my role in the organisation and the importance this reflection provided to further inquiry in the study areas. It also demonstrates how strategies were developed during the data collection process to achieve appropriate data collection practices and maintain ethical research practices. This chapter also sets out the justification for a change to the original programme of study.

Chapter four outlines the phases of programme activity which occurred in the two different case studies. The chapter is divided into the two case study areas and in each section covers the development, implementation, data collection and analysis process.

Chapter five provides findings from each aspect of the data analysis. This information is then re-presented as broader themes for each case study and then presented again at its highest level as the major findings from the programme of work. This chapter also includes deductions of how the key concepts contribute to the development of new knowledge and the main product from the research.

Chapter six links the major findings and new knowledge from this research to other work that has been presented. It outlines the uniqueness of this knowledge from what other researchers have presented. This chapter also reflects upon the methods used and particularly the impact that researching in the real world had on design. It outlines the contribution to practice of this research.

Chapter seven will include a summary and concluding comments and provide an outline of attendance to meeting expectations set out earlier in the programme and the course requirements. It provides an overview of recommendations for groups within and the contribution to practice. It also identifies where further research is needed.

Chapter 2: Terms of reference and literature review

Terms of reference

This research focuses upon the outcomes of middle manager led change and the views of those involved in the change processes. The study is set in the NHS in Wales and in the public health system in New Zealand. The aim is to understand how the values and views of front line staff align or conflict with manager views and explore what this may mean for collaborative and partnership working. The success of the study will be measured by the ability of the researcher to develop new knowledge on which a model for transformative engagement can be based. The stakeholders of this study are senior and middle managers, front-line staff and ultimately patients and their families.

The project was developed to address one main research question and four sub questions

Research question:

1. What knowledge do health sector middle managers require to undertake transformative engagement with staff and patients?
    I. Are there changes to the team as a result of the implementation of change strategies?
    II. What features of the strategies were important for managers and front line staff?
    III. Were the strategies perceived as useful and sustainable?
    IV. What 'governance' themes emerged following implementation of the strategies?

This project aims to study the impact of middle manager led strategies on groups of staff in Wales and New Zealand (NZ) and to develop a guidance model and resource that is transferable to NZ and UK NHS managers with relevance to other health sector managers.

The project was designed to achieve the following objectives:

To search for evidence of important quality improvement work carried out when manager led strategies were implemented.

1. To study staff, patient and manager perceived effectiveness of the strategies implemented.
2. To develop theoretical concepts and models for operational managers leading change and quality improvement in the NHS.

Literature review

A literature review was undertaken at two major stages of this programme of work. Initially an extensive literature search was conducted using multiple databases including Cochrane, Medline, PubMed, Emerald, BJ, Library of Congress, British Library and the World Wide Web (for popular opinion, political opinion and policy documents from UK and NZ). The key search words were quality improvement, clinical governance, staff satisfaction, patient involvement, and NHS modernisation, changing practice complexity theory, management ethics, codes of conduct (health) and management and leadership in health. Material was subsequently sorted by levels of evidence. It was apparent that most of the literature regarding quality improvement and change in the NHS only included a few observational studies and the studies did not provide strong evidence. Evidence was either low (one or more studies with severe limitations) or very low (expert opinion, no direct research evidence, one or more studies with very severe limitations) (Greenhalgh 2001, p18).

The first part of this literature review focussed upon the work that underpinned the NHS modernisation and clinical governance. The purpose of this was to understand what had been learned about the effectiveness of different strategies and various technical approaches and understand where there were weaknesses in either the strategies or the application of the strategies.

With regard to the types of observational studies carried out - Walshe and Freeman assert that the

> *"effectiveness of many quality improvement interventions has been studied, and research suggests that most have highly variable effects which depend heavily on the context in which they are used and the way they are implemented"* (Walshe and Freeman 2002, p85).

Much of the literature was prescriptive on use of the tools and techniques and much early evaluation (1990's) focussed upon whether the tools worked. Walshe et al propose that future research should assess *how and why* they work - what they called the "determinants of effectiveness" instead of *whether* they work (Walshe and Freeman 2002, p87). .

The second phase of literature search took place following the conclusion of the each of the phases of study. This was due to the development of new literature and inquiry into the emerging themes from the study – particularly focussed upon the context in which change may take place. This further exploration included leadership theory as well as complexity theory.

The review of literature is presented as views of organisation (page 23), overview of key improvement strategies in health (page 32) and service user involvement (page 47). The literature then reviews relevant ideas and research from the theory and practice of leadership (page 52), different types of leadership (page 58), complexity and alternative theories of leadership (page 64) and followership (page 81). Lastly there is a review of ethics and management (page 76).

Views of organisation:

Bolman and Deal (2003, pxv) suggest that it is possible to view organisations as factories, families, jungles and temples. There has been an emphasis in healthcare to aspire and behave more like a factory and less like a family,

jungle or a temple. Healthcare in the UK and across first world countries has developed two related concepts which encapsulate the idea of healthcare as more of a factory – NHS modernisation and clinical governance. Both of these concepts call for a rational, scientific approach to delivering healthcare.

Whilst there is some acknowledgment of the view of the organisation as a family (in which human relations are important), and a jungle (in that politics are important) and a temple (in that what actions stand for is important) either by nature or by design (Bolman and Deal 2003, pxv) – these elements appear less visible in the push to modernise and achieve good clinical outcomes and effective organisation.

I found that the role of the modern NHS could be viewed through the six assumptions of a machine put forward in the structural framework by Bolman and Deal (2003, p45).

1) *"Organisations exist to achieve established goals and objectives*
2) *Organisations increase efficiency and enhance performance through specialisation and a clear division of labour.*
3) *Appropriate forms of coordination and control ensure that diverse efforts of individuals and units mesh.*
4) *Organisations work best when rationality prevails over personal preferences and extraneous pressures.*
5) *Structures must be designed to fit an organisation's circumstances (including its goals, technology, workforce, and environment).*
6) *Problems and performance gaps arise from structural deficiencies and can be remedied through analysis and restructuring."*

(Bolman and Deal 2003, p45)

From this I have concluded that Total Quality Management (TQM) has provided many of the fundamental principles and strategies behind the NHS

modernisation and Clinical Governance. It is relevant to establish the principles and beliefs about knowledge behind this approach in order to study how it is similar or different to other approaches.

The quality improvement methodologies, whilst all different, all have the similar assumptions about the beliefs behind quality improvement work:

I. *"High quality is cheaper than low quality*
II. *People want to do good work.*
III. *Quality problems are cross-functional*
IV. *Management is ultimately responsible for quality." (*Hackman and Wageman in Bolman and Deal 2003, p155)

An original proponent of quality improvement was Joseph Juran. He proposed three phases to managing for quality. Quality planning, quality control and quality improvement (Gryna, Chua et al. 2007). Through the use of a quality improvement process, waste is expected to be reduced to below 10 percent. The difference between the old zone of control (old ways) and new zone of control (after quality improvement had taken place) is referred to as chronic waste and the "costs of poor quality". The categorization of quality costs is an important aspect to many improvement methodologies due to the assumption that *high quality is actually cheaper than low quality*. Juran (ibd) refers to six broad categories of costs internal failure costs, failure to meet customer requirements and needs, cost of inefficient processes, external failure costs, appraisal costs and prevention costs.

Total Quality Management assumed that aligning the actions of individuals (to the espoused goal of high quality health care) was the main ingredient to improving the system. This presupposes that the only goal for an organization is to deliver (improved) health care. The TQM approach would appear to over simplify both what a healthcare organisation is and what can consistently and predictably be achieved using the tools and techniques

described. It does not for example acknowledge the myriad of functions that a healthcare organisation provides to a community including: a place to socialize; to receive income; to do research; an academic institution for teaching; a source of referrals to private practice, and a place to practice medicine. Whilst there may be some concerns that some of these activities may not be legitimate aims of an organization, they never the less do exist and are a reality. Fox (1966) describes two typologies in industrialised relationships which offer a frame or reference for viewing manager and staff relationships and subsequent actions. The unitary approach applies when the aims of management and staff are seen (by managers), as shared and similar. The pluralist approach is when contractual relationship satisfies the interests of separate but interdependent groups such as managers and staff (via trade unions). The pluralist is where managers accept that there can be other interpretations of the world and accept this. In 1974 Fox added a third approach which is described as an illegitimate relationship characterized by domination of one group over another (Fox 1974, p6). Using Fox's typology, it would seem that there is a view of inherent conflict of interest between employees and employers working in health (in other words the pluralist and radical frames of reference are more prevalent than the unitarist). This suggests that there are basically two approaches; a unitarist which is inflexible mangaerialism and a pluralist approach. The pluralist approach recognises that there are alternatives to managerial objectives and negotiation is required by both employees and employers to accommodate alternative views.

Whilst the principles of NHS modernisation and clinical governance go some way to address a more pluralist point of view of what an organization is, there is a heavy influence from scientific management (Hewison, 2004, p344). Thus the centralized programmes of modernization in the NHS and in New Zealand public health system have largely concern for a rational approach based on an industrial model. Whilst there has been concern for individual's workplace needs and aspirations, these could be seen as "add on" – and not part of the core approach. A combined human resource

approach with scientific approach is perhaps used as a way of achieving efficiency in that organization need ideas, energy and talent (Bolman and Deal 2003, p115) however the main thrust of the modernization has been to improve the system through top down design with some input from staff, not staff as the starting point.

What has been described so far is a metaphor for organisation as a machine:

> *"The emphasis is on predetermined goals and objectives and the organization is expected to operate in a systematic, efficient and predictable manner."* (Kernick 2004, p85).

Organisations designed and operated as if they were machines are usually called bureaucracies. Morgan describes them as a

> *"state of orderly relations between clearly defined parts that have some determinate order.. we tend to expect them to operate as machines: in a routinized, efficient, reliable and predictable way"* (Morgan, 2006, p13).

This image of an organisation fits with the quality improvement approach to what an organisation is, how it works and what it aspires to be. Kernick however proposes that a more fitting metaphor for the NHS if one really observes what happens, is as an ecosystem (or a complex adaptive system). This metaphor recognises local networks as non-linear and always changing (Kernick 2004, prologue pxv). It denies the possibility of a "top-down" approach by proposing that power and influence from the top is limited (although not impossible). He claims that this approach

> *"… does not replace normal science or contest its claims to reliable knowledge. However it does offer an analytical framework to complement the rational model of decision-making that resonates with the experiences of health care managers and practitioners and*

offers a new perspective…" (Kernick 2002, p121).

The eco-system metaphor recognises that a hierarchical, command and control model with rigorous evaluation at every level, does not provide the desired outcomes because the NHS is complex and a non–linear system. This model postulates that the emphasis should focus on strategies which engender "long-term agreements, trust and mutual responsibility" (Kernick 2002, p123). In recognising the non-linear nature of systems in the NHS, many of the strategies that evolved were themed and worked with smaller units of staff.

In Tate's (2013) metaphor of a fish tank for an organisation we focus on the unofficial and complex ecosystem that may be useful in assisting managers and leaders to achieve more. Included in this are different characters including:

> *"… show offs… personal favourites and the less glamorous… we observe pecking orders… toxins and detritus. We see species whose job is to clear up the mess at the bottom, and those who service the hygiene needs of those higher up' and keep their image clean…"* (Tate 2013, p5)

Tate proposes that managers mostly notice the individual fish and not the quality of the fish tank and what surrounds the fish. Tate proposed that we notice the fish tank (and not just the beautiful fish) if we are primed to observe organisations as a whole system and recognise its politics and the effect on overall performance (ibid pg. 12).

It is proposed that individuals within a system use internal rule sets that drive their actions. These may be expressed as instincts, constructs and mental models (Plsek and Greenhalgh 2001, p625). As these rules may not been shared, explicit or even logical (from someone else's point of view), this may lead to difficulty in determining a direct cause and effect

relationship.

For this reason there has been a focus upon two factors that are thought to be important for cause and effect relationships – degree of certainty and level of agreement. Stacey developed a model which is called the "edge of chaos - the zone of complexity" (Stacey 2002, p28). When issues or decisions are close to certainty one can use past experience or a scientific approach to predict outcome. When functioning at the other end of the spectrum, the situation may often be seen as unique or at least new to the decision makers. Links between cause and effect are less clear. Certainty was placed on the horizontal axis. Agreement was placed on the vertical access and is the level to which a group, team or organisation agrees about the issue or decision.

Stacey (2002) refers to the area five (between chaos (4) and the regions of traditional management approaches (1, 2 and 3) as the zone of complexity (5). Stacey proposes that traditional methods for management do not work well in the zone of complexity. He suggests that managers and leaders need to have a range of approaches to deal with the diversity of contexts in this zone. He proposes that these areas require more intuition.

Plsek and Greenhalgh suggest that complexity is

> *'a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent's actions change the context for other agents'* Plsek and Greenhalgh 2001, p625

The type of management activities involving change and improvement that could be categorised in the zone of complexity would appear to be significant in number and importance. Whilst the experience of the manager and leader may contribute to moving a number of issues into the management areas (1,2,3 – which are more predictable) there would appear

to be a significant volume of change work for which detailed planning and specification (and viewing the organisation as a machine) would appear to be futile. Plsek and Wilson (2001, p747) propose that there are ways to create an environment in which innovative complex behaviours can emerge to deal with the zone of complexity. They propose that systems need fewer rules and require simplicity to enable maximum creativity and innovation - the four categories of minimum specifications they cite as important are direction pointing, boundaries, resources, and permissions.

Argyris was the first to use the term "psychological contract". This term refers to the idea that there is a reciprocal (tacit) exchange that occurs between employer and employee (Argyris 1960). Levinson et al proposed that these obligations towards each other are a:

> *"series of mutual expectations of which the parties in the relationship may not themselves be dimly aware but which nonetheless govern their relationship to each other"* (Levinson, Price et al. 1962, p21).

This suggests elements of unconscious behaviour in which interactions and intentions are not necessarily apparent and open to multiple interpretations. Hannabuss describes that there are four states of knowing

> *"Knowing that you know, knowing that you do not know, not knowing that you know and not knowing that you do not know".* (Hannabuss 2000, P402)

Hannabuss proposes that states of not knowing may arise innocently or through an indifference to learn and update knowledge and skills. The problem with this view of competency in a manager is that it does not take into account firstly the constantly changing socials situations that people work in. These informal organisational structures are described by Kernick as

> *"Fluid, spontaneous conversation from which meaning or knowledge merges within the conflicting restraints of power relationship. Through these informal and local interactions, the future is continuously created in the present." (*Kernick 2004 p112)

The idea that a manager is unconsciously incompetent because they failed to act in a particular way (or failed repeatedly) to act in a certain way, may ring true if we were talking about a small group of people who had received no management training or support. I do not believe that the literature supports the idea that there is only a small number of managers or leaders who are incompetent and are constantly undertaking bad change management activities. It would appear that the act of labelling individuals as unconsciously incompetent assumes that there is one truth with which individuals or organisations can be measured. It also assumes that the context has limited relevance and it concludes that there is a 'blame' mechanism which needs to be satisfied. To explore this concept, I have likened this to the analogy of "*lynching or learning*" used by Patterson (Health and Disability Commissioner,NZ, 2008). Patterson referred to the approach that New Zealand has taken to make finding about whether an indivudal provider or organisation has breached the patients' rights. He summarises the outcomes as

> *"Far more often, we single out DHBs (District Health Boards) and other organisational providers as being in breach of the Code, and acknowledge the impossible situation faced by individual medical staff. The combination of HDC's approach to finding doctors in breach of the Code, and the Medical Council's use of competence reviews to help the poorly performing practitioner, has led to a dramatic decline in discipline."* (Patterson 2008, p109)

Whilst blaming the manager (as we did the doctors in previous times (BBC News, 2001:online), may satisfy the needs of some people, it does not lead us to anywhere new in terms of new knowledge. The idea that the outcome

is a product of the system in which it works, is not new. Berwick proposed that "*every system is perfectly designed to achieve the results it achieves*" (Berwick 1996, 619). It is difficult to see how this idea of a manager being a 'product of the system' can be adapted to provide insight into change management (and the many perspectives managers and front-line staff perceive). This research would suggest that the analogy is more akin to the famous parable about the blind men and the elephant – where everyone's experience of the elephant is different and whilst real for each person, is not the same as everyone else. The understanding that there are many truths and respect of different perspectives of the truth may be useful in viewing context and balancing approaches to change.

The idea of espoused theory and theory in practice was described by Argyris and Schön as:

> *"When someone is asked how he would behave under certain circumstances, the answer he usually gives is his espoused theory of action for that situation. This is the theory of action to which he gives allegiance, and which, upon request, he communicates to others. However, the theory that actually governs his actions is this theory-in-use." (*Argyris and Schön 1974, p6-7)

The observation of psychological contracts, the theories in practice or 'theory-in-use' and the espoused theories may form a critical component of this study in order to address the research questions posed.

Overview of key strategies

Modernisation initiatives from NHS agencies within England, Scotland, Wales and Northern Ireland have focussed on thematic improvement closely aligned to performance targets (Buchanan, Fitzgerald et al. 2007, pgxxii). The approach to the improvement work was pulled from many quality perspectives and were a combination of top down and bottom up approaches (such as a clinical collaborative whose aim was to create specific improvements based on the learning of thousands of improvement

projects (Bevan 2007, p8). The booked admissions project allowed patients to choose dates of their appointment and used waves (orchestrated implementation) to disseminate best practice into the mainstream and ultimately reduce waiting times (Neath 2007, 115). In addition there have been other initiatives focussed upon improving how teams work to deliver better care including – high impact changes, transforming care at the bedside, clinical microsystems and clinical care pathways.

In the widely used publication *10 high impact changes* (NHS Modernisation Agency 2004) the authors proposed a change in thinking from traditional improvement strategies to a new group of potential improvement strategies The difference between current and potentially new strategies appears to reflect the change that occurs in single loop learning and double loop learning. The first set of strategies appeared to view failure to "*achieve the intended ends leads to a re-examination of means and a search for more effective means"* (single loop learning) (Argyris, Putnam et al. 1985, p53). The second set of strategies focus less upon local performance and more upon the total system. Whilst still concerned for the means, they appear to presume that the intended consequences may require review, reflection and reframing. This is described by Agryris as "double loop learning" (1985, p53. It appears that the new strategies proposed encourage double loop learning where new paradigm shifts mean that old problems become obsolete. This suggests that double loop learning would encourage a more pluralistic view of organisational learning due to multiple opportunities to review the goal or the end point.

There is a further learning loop inspired by Agryis and Schön although the term does not appear explicitly in their published work (Tosey et al, 2012, p 291). This type of learning has been referred to as *"beyond and superior to "single loop" and "double loop" learning and is concerned with the underlying purposes, principles or paradigms"* (ibid p295). This type of learning would appear to question the nature of the business itself. It goes beyond questioning "are we doing things right" (single loop), "are we doing

the right things" (double loop) . It moves to "*can we participate in making well-informed choices regarding strategy, objectives etc"* (ie triple loop). (ibid p296). Triple loop learning is not obvious in the *10 high impact changes* possibly because the areas of focus were pre-judged. The context therefore could be said to be less relevant. *10 high impact changes* suggests (like many other modernisation agency programmes run) that the strategies and principles were already decided (by politicians, health leaders, government agencies) and focussing on the doing the right things and doing things right were the main priority and perhaps left control of the principles and strategy in the hands of the politicians.

The change in focus to double loop learning whilst it offers a more pluralist view, still treats the organisation as a machine – it has adjusted the technical side of the improvement strategy slightly but it maintains what Stacey refers to as "management tools of instrumental rationality" (Stacey 2012, p4). Thus the dominant discourse regarding change is heavily focused upon top down management tools.

The setting of targets and performance measurement of system parts is described in Theory of Constraint terms as *local versus system optima*. This theory proposed that if:

> *"all the components of a system are performing at their maximum level, the system as whole will not be performing at its best"*
>
> (Dettmer 1997)

The focus on the interdependence and variation within each department in a hospital increases the relevance of this concept. The *work smarter* strategies are derived from Theory of Constraints (Goldratt 1984) and demonstrate the importance of the entire process over local optimisation (often unknowingly at others expense). The potential strategy to look at the entire system with a focus on the patient pathway is not traditionally the mandate of individual managers or staff. Departments and managers

have traditionally fought for precious resource i.e. winning over other departments was seen as successful. The front-stage (publicly stated) and back stage (privately stated) goals of managers and staff are not always the same and would appear to be very important to relationships. Added into this is what is not said about strategies (or the work) and in which both employees and employers may be unaware of the difference. This relates to the theories in action (espoused views) and the theories in use (the actual actions) which may be quite different (Argyris and Schön 1974).

The gap between what is known and what happens in practice is well documented. The three reports issued from the Institute of Medicine in the US explore the need for fundamental change – "To err is human: building a safer health system" (Kohn, Corrigan et al. 2000), "Crossing he quality chasm" (Committee on Quality of Health Care in America 2001) and "keeping patients safe" (Institute of Medicine (US) 2005). The US response to similar quality issues as faced in the UK has been to draw together the methodologies through the IHI (Institute for Health Improvement) recently through a 100 000 lives campaign and then a 5 Million Lives Campaign[1]. The 100k lives campaign involved recruiting hospitals across the US to sign up to implement six "evidence-based practices". A review of the lives saved queried the actual number, however it acknowledged that the campaign "*generated unprecedented amounts of social pressure for hospitals to participate"* (Wachter and Pronovost 2006, p 623). Don Berwick was employed by the NHS to help transform patient safety (Kingsfund, 2013). This review identified four overarching recommended commitments:

> *Place the quality of patient care, especially patient safety, above all other aims.*
>
> *Engage, empower, and hear patients and carers at all times.*
>
> *Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work.*

[1] A national initiative that aims to protect patients from five million incidents of medical harm in US hospitals between December 2006 and December 2008

> *Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.*
>
> (Berwick 2013, p4)

Transforming Care at the Bedside (TCAB) (called Releasing Time to Care in the UK) started in 2003. The programme worked in medical and surgical wards and focused on - safe and reliable care; vitality and teamwork; patient-centered care; and value-added care processes. The programme combined quality improvement methodology with implementing best practice. It used collaborative working to maximize the cycles of improvement. The programme worked with front-line staff to improve the work environment and quality of care for patients. It focused on wasted resources and the costs of poor quality. Anecdotal evidence in Nursing Journals is that staff and patients like the changes that have occurred as a result of the work completed (Simmons 2005; Viney, Houston et al 2006; Martin, Greenhouse et al. 2007). Self reported examples of outcome through the use of TCAB include reduction in length of stay by 20%, increased job satisfaction and reduced turnover to 11.29 (from (20.77), 60% bedside care up from 25-30% and lots of improvement ideas from staff (The Robert Wood Johnson Foundation and Institute for Healthcare Improvement 2007).

The clinical microsystem approach uses many tools from quality improvement theory and like "transforming care at the bedside", works with units of front-line staff. The purpose of the microsystem is to improve care *from the inside out* (Nelson, Batalden et al. 2007).

> *"A clinical microsystem is a small group of people who work together on a regular basis to provide care to discrete subpopulations of patients. It has clinical and business aims, linked processes, and a shared information environment, and it produces performance outcomes. Microsystems evolve over time and are often embedded in larger organizations. They are complex adaptive systems, and as such they must do the primary work associated with core aims, meet*

> *the needs of their members, and maintain themselves over time as clinical units."* (Nelson, Batalden, et al. 2007, p7)

The clinical microsystem approach used the *patient value compass.* This has four directions – satisfaction, costs, functional status and clinical status. It is concerned with outcomes that matter to managers, staff and patients and upon the relationships between all three groups. It proposes that the micro system is

> "*the basic building block of any health care delivery system..*(and) *the unit in which espoused clinical policy is put into practice…* (and)*… it is the place where good value and safe care are made"* (Nelson, Batalden, et al. 2007, p7)

Clinical Microsystems use the action research derived Plan, Do, Study, Act (PDSA) methodology to experiment with improvements and make changes (Nelson, Betalden et al 2007). This approach places emphasis on a specific role for managers in the clinical microsystem as a facilitator.

Clinical Care pathways are

> *"integrated management plans that display goals for patients, and provide the sequence and timing of actions necessary to achieve such goals with optimal efficiency*"(Panella, Marchisio et al, 2003, p509).

Clinical care pathways are seen as the clinical embodiment of quality improvement (Iedema and Degeling 2001, p 13). Pathways seek to describe best clinical practice and expose unwanted, unintended variation. Evaluation of care pathways through systematic review identified that

> "*readers should be cautious when interpreting the results… because of the confounding factors and sources of contamination affecting*

> *the evidence-based validity of the outcomes".* (El Baz, Middel et al. 2007, p1356)

The context in which pathways were developed again appears to be pivotal. In interviews with clinicians where pathways were introduced 10 years previously, a number of supporting factors were thought to contribute to the Clinician owned pathways. These included a strategy to develop pathways in the organisation, education on quality improvement methodology and education that linked increasing quality with reducing costs through reducing unnecessary and un-intended waste in resources (Cumming and Cochrane 2008).

Whilst all types of Total Quality Management acknowledge the role that staff play in quality improvement there has been limited success in routinely engaging staff in the NHS. In 2001 it was estimated that less than 15% of NHS staff were actively involved in modernisation work (Bate, Robert et al. 2004). Perhaps the technical nature of the work and the speed with which change occurred in the English NHS since 2001 which required special teams and programme to be set up in hundreds of hospitals meant that limited front-line staff were involved. Whilst many of the changes became "mainstreamed" there was considerable concern for local teams to continue the principles of modernisation. An evaluation carried out by the NHS Modernisation Agency in England (Buchanan, Fitzgerald et al. 2007) concurred with Walshe et al that the success of improvement work is largely dependent upon the context into which it is introduced.

In terms of organisation wide investment in programmes there has been concern over the last 10 years that strategies have not delivered what was anticipated. In 2003 an article in Quality and Safety in Healthcare stated that

> "*there is little evidence to support the claim that TQM (Total Quality Management) programmes will act as a catalyst to achieve organisation-wide change"* (Locock 2003, p54).

The research reported by the Modernisation Agency staff (English NHS) concerned sustainability and spread of new working practices (Buchanan, Fitzgerald et al. 2007) explored the phenomenon of how and why improvement methods worked and also explored the "determinants of effectiveness".

There were four critical success factors attributed to the success of the booking system project (Buchanan, Fitzgerald et al. 2007) - adapting to change through knowledge and experience; ability to develop relationships; small, continuous changes and personal characteristics. Examination of the context for change demonstrated how important long standing relationships, local knowledge and resilience was for the success of the programme.

The heavy reliance on context, personalities and relationships may explain the appeal of small continuous change. PDSA (plan-do-study-act) cycles have been used throughout the many health systems (Taylor, McNicholas et al 2013, p5). PDSA (or Deming cycles) involved measuring a process, making a small change on a small scale and evaluating the result. This is then repeated multiple times, each time making a change (ibid p2). The appeal is that they are low risk and staff can be brought on board with local examples of how effective a pilot change process was. The effectiveness of the PDSA (plan-do-study-act) technique is reported in the literature from improvements made to timeliness and an increased ability to care for acutely unwell patients (Provonovost, Morlock et al. 2000), safety and the reduction in adverse drug events and other preventable injuries to patients (Farbstein and Clough 2001; Eisenberg and Painter 2002; Hobar, Plsek et al. 2003; Leape, Rogers et al. 2006; Marangōvan de Mheen, Stadlander et al. 2006; Sorokin and Gottlieb 2006; Bittle, Charache et al. 2007), effectiveness – in care of patients with asthma and other long term conditions (Wroth and Boals 2005; Buhr and White 2006; Olenginski, Newman et al. 2006; Gray, Eden et al 2007) efficiency – in delivering improved care for patients with heart failure and rheumatic fever (Nolan, van Riper et al. 2005; Harrington and Newman 2007; Newman and Harrington 2007).

PDSA (plan-do-study-act) type cycles were first described by Lewin in his support for action research "research which will help the practitioner" (Lewin 1946, p34) Lewin proposed that

> "*rational social management, therefore, proceeds in a spiral of steps each of which is composed of a circle of planning, action and fact-finding about the result of the action"* (Lewin 1946, p38)

Lewin recognised that this cycle was essentially a social process in which individuals discussed and debated decisions and learned as a group in the real world. Action science which is described by Argyris as building on action research (incorporating theory building and testing) (Argyris 1985, px), is purported to translate scientific knowledge into practical knowledge.

A common feature of action research is the participatory element. Some experts hold the view that:

> *"action research is located in the participatory worldview and that it is unique because it is context-bound and involves action which is designed to change local situations."* (Koshy et al p13).

The concern for context and local action also reflects the democratic nature of action research in that participants perceive the need to change, are willing and play an active part in the change process. This moves the power base of the researcher from director to more of a facilitator and consulter (Meyer 2000 p178).

Clinical governance

In 1998 the BMJ had the first of several articles in which Clinical governance was launched. Few could argue with the aims of clinical governance – ie

> *"For the first time, all health organisations will have a statutory duty to seek quality improvement through clinical governance. In the*

> *future, well-managed organisations will be those in which financial control, service performance, and clinical quality are fully integrated at every level".* (Scally and Donaldson 1998, p64)

Clinical governance has however not remained the sole domain of practitioners. A review of the Bristol inquiry in the BMJ (Smith 2001) highlighted the role managers played in the breakdown of systems and their role in clinical governance –

> "*… evidence of underfunding… constant shortages of trained nursing staff…. level of specialists was always below the level deemed appropriate… consultants lacked junior support… expected to care for patients in places that were several hundred yards apart… facilities and necessary medical equipment had to be funded through the good offices of a charity*. (Smith 2001, p179-180)

This appears to be the first time that a review placed some of the blame on the "system" and management in the UK.

In 2006 a highly critical report by the Healthcare Commission concerning what the health minister Andy Burnham called "inexcusable"

> *"failings by senior managers at Stoke Mandeville Hospital, where two outbreaks of C difficile affected 334 patients, killing at least 33.* It was reported that *senior managers at Buckinghamshire Hospitals NHS Trust, which runs Stoke Mandeville, were too preoccupied with targets on reducing waiting time for emergency care"* (Gould 2006, p215)

A study carried out in 100 trusts in England found that there was more

> "*… perceived progress in areas concerned with quality assurance than quality improvement* and that *directorate level managers"*

> *perceptions of achievement were found to be significantly lower than those of their board level colleagues on all domains other than improving performance"* (Freeman and Walshe 2004, p335)

Freeman and Walshe go onto suggest that

> "*clinical governance committee provide a "theatrical" function, reassuring the board that all is well while allowing "business as usual" at lower levels*" (Freeman and Walshe 2004, p341).

There is significant rhetoric surrounding clinical governance and much skepticism. In the literature clinical governance is often used interchangeably with quality improvement. Clinical Governance as an adjective describes a number of concepts and activities (including professional development, appraisal, audit, analysis of events, mortality and prescribing review, providing information about doctor performance to patients, whole team working, openness, accountability and the list goes on (Gerada 2006). The term is often used as a noun which is problematic as this supposes that clinical governance is an outcome or something you can see.

A recent survey carried out by the New Zealand Association of Salaried Medical Specialists (ASMS) of District Health Boards concludes that there was a failure by management to engage with hospital specialists and involve them in decision making (Scoop Media, 2014). 30% of members surveyed thought their DHB was genuinely committed to distributive clinical leadership, 47% felt their DHB was not, and the remaining 23% were not sure. Perceptions of how committed different levels of management were to enabling effective distributive clinical leadership reduced as the management level reduced ie highest ratings were for the Chief Executive Officer, lowest at the middle manager level.

In 2004 Degeling (Degeling, Maxell et al. 2004) refer to clinical governance in most UK trusts as being far from the "bottom up mechanism" that was

planned. They described clinical governance as being oriented to "silos" where risk, audit and quality departments each attempt to satisfy accountability of the trust managers. The evolvement of these "silos" has meant that "front-line" staff are not always explicitly involved with clinical governance activities.

A study carried out to explore consultant attitude to clinical governance found that the:

> "*cultural context, level of technical support available, ability to communicate clear goals and strategies and the presence of structures to support delivery, all contribute to shaping specialists' attitudes to clinical governance and in turn influence levels of engagement…*" (Hogan, Barnett et al. 2007, p 622)

The elements cited by clinicians as important for their engagement in clinical governance are often not elements that are under their control but are overseen by the managers. This leads to tension between medical staff and managers (Edwards and Marshall 2003). Studies eliciting the views of staff regarding the main thrust of the modernisation agenda in the NHS namely – the systematisation of work, clinical autonomy, financial realism and accountability, have identified wide differences in beliefs between staff groups (Degeling, Maxell et al. 2003). This study showed that NHS managers, medical managers, medical clinicians, nurse managers and nurse clinicians have "*profession based conceptions of clinical work*" (et al, page 326). The apparent conflict between managers and clinicians is consistent throughout England, Wales, Australia and New Zealand. (Degeling, Maxell et al. 2003)

The managers view is largely paralleled with the policy reform over the last 25 years. The enactment of the health reforms by managers aims to get clinicians to systematise care. Whilst the research shows that nurses hold systematised conceptions of clinical work, medical clinicians generally do

not (Degeling, Maxell et al. 2003). This has been a problem, as there has been proliferation of standards, guidelines, clinical care pathways and care bundles to which all clinicians are expected to adopt and adapt to. To force systematisation it would seem that the government strategies have been to introduce and given more credence to targets, commissions, audit reports and star ratings. Politicians thus using manageralism to govern from afar (Clarke, Gewirtz et al. 2000, p10).

Clinical Care Pathways, whilst usually welcomed by nursing staff are less enthusiastically taken up by medical staff, due to perceived threat to their autonomy (Dans 1994). As a result, they have not been routinely incorporated into the NHS or public health service in NZ.

Research regarding how to get clinicians to systematise care is quite extensive. A systematic review undertaken in 2006 concluded that

> "*feedback can be effective in improving professional practice … absolute effects of audit and feedback are likely to be larger when baseline adherence to recommended practice is low and intensity of audit and feedback is high"* (Jamtvedt, Young et al 2006 p436).

An article by Dopson et al (2002) reviewed 7 studies to examine diffusion of innovation with regard to clinical evidence uptake. The study shows that *"there is a weak relationship between the strength of the evidence base and clinical behaviour change"* (Dopson, Fitzgerald et al. 2002, p44). Two different opinion leaders were found to be relevant (expert and peer). The expert opinion leader was "*seen as the higher authority, able to explain the evidence and respond to academic debate"* (ibid, p44). The peer opinion leader have applied the innovation in their own practice and give confidence and support. The first was thought to be useful early in the process and the second during the later phases of implementation (ibid, p44). A cruicial factor was reported to be the hostile opinion leaders who undermine or dilute the views of the positive change champions.

Enacting the evidence was reported to be linked triggers and context specific. In other words stronger evidence did not cause the innovation to diffuse faster (ibid p44). Dopson et al referred to push factors (of the creation of knowledge) and pull factors (of patient need or policy priority). Additional key factors which increased the change of evidence being used included:

- *"Condition was life threatening*
- *Can be applied to a large patient population*
- *Additional costs*
- *Shift of work across professional boundaries*
- *Patient compliance*
- *Accords with the practitioners experiential knowledge"* Source: (Dopson, Fitzgerald et al. 2002, p44).

Rogers offers four elements in the diffusion of innovation which are relevant at this point. He proposes that diffusion is dependent upon the type of innovation, how this is communicated through certain channels over time and among members of a social system (Rogers 1995, p11). The four dependencies therefore are nature of the innovation (advantage, compatibility) communication channels (peer group, colleagues, mentors), time and social system (patterned social structure) (ibid p11).

A review of the NHS institute programmes (booked admissions project and the cancer collaboratives) found that contributing factors to scepticism and resistance by medical staff was misunderstanding of the aims, methods and benefits (Gollop, Whitby et al 2004, p112). Reducing uncertainty and "*discovering that changes could actually be quite small eliminated some resistance…" (ibid p112).* Finding the right overt or covert "hook" were found to be important for engagement.

There was also evidence that single events could have a significant affect in engaging sceptics – process mapping (detailing how a "typical" patient moves through the system, revealing delays and duplication). This was seen as a trigger which highlighted their limited knowledge of the complete patient experience.

Marriott proposed a case for dissemination strategies as an essential component of quality improvement (Marriott, Palmer et al (2000). They suggest that communicating information to all those that might need it in a large and complex organisation is difficult and that it must be tailored to meet the needs. They suggest that three characteristics are important in tailoring the message including source (credibility; proximity), the content (clarity and brevity; consistency with existing beliefs and attitudes) and the vehicle or channel (appropriateness to target audience; opportunities for systematic instruction).

The move to improving practice through monitoring and dissemination of performance data is commonplace throughout the UK NHS and the New Zealand Health system. Bradley et al propose that there are common strategies for successful data feedback to support performance improvement (Bradley et al. 2004, p 26). These included developing credibility of the data, timeliness of the feedback, benchmarking others, feedback within the same professional group and consistency in the feedback.

A systematic review reported in 2006 and then updated in 2012 identified that:

> *"Audit and feedback generally leads to small but potentially important improvements in professional practice. The effectiveness of audit and feedback seems to depend on baseline performance and how the feedback is provided".* (Ivers, Jamtvedt et al. 2012, p434)

Service User Involvement

Core principle number three in the NHS plan (Department of Health 2000) stated that:

> *"The NHS will shape its services around the needs and preferences of individual patients, their families and their carers. … patients and citizens will have a greater say in the NHS, and the provision of services will be centred on patients" needs".* (Department of Health 2000 p4)

Subsequent to this, numerous prescriptive texts refer to the importance of patient and carer involvement in quality improvement programmes and a different methodology to engage communities including *a Guide to good practice* (Cumming 2005) published in Wales and the *Improvement leaders guides* (NHS Institute for Innovation and Improvement 2005).

A further department of health documents strengthened the position of patients and family in decision making in the NHS (Department of Health 2010). The new NHS constitution (2014) reinforces the involvement of patients, carers and community in development of the NHS:

> *"You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services."* (Department of Health 2014, p9)

The case for involvement of consumers in New Zealand is found in law. Both in the Treaty of Waitangi and a Bill passed in parliament in 1990. The Treaty of Waitangi defined political participation as a right of the Treaty partners, Māori as tangata whenua, and the Crown (Durie, 1998). In July 2002 the NZ government introduced primary care reforms which were aimed at:

> *"improving health and reducing disparities by reducing co-payments, moving from fee-for-service to capitation, promoting population health management and developing a not for profit infrastructure with community involvement to deliver primary care." (*Hefford and Crampton et al 2005)

This meant that communities in many areas (particularly in the North island) not only advise but run their own primary care systems – thus they are governed by consumers. There are over 100 Māori provider primary care trusts in New Zealand.

The Health and Disability Commissioner (HDC) Act was enacted in October 1994. It was passed in order to implement the recommendations of Judge Cartwright (regarding the Cervical Cancer Inquiry Report – 1988). Cartwright stated that there was a strong need for the establishment of a commissioner as an independent complaints resolution and education body and a Code of patients' rights (Health and Disability Commissioner 2014). The role of the commissioner is of independent reviewer of breaches to the code of conduct and is appointed by the Governor General (Patterson 2008, p 103). This is different from other countries where appointment is through the Minister of Health (or equivalent).

This role and office is viewed by some as important in the ability to learn from mistakes and encourage a position of inquiry. Merry and Seddon suggest that:

> *"The Commissioner has unusually wide ranging powers that allows him to enquire as to the contribution to an adverse event by anyone responsible for the provision of healthcare, including administrators. This has facilitated a world-leading focus on addressing aspects of the system, which contribute to patient harm rather than only seeking to identify individual scapegoats when things go wrong." (*Merry and Seddon 2006, p2)

Whilst there has been no equivalent development of central policy in involvement of consumers in New Zealand (in the way that that has occurred in the UK), the Health and Disability Code (which has been in constant use since 1996) would appear to be the pillar in which advocacy, devolvement of decision making, and governance stem from. The Commissioner of 2008 saw his role as a catalyst for "learning" not "lynching" (Patterson 2008, p 104).

The idea of developing communities of practice (with regard to consumer involvement) is not new, first discussed by Lave and Wenger in the early 1990s. Wenger et al suggest that a community of practice may be described as:

> *"Groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interaction on an on-going basis"* (Wenger, McDermott et al. 2002, p7)

Wenger describes key outcomes for a community of practice as being mutual engagement (including common actions and ideas), a joint enterprise (where ideas and communication are constantly renegotiated) and achieving a shared repertoire (where words, routines and ways of doing things are established) (Wenger 1998, p73).

In 2002 a systematic review was published that examined the effects of involving patients in the planning and development of health care. This review deemed that

> *"… the evidence base for the effects on use of services, quality of care, satisfaction, or health of patients does not exist"* (Crawford, Rutter et al. 2002, p1263)

Despite this, programmes to involve patients and carers in improvement programmes and governance within hospitals have continued with sometimes-mixed results. A recent study which looked at user involvement in stroke services over 3 years concluded that even though there was an aim to involve users, the programme staff

> ".. programme *largely determined how user involvement was put into practice. Little evidence was found of user involvement directly contributing to improved quality of services except in a few limited areas*" (Fudge, Wolfe et al. 2008: p319)

In an article called *"experience-based design: from redesigning the system around the patient to co-designing services with the patient"* (Bate and Robert 2006), the authors propose that healthcare needs to move on from asking the patient what was good and what was not, to find out details of what the experience was or should be like. This moves the patient from being a passive recipient of a service to being integral to the improvement and innovation process. The authors suggest that there is a continuum of patient influence.

The suggested components of good design suggested by the authors (Bate and Robert 2006) are actually a re-presentation of the components of quality (freedom from deficiency and the right features). They propose that experience-based design (EBD) is "*an extension of the current trajectory of improvement methods that will not entail starting anything from scratch.*" (Bate and Robert 2006, p307).

Buchanan et al (2007) in their review of the NHS Modernisation Agency (which existed between 2001 to 2005) identified two outcomes that remained difficult to address. They were sustainability (and ongoing improvement) and spread (to other parts in the organisation). They described sustainability as

> *"The process through which new working methods, performance enhancements and continuous improvements are maintained for a period appropriate to a given context. The opposite of sustainability, where change is not maintained and benefits are lost, is decay."* (Buchanan, Fitzgerald et al. 2007, pxxii)

Spread was described as -

> *"The process through which new working methods developed in one setting are adopted perhaps with appropriate modifications, in other organisation contexts. The opposite of spread, where changes at one site are not adapted and adopted by others, is containment."* (Buchanan, Fitzgerald et al. 2007, pxxiii)

More recently the Darzi review (Department of Health 2008) articulated that changes should be locally led, patient-centred and clinically driven. That high quality care for patients and the public – is one that works in partnership to prevent ill health, providing care that is personal, effective and safe. That there should be freedom to focus on quality and to put frontline staff in control. That all staff should be supported to deliver high quality care and specifically that managers must be involved in the core business of clinical practice, and helping, supporting and challenging clinicians to deliver the best possible care for patients (Darzi 2008, p750).

A core premise driving this research was to gain an understanding of effective manager-led strategies, which behaviours of managers are important to outcome and on-going relationships and to share this understanding in a useable form. Theories around leadership form the next section of the literature review. (To review what I Papadopoulos has said about leadership and cultural competency – book ordered?. Covered later under research practice.)?

Theory and Practice of Leadership

Change methodology in the NHS has been heavily influenced by the positivist approach through the use of Continuous Quality Improvement (Reid 2002). Positivism is linked to quantitative empirical science, it is confidence that scientific evidence is both accurate and certain, and is objective and free from opinions, beliefs, feelings and assumptions (Crotty 2003, p27). There has been an emphasis upon managers and leaders orchestrating changes within the system by planning through logic and problem solving to achieve desired objectives. The origins of this approach lies with Fredrick Winslow Taylor (1911) who developed a new scientific management approach which included standardising work to the extent of de-skilling workers. The responsibility for the work was with the managers (which prior to this time the knowledge/expertise was held by the workers). The focus was on studying the components of the task and maximising efficiency through partnering the right worker for a specifically designed task. Additional payments were made if workers exceeded certain targets. The directing of what work was done and how the work was done moved under Taylor from the workers to the managers. Taylor perceived the incentive for workers would be to work faster and make more money through increased efficiency in producing more. However, Taylors 'money motivator' approach was adapted by managers, notably Ford (1922, page 43), so that work efficiency was increased though scientific management and the money motivator was reduced or taken away. Mary Parker Follett, who made such a big contribution to participatory organisation studies in the 1930s (Follett et al 2003) proposed that the conflict between managers and workers did not need to rely on only two options to resolve the conflict (ie domination and compromise) but could include what she called integration.

> *"when two desires are integrated, that means that a solution has been found in which both desires have found a place, that neither side has had to sacrifice anything".* (Follett, Metcalf et al. 2003, p3)

Follett proposed that democratic group organisation was better than

hierarchical bureaucratic organisation for resolving conflict. Some would say because Follett was a woman, she never gained the recognition of male researchers in the field. Whilst she emphasised the contribution of managers as being important it was in a different way to how Taylor viewed their contribution. Taylor viewed managers as directing the work, Mary Follett-Parker viewed managers as contributing to the culture of the organisation with an interdependency in relationships which highlighted the social aspects of manager and worker interaction.

Joiner (Joiner, Reynard et al. 1994) proposes a simple model using a triangle which integrates the desire for quality, the scientific approach and the people elements. This aims to explain how important the balance between the elements is to successful management (Joiner, Reynard et al. 1994, p12).

Quality improvement project managers in the NHS have traditionally been employed to focus upon the technical aspects of problem solving the process of change with members of a team (usually representatives),(Improvement). Operational mangers have traditionally spent their time focussing on issues that arise within the service (including patient complaints, machine breakdowns, plant renewal, efficiency) and the team (making rosters, reviewing sickness, recruiting) (The NHS Confederation 2007). The quality improvement role and the operational role were developed separately over the 1990s, with the Modernisation Agency, and in 2000s with the introduction of the NHS Institute for Innovation and Improvement. In 2013 there is the NHS Improving Quality team. A quality improvement person (usually from outside the group) worked with selected staff to make service improvement using whatever tools and techniques were supported within different programmes at the time. This role did not provide lasting oversight or accountability for the operational management after the project was complete. The operational manager was expected to engage with the service improvement work and continue to achieve results once the project was complete. This appeared to set up an area of conflict between the quality improvement manager and

the operational manager. My personal experience in my role as quality improvement manager was that the operational managers did not fully support the introduction of this role or the work that was undertaken. Wilson proposed that the role of middle management is fundamental to making service improvements and that the role they have played has been misunderstood and is critical to improving services (Wilson 2011). My own experience in working as a quality improvement manager was that I was not always viewed positively and I was more of an interruption to the operational manager's work and an interference to what front-line staff were employed to do. In many ways the quality improvement facilitator or manager was involved in working on the bottom up strategies and the operational manager provided the top down direction.

Storey (2000) provides a distinction between what managers do and what leaders do. Table 1 list the differences

Table 1: A summary dichotomy: managers versus leaders

Managers	*Leaders*
Are transactional	*Are transformative*
Seek to operate and maintain current systems	*Seek to challenge and change systems*
Accept given objectives and meanings	*Create new visions and new meanings*
Control and monitor	*Empower*
Trade on exchange relationships	*Seek to inspire and transcend*
Have a short-term focus	*Have a long-term focus*
Focus on detail and procedure	*Focus on the strategic big picture*

Source: Leadership in organizations – current issues and trends (Storey, 2000, p7)

This model places leaders in a higher position than managers both in how they theoretically think about the world and in terms of what they are espoused to do. Some argue that leadership is a part of management (Mintzberg 1989, p16).

Stacey (2012) proposes that it is not helpful to define managers and leaders as different.

> *"In reality, leaders do find that they have to attend to often*

> *mundane administrative tasks and managers do have to lead those who report to them if they are to get anything done."* (Stacey 2012, p4)

Stacey concludes that leaders and managers are the same in that they are "*aspects of a legitimate power role in an organisation and they cannot be separated*" (Stacey 2012, p4). For the purposes of this study I have chosen not to differentiate between the titles of managers and leaders as what we are wanting to explore is what the people in positions of authority (and power) do, that seems to be effective (yet to be defined), or not – not what type of role they were playing at the time. This study defines operational managers from leaders to provide a context for the discussion. When the term manager is used, it (usually) refers to operational managers (with a specific set of roles) and leaders (clinical or non-clinical leaders – the majority providing advisory roles). Executive level ie CEO are usually described as leaders of organisations.

Sustainability and spread of new working practices has been difficult to achieve in the NHS (Bevan 2007, pxvii). Operational managers have struggled to both replicate and maintain improvements once a project management phase has been completed. It is often operational managers, particularly middle managers, whose responsibility it is to improve services as well as manage the day-to-day work. This raises the question as to what could be done to prepare an environment for quality improvement work that would increase effectiveness at the front line.

Pettigrew (1992, p274) identified eight attributes of the organisation receptive to change and innovation:

> *"clear strategy, skilled leadership, external pressures, supportive culture, good managerial-clinical relations, co-operative inter-organisational networks, clear goals and priorities, fit between change agenda and organisation"* (Pettigrew 1992, p274)

A key responsibility for managers and leaders is to develop strategies and behaviours that maximise the presence of these attributes because they

> "*… increase the probably of innovation being adopted and successfully implemented. The continuing configuration of those attributes may also contribute to the sustainability of change".* (Buchanan, Fitzgerald et al. 2007p55)

This panacea of readiness would appear to be difficult to develop if you were unlucky enough to work in an institution that had achieved very few determinants of success. The lack of certainty of success in organisational change may be due to the lack of cause and effect seen in organisations, for example if I do A then I will get B. If I do A and I don't get B – why not? Was it because A was not the important ingredient or was it because there were factors C through E that caused A not to work in the way expected? This would fit with the conclusion that a view of an organisation as complex and organic may be more appropriate. The underlying culture, social networks and degree of trust perceived by individuals in an organisation would appear to be significant factors in providing the context for change to occur. Thus the act of undertaking change and the preparedness for change is not a prescription. It demands a mind-set for all stakeholders that can be applied and adapted depending upon the situation – it is not a mechanistic approach to all situations. Belbin (1996) describes change and organisation through the roles that team members' play. He proposes that the preferences of the team members in how they communicate and what their specialist skills are determines the success or failure of the team endeavours (Belbin 1996, px).

Following the changes in the 1990s, the term partnership (between managers and staff) has become an important feature of the NHS rhetoric from industrial relationships (Department of Health 2012) to improving working relationships (Shared Services Partnership 2013), (Samual 2011).

Partnership is inherent in the NHS constitution commitment to employees (Department of Health 2009, p10).

> "*The NHS commits:*
>
> - *to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities (pledge);*
> - *to provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed (pledge);*
> - *to provide support and opportunities for staff to maintain their health, well-being and safety (pledge); and*
> - *to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families (pledge)."* (Department of Health 2009, p10)

The constitution therefore requires managers and leaders to work collaboratively with staff and patients to achieve high quality care.

Research into leadership has expanded significantly over the last 20 years as private and public institutions strive for the strategies that will make their business more profitable, more efficient and held in high esteem. For the purposes of examining relevant literature surrounding middle management, it was felt important to review the history of approaches to leadership evident over the last 100 years particularly as old approaches have been revisited albeit with modern adaptations.

Different types of leadership

The trait or "great man" leadership approach was prevalent during the Victorian era until the 1930s. The heroic leader "*...achieves by his own*

Herculean efforts – knowing all and doing all…" (Sinclair 1998, p52). Sinclair also refers to the past images of Australian leadership that are very similar to the European history of New Zealand. The tough stoicism and self–sufficiency of the settler and bushman is part of the iconic images of national identity – even today. It was thought that what differentiated leaders from non-leaders was their enduring personal characteristics or "trait" (Alimo-Metcalf and Alban-Metcalfe 2002, p203. Man (1959) and Stodgill (1948) in (Alimo-Metcalf and Alban-Metcalfe 2002, p302), showed however that there were inconsistent findings in relation to the personality characteristics for leaders from non-leaders and more importantly more effective leaders from less effective.

The second phase of leadership is described as the behavioural approach (1950s). As opposed to distinguishing traits, researchers tried to determine what effective leaders do, how they delegate, communicate, motivate. This focussed on two aspects of leadership behaviour – function and style. Blake and Mouton's "managerial grid" (Bolman and Deal 2003, p341) exemplifies this in that it looks at behaviours on two axis of a 9 by 9 grid. One axis is "concern for task", the other is "concern for people". Although the search for behaviours that could be classified as contributing to good leadership has continued, the approach proposed work in the 1950's was superseded by contingency or situational leadership. Situational leadership arose because the behaviour list approach was seen as giving

> *"little attention to constituents other than direct subordinates and assumes that a leader who integrates concern for task with concern for people is effective in almost any situation"* (Robson 2002, p341)

This third phase recognised that leadership varies with the situation. Leadership for low-level supervisors is related but different to the chief executive officer. It also recognises cross cultural aspects and some of the attributes of followers. The premise is based on leadership being relevant to the task and that leaders need to adapt their style to the maturity of the group. Hersey developed the situational leadership model which described

leadership through participation, leadership through delegation, leadership through selling, leadership through telling - Hersey (1984) in (Robson 2002). Tailoring the behaviour of the leaders to the situation was a key component.

The first three approaches to leadership are now described as "management" or "transactional leadership".

> *"This is because they were based on principles of creating order and maintaining the "status quo" in organisations by those in leadership positions influencing the behaviour of their "subordinates" through the use of reinforcement – offering a quid pro quo for behaving in ways that enable the organisation to achieve what the leader saw as the objectives."* (Alimo-Metcalf and Alban-Metcalfe 2008, p6)

Fox developed a typology which looks at employment relationships in three ways. The first is that there is a social membership that satisfies common interests – thus it is described as unitary. The second is that it is a contractual relationship that satisfies interest of separate but interdependent groups – thus described as pluralist. The third is described as an illegitimate relationship characterised by domination of one party over another – described as radicalism (Fox 1974). The frames of reference held by different participants and particularly leaders will determine the style and type of leadership appropriate.

Whilst elements of these approaches are discussed, debated and adapted today, they emerged at a time of what has been described as stability. Following the oil crisis, a recession in the West and increasing competition from different economies, thoughts about leadership changed and new leadership paradigms emerged. The new leadership mantra was the transforming leader. One who could articulate a vision, communicate this with passion and charisma and thereby create meaning for the organisation to transform its culture. The heroic models were revisited in the 1980s and

90s. This work was largely based on American white males (Alimo-Metcalf and Alban- Metcalfe 2008):

> *"Distant charismatic leaders were characterised as having, for example, rhetorical skills, an ideological orientation and sense of mission, as being persistent and consistent, and as not conforming to social pressures…" (Alimo-Metcalf and Alban- Metcalfe 2008)*

With the corporate scandals surrounding the collapse of Enron in 2001 and other companies which followed there has been increasing concern with the potential dangers of charismatic and inspirational leadership. Thus the fall of the fourth model has given way to what is described as the post-heroic leadership model of the nearby leader and the concept of engaging leadership.

The fifth model proposed differs from the heroic models because it is based on serving and enabling others to display leadership themselves. Because the work has been centred upon public services, in the United Kingdom and with a largely female population - including research carried out in the NHS it is vastly different to the US heroic models.

> *"It is not about being an extraordinary person, but rather a somewhat ordinary, vulnerable and humble, or at least a very open, accessible and transparent individual." (Alimo-Metcalf and Alban- Metcalfe 2008)*

Engaging leadership proposes that the attributes of the leader were quite different to what has gone before. It is a move away from the leader being separate from followers and recognizes the interdependency of the leader-follower relationship.

The fifth approach proposed is a model of engaging leadership. The Alban-Metcalfe and Alimo-metcalfe model is represented by four clusters of dimensions or scales: engaging individuals, engaging the organisation (or

team), moving forward together and personal qualities and core values. The model is based on a servant as leader model (Greenleaf 1973) and it emphasises the connectedness of the team. A further component proposed is that the model is not working on a static entity but is constantly changing. In summary the *"business values the employee and the employee values the business"* (MacLeod and Clarke 2009, p7).

This fifth approach proposes that there is a relationship between clusters of leadership behaviours that are described as competencies i.e. the "what of leadership" and the engaging or "nearby" transformational leadership – the "how". Alban-Metcalfe and Alamo-Metcalfe propose that a balance is required for effective leadership to be achieved (Alban-Metcalfe and Alimo-Metcalf 2013) page 58. The types of behaviour associated with competency (the what) includes respecting diversity, developing individual potential, communication, developing the team, planning, stakeholder awareness, future orientation, commitment to excellence, personal qualities, reflective skills. The features of engaging leadership (the how) in contrast include – showing genuine concern, enabling, supporting a developmental culture, focusing team effort, building shared vision, facilitating change sensitively, acting with integrity. Through the study they conclude that there is evidence that the way a leader acts has a significant effect on the attitudes to work and the wellbeing of his/her direct reports. They pose that there are a number of factors which affect this including gender.

The five approaches described above are attempting to define alternative typologies for assessing what leadership may be about. Grint (2005, p19) poses four non-hierarchical foundations for viewing leadership.

> *"Is it who leaders are that makes them leaders?*
> *Is it what leaders achieve that makes them leaders?*
> *Is it where leaders operate that makes them leaders?*
> *Or is it how leaders get things done that makes them leaders?"* (Grint 2005, p19)

In order to explore the who, what, where and how in more detail further review was undertaken following the analysis of the second case study to look at the idea of what leaders and followers actually do in more depth. This included offering alternatives to the dominant theories of leadership tools and techniques, exploring existential perspectives, developmental processes, leadership as based on power, practical wisdom (*phronesis*), and spiritual leadership.

Managerialism (being similar to professionalism) relates to how social and organisational processes are linked to claims about who possesses the right to direct, coordinate or run organisations (Clarke, Gewirtz et al. 2000, p8). New managerialism is said to have emerged in the 1980s because public sector organisations were seen as lacking '*proper management*' (Pollitt 1993). This was seen as a result of the oil and subsequent world economic crisis. Managerialism is described as replacing the values and practices of public administrations with a different focus more aligned to private industry:

> *"a new language of welfare delivery which emphasises efficiency and value for money, competition and markets, consumerism and customer care"* (Butcher 1995, p161).

There was also a belief that the objectives of social services '*can be promoted at lower cost when the appropriate management techniques are applied' (Cutler and Wain 1998, pixv).*

Clarke et al (2000) pose that managing is often presented as a -

> *"Neutral, technical set of activities, performed by neutral technical experts, in pursuit of goals defined by others - and that invocation of neutrality is at the core of 'managerialism' as an ideology"* (Clarke et al 2000, p8)

For myself as a clinician and then a manager in 1997 (albeit a project manager), I was educated and coached in a direction which held with these (managerialist) beliefs. Clarke proposes that managers are political although often presented (or present themselves) as 'neutral' technical experts. He proposes that the techniques themselves are political and therefore managers cannot be neutral (2000, p8). I have observed that the idea of neutrality (as seen by a manager) is an area of friction between professionals (medical or otherwise) – who do not view managers as neutral. Professionals are invited or expected to hold personal beliefs about their convictions however managers are expected to keep their personal beliefs to themselves and support the corporate line (defined by government or higher echelons). This idea of manager neutrality may be perceived (by managers) to give a manager the high moral ground however this view does not appear to be held by clinicians or front-line staff. Professionals and clinicians are sometimes perceived by managers and politicians to have vested interests (House 2009, p23). One role of management (and commissioners) in this scenario is to work with clinicians as a neutral party to ensure transparency and fairness is achieved (NHS England, 2014). The second purpose of managerialism is that it has provided politicians with a means of control 'at a distance' (Clarke, Gewirtz et al. 2000 p 10) which may not have been possible if working solely through professional groups or clinicians.

Cunliffe proposes that there are a number of assumptions about managerialism including –

> *"managers are skilled experts who have the right to act as agents for owners and shareholders, are characterised by rationality and neutrality, pursue efficiency, the right to make decisions and give instructions to employees without seeking consent, act in line with the common good, use scientific management techniques*" (Cunliffe 2009, p19)

Thus over the 1980s and 90's there was a change in power base and an effort to '*displace or subordinate the claims of professionalism'* (Clarke, Gewirtz et al. 2000, p9). It is posed that (as a result of emerging managerialism) it is no longer true that professionals are well placed to 'know best' but that managers are in a better place to '*do the right thing*' (Newman 1998, p333). This clearly creates an environment in which the contest of control between clinicians and managers is present.

Complexity and alternative theories of leadership and followership

Stacey, who is a proponent of a theory called complex responsive processes, suggests that the taken-for granted notions of the dominant theories of planning, control, tools and techniques is a problem because they cannot achieve what they espouse to achieve. He proposes that:

> *"The tools and techniques of instrumental rationality are based on the possibility of prediction. Since the world is characterised by important degrees of unpredictability, the tools and techniques cannot fulfil their proclaimed purpose of enabling managers to choose favourable outcomes."* (Stacey 2012, p57)

Stacey goes further to suggest that the dominant training methods have limitations as they do not provide for the expert level of performance which has been shown to work without rules (and tools and techniques).

From an existential perspective leaders always have a choice. This requires that a leader is aware that whilst they may wish to be judged on what they think and feel (beliefs), they will inevitably be judged on their actions. Thus from an existentialist point of view – *"how we choose to act defines who we are"* (Medina 2011, p77). An extension of this perhaps is that how others perceive leaders to act – defines them.

Sonnenfeld proposes that the most memorable of leaders

> "*possessed powerful skills at candid self-assessment of strengths and*

> *weaknesses, keen situational analysis and the capacity to reframe past setbacks into future success"* (in Sonnenfeld 2001, p191 in Medina 2011)

Strang and Luhnert (2009) propose that the transition from transactional to transformational leader is not just a developmental process in history but a personal developmental hierarchy that individuals move through - It is proposed that the

> *"constructive-developmental theory conceptualizes the process of development as a life-long journey, contingent upon time, experience, change, and perspective. All individuals develop from one stage to the next without skipping stages, and it is not possible to regress from a higher level to a lower level because once a person is able to take perspective on his/her lens (subject), this lens can no longer be the framework for viewing the world.* (Strang and Huhnert 2009, p422)

This approach recognizes the impact that experience plays in the development of leadership and provides an interplay between nature versus nurture which is important for the concept of developing leadership capacity. The rate and triggers for development as well the highest level achieved is proposed to vary among individuals. As they move through the levels their self-definition changes from externally-defined to internally defined – thus changing from self to others, and the world moves from simple to complex (Strang and Huhnert 2009, p422).

Stacey proposes a similar developmental process in which a novice leader's actions are defined by rules whereas an expert or proficient practitioner has an "*intuitive ability to respond without rules*". They have "*experience based intuition responding to situational cues*" and are often "*unaware of the skills they are acting upon*" (Stacey 2012, p55).

The problems associated with making changes that are frequently imposed are varied and many. Firstly the care processes involved in hospital wards and departments are often easy to summarise but are just that – a summary. The patient comes in, they are assessed, they are given immediate treatment then are assessed to get a diagnosis, a plan is made and then they move on to another area. Making a change in one part of the process can lead to unintended consequences that may not be known at the outset. 'Wicked problem' is a term that has been coined to describe problems associated with complex social systems or planning. Grint proposes three types of problems, critical, tame and wicked (Grint 2008, pg. 15). Critical problems require an authoritarian approach because they occur in a crisis. A tame problem may be complicated but is resolvable as there is only a limited degree of uncertainty. Grint proposes

> *"that a (scientific) manager's role, … is to provide the appropriate processes - the veritable standard operating procedure (SOP) - to solve the problem. Examples would include: timetabling the railways, building a nuclear plant, … planning heart surgery… "*
> (Grint 2008 pg12).

A wicked problem is wicked, not because it is complicated but because it "cannot be removed from its environment, solved and returned without affecting the environment" (Grint 2008, pg12). An example of this might be where doing heart surgery is a tame problem (i.e. we know how to do it, is has been done before). At some point we may need to make a political decision about who gets heart surgery and on what criteria. This becomes a wicked problem because it becomes a contested arena.

Grint suggests that

> "*the category of problems is subjective not objective - what kind of a problem you have depends on where you are sitting and what you already know (ibid pg 12)*

Flyvbjerg uses Aristotle"s concept of *phronesis* in order to understand the nature of expertise and solving problems. He uses Aristotle's three modes of knowing – episteme, techne and *phronesis*. Episteme refers to universal laws and is context free. Techne is how to do something which has precise rules, is analytical and pragmatic also context free (Flyvbjerg 2001, p3). *Phronesis* is described as practical wisdom or practical judgment – it is pragmatic, context dependent and oriented towards action. Flyvbjerg proposes that *phronesis* is at the core of political, economic and cultural development in any society because it encompasses values, interests and power (ibid p3). Flyvbjerg states that *phronesis* is the most important intellectual value because it balances instrumental rationality with value-rationality. Stacy proposes that it is this third mode of knowing that appears most allusive

> "*dominant discourse on organizations and their management reflects episteme, and its tools represent the techne way of knowing. It takes little account of phronesis"*. (Stacy 2012, p56)

Dreyfus and Dreyfus et al. (1986, p21) refer to a progression from novice to expert based on acquiring skills of analysis initially limited to situations and expanding to non-context specificity. The expert or proficient would appear to be akin to the notion of *phronesis*, or practical wisdom – it has also been referred to as foresight. "*they can envisage what is good for themselves and for people in general*" (Aristotle cited in Adair 1989, p74). Linked with *phronesis* are notions such as "good", "right" thus alluding to ethical dimensions. Whilst "*common-sense, experience and moral goodness are the ingredients of such practical wisdom*" (Adair 1989, p75), it may not be difficult to see why people aspire to *phronesis*. It is difficult to understand the barriers to being viewed as having achieved it. One reason for this may be the view that a person is a temperate person or what Aristotle referred to as a continent person (Hinman 2006, p251). The temperate person does what is right because they want to, the continent person also does what is right but does not really want to do so. Rules are said to govern and control the non-temperate person (Hinamn, 2006 p252).

Thus the question is raised regarding the true motives of the continent person even if they do the right action.

Virtue ethics is helpful to provide a broader platform and personal context in which decisions may be made. This Aristotelean concept offers a potential foundation on which *phronesis* could be achieved. Russell provides a summary of Aristotle's view of virtue ethics (Aristotle and Brown, 2009):

> *"for virtue ethics, the focus is not so much on what to do in morally difficult cases as on how to approach all of one's choices with such personal qualities as kindness, courage, wisdom and integrity"* (Russell 2013, p2)

Virtue ethics is not only about making the right decision but about how the decision maker is seen to be living their life. For example –

> "*people who may feel confident in the rightness of their actions can sometimes be brought up short when asked whether they are also being generous, or considerate, or honest." (*Russell 2013, p2)

In contrast to good governance or leadership outlined above, there is a Machiavelli style of leadership. Adair proposes that Machiavelli's theme was "*power: how to attain it and how to hold it. By power he meant the subjection of people to the will of the ruler*." (Adair 1989, p153). This was based on a belief that "i*t is far better to be feared than loved*" and

> "*The bond of love is one which men, wretched creatures that they are, break when it is to their advantage to do so; but fear is strengthened by a dread of punishment which is always effective*" (Machiavelli cited in Adair 1989,p153)

Michels "iron law of oligarchy" written in 1915 proposes that all

organizations will inevitably succumb to the rule of an elite few (Michels 1968, p393). Thus holding onto power through bureaucratic means (and theoretically justified means) is likened to holding onto power through aristocracy etc. This theory proposes that all organisations are led by successively dominant minorities, for the purpose of the NHS and public health systems this could be managers, or medics or member of the community (as in membership of the District Health Boards in New Zealand). Michels poses that it is difficult to see the difference because they are all dominant minorities.

With the acknowledgement that managers and leaders are minorities in positions of power, the issue of bad governance is important to examine especially in the context of what is intended and how behaviours are perceived as intended. In other words what may have been intended or aspired to as good, were not perceived in that way by the recipient. Acknowledging that there is no one truth requires exploration into the possibility of unintended consequences of governance or leadership.

The "*allegory and effects of good and bad government*" series of paintings in Sienna Italy, completed in around 1339 clearly intended to show the cause and effect situations of corrupt, tyrannical governing in comparison to those of virtuous governing (Lorenzetti, 1339). The painting was commissioned by a civic group (council) and is perhaps an easily recognizable translation of a modern management tool where town leaders provided a vision, values and mission statement for the community in which they served. It had the added advantage of being in the meeting rooms and it could be assumed acted as a constant reminder for the council to remain just and good in the then republic of Siena, Italy. The *effects of good and bad government* are described in detail for the town and country on opposite sides of the building. The painting shows the connections between different groups of the community. The characters (and community) are portrayed by *faith, hope, charity, peace, fortitude, prudence, magnamity, temperance and justice*. Below the tyrant, justice lays bound. These

figures are flanked by *cruelty, deceit, fraud, fury, division, war, avarice, pride and vainglory*. In viewing this ancient civic painting and reflecting upon our modern society it is clear that many of the old problems remain. In the case of medieval Siena, the families of the town were so anxious that the leaders (aristocracy) did not become corrupted; the nine leaders (of the council) were rotated every two months (Lorenzetti, 1339).

Leaders of large corporations have been found wanting - some with deliberate forays into bad governance and some with unwitting and unintended forays into bad governance as in the UK NHS Trusts at Bristol (Smith 2001), Staffordshire (Smith and Bingham 2009). In the pressure to make changes and satisfy masters, do managers and leaders unwittingly and unintentionally provide bad governance and if so – how and why does this happen and can this be justified?

Stacey suggests that leaders and managers employ techniques of disciplinary power (Stacey 2012, p6). Whilst these may be legitimate (and not negative or unethical), he proposes that it is important to study local interactions, and the ideologies and abstractions in play to understand how change really occurs.

To understand power we accept that there is interdependence between human beings. I cannot do whatever I like because I need others and they may not like what I do. As they need me, neither can they do whatever they like. Power (or influence) comes from when the need is not equal. Stacey proposed that the "*pattern of power relations will always be skewed more to one than to another*" (Stacey 2012 p28). This is always expressed as inclusions and exclusions - for example the groups that we belong to and the ideologies that we hold. Stacey proposes that ideology may be thought of as a combination of norms and values. Norms are obligatory or constraining so they restrain and determine what ought and what ought not to be done. Norms evolve in a society and they provide a basis for evaluating and choosing between desires and actions. Adherence to norms

are sustained by the social process of shame (Stacey 2012, p31). Norms whilst different from values are considered to be inseparable from values. Values are ideals, are attractive and compelling, voluntary and motivate. Stacey proposes that values are connected to ethics and provide the criteria for judging what is the "good" action.

The way in which managers/ leaders and front-line staff exercise power in their relationship is the core component of the change process. Whilst it may be important to determine good, just and effective behaviours it is equally important to examine bad, unjust and ineffective behaviours. Stacey proposes that there are two ways in which managers/leaders can undertake change and exercise power. One is deemed as legitimate and ethical and the other is not. He refers to the first one as being disciplinary power – which has an aim to control people and their actions. He describes disciplinary power as

> *"a specific form of power which operates through the use of simple instruments of hierarchical observation, normalizing judgment and examination"* (Stacey 2012, p66)

Quite simply this refers to having oversight or surveillance (hierarchical observation) of specific performance target areas (normalizing judgment) and examining these activities. The notion of disciplinary power being good is emphasized. If carried out in reflexive ways the opposite is also true.

> *"when the techniques of disciplinary power are simply applied in un-reflexive ways, they create the potential for bullying and domination"* (Stacey 2012, p78)

This suggests a possibility for unintended outcomes due to a number of failings (inexperience, thought that the outcomes justified the means) rather than deliberate action of for example bullying and domination.

Coercive persuasion however sets out to *"break down the personalities of people and reconstruct them in ways that are chosen by the most powerful"* (Stacey 2012, p80). Coercive persuasion is based upon brainwashing and for the purposes of delineating ethically sound behaviour from ethically unsound behaviour – it is easy to see how there is cross over. Examining institutional norms and motivations may also provide insight as to how…

> "*Socially constructed ways of thinking and making sense of the world can be conditioned by hegemonic influences that we often take for granted" (Cullinane and Dundon (2006)*

I have examined and drawn parallels between the process of brainwashing (coercive persuasion) to some dominant change programme techniques, to demonstrate the similarities and expand upon this matter further.

For the purposes of this example, I have used the learner in the Health Service as an employee engaged in a change process. The first step of coercive persuasion is to prevent the learner from leaving the learning experience. Whilst this would normally be thought to be irrelevant in the NHS and New Zealand public health system – it is often cited as quite difficult to leave work funded change programmes and sometimes there is only one hospital or department in which to work – thereby the learner may actually not be able to leave the learning environment. The second part is to provide intense interpersonal and psychological pressure to destabilize their individual sense of self, beliefs and values. This perhaps could be seen as an intensive learning programme which depending upon where the learning is, could provide a significant amount of internal conflict. It may also involve a weekend away, intensive team building etc. The third part is to put people into teams so that mentoring of less experienced can take place. Usually programmes of change involve teamwork of some sort. The fourth part is to reward team members who demonstrate new collective values. Visits from senior executives, presentations to the executive would all fit into this category and finally the fifth stage is to promote the new

values in many different forums. This could include conferences, national seminars. There is very little in this description of coercive persuasion that does not happen within any number of organizations. Stacey (2012, p80) proposes that coercive persuasion can never be legitimate and never be ethical because it does not involve learning and is based on the premise that the most powerful seek to break down the old ways and reconstruct in their chosen ways. Stifling any learning (and not allowing reflexive activity) is a core component of coercive persuasion. It is on this basis that the stated objectives of change programmes diverge from coercive persuasion. In practice i.e. in the real world (i.e. outside the classroom), this remains to be seen as there is some reported evidence of bullying in the NHS related to meeting health targets (McWatt 2013), (Smith 2013). Ofshe (cited in Stacey 2012, p83) argues that coercive persuasion has a very poor record of actually changing the beliefs of individuals.

The impact of target driven approaches was discussed as part of the Francis inquiry and identified a number of cultural themes associated with deficiencies that had been identified including:

- “Bullying;
- Target-driven priorities;
- Disengagement from management;
- Low staff morale;
- Isolation;
- Lack of candour;
- Acceptance of poor behaviours;
- Reliance on external assessments;
- Denial “ (Francis 2013, p1361)

It is interesting to consider how a target driven approach can be eliminated when it would appear that financial and process targets (such as money and timeliness through the emergency department) appear to be replaced with targets related to quality and outcomes. Will we see a difference in

behaviour related to the types of targets or will the behaviour surrounding achieving the targets remain "*punitive and shouty*" (Thorlby et al, 2014 p24)

> *"Trust B, for example, had developed a comprehensive set of nursing metrics at ward level, which were measured and reported in real time. The data were also published for patients and families to read. The same trust also now uses peer review of wards and departments, and has set up a nurse response team to intervene when a ward or department is shown up as underperforming against these metrics".* Thorlby et al, 2014, p19

The report went on to outline how local monitoring of clinical indicators had been instigated. However there was no reference to how strategies to change the culture might assist with this. Words like 'intervene and underperform" demonstrate a 'them and us' thinking about remediation and appear to be quite different to a more supportive approach which might use words such as coaching, mentoring and reflection.

Drath proposes that relational leadership is more appropriate than leader/follower (or them and us). He assumes that:

> *"in trying to make leadership happen while working together, people construct one another and become such things as leaders and followers" (*Drath 2001, pxvi)

He assumes that individuals do not come together with titles of leaders and followers but

> *"who actually come into being as various kinds of individual persons through connection, interrelation, language, joint action and the shared creation of knowledge"* (Drath 2001, pxvi)

This suggests that titles are irrelevant and it is how you conduct yourself that determines how the group get things done.

Komives et al (2013) present five components for relational leadership including – inclusiveness (of people and points of view), empowering (of others who are involved), purposeful (common purpose or goal), ethical (good or moral in nature) and process oriented (how oriented to being and remaining a group) (Komives 2013, loc.1792)

One senior clinician (who was interviewed as part of the 'Francis Report: one year on') explained that *"If management behaviour is punitive, shouty and target driven, that filters down"* (Thorlby et al, 2014 P24). He went on to describe efforts to make messages to staff more positive, less target driven and more focused on the benefit to patients"

A study published in 1960 concluded that the projection of self into superiors and juniors was evident in nursing teams. They reported that each nurse

> *"… tended to split off aspects of herself from her conscious personality and to project them into other nurses. Her irresponsible impulses, which she feared she could not control, were attributed to her juniors. Her painfully severe attitude to these impulses and burdensome sense of responsibility were attributed to her seniors. Consequently, she identified juniors with her irresponsible self and treated them with the severity that self was felt to deserve. Similarly, she identified seniors with her own harsh disciplinary attitude to her irresponsible self and expected harsh discipline"* Menzies Lythe (1960, p448)

Is this what occurs between managers and front-line staff? Is there is a projection of attributes that is reinforced at each verbal encounter unless there is mitigating evidence to suggest otherwise? This would suggest that

there are many conscious and unconscious barriers that require countermeasures if there is to be a change in relationship and culture between front-line and management staff.

Ethics in Management

Articulation of common aims for 'the good of the patients' (and managers, staff and patients) is laudable but may not be sufficient. Managers are measured by what they do and how they 'practice' rather than what they say they do.

Patankar (et al 2005,p4) refers to Humphreys (1999) moral principles related to competencies associated with ethical behaviour (table 2).

Table 2: Six moral principles and corresponding duties (Patankar et al 2005, p4)

Principle	**Duty**
Autonomy	Respect the autonomy of others.
Non-malevolence	Not to inflict harm on others.
Benevolence	Promote good to others.
Justice	Give others what is owed or due to them (what they deserve).
Truth-telling	Disclose all relevant information honestly and intelligibly.
Promise-keeping	Be faithful to just agreements, honour contracts.

For example the principle of non-malevolence – it is a managers duty to not inflict harm on others – either intentionally or unintentionally through oversight, 'heat of the moment disagreement', intention to ignore suggestions from staff etc.

The idea of ethical competence is not new. Karsing describes ethical competence as:

> "*the capability and willingness to adequately and carefully exercise tasks, taking all the relevant interests into account, based on a reasonable appraisal of the relevant facts*" Karsing 2001, p40.

Whilst this definition is useful in presenting a general understanding it is difficult to understand what is meant by for example "taking all the relevant interests into account" – may this refer to putting the interest of patients ahead of the interests of staff welfare – i.e. doing things for the greater good? If you were unaware of how your behaviour was perceived by staff, does this mean that those facts were irrelevant at the time or that it was not reasonable for you to be aware of them? It is for this reason that perhaps an extension of ethical competence is required. Bowman illustrates

that awareness and cognizance of ethical dilemma are key to ethical competency. Bowman identified that ethical competency consists of "*(a) principled moral reasoning, (b) recognition of ethics-related conflicts, (c) refusal to do something unethical, and (d) application of ethical theory*" (2004, 26).

Schrijver and Maesschalk (2013 p37) take the four elements above and constructs a framework which restates aspects concerning ethical rules and standards. It also ventures into areas of awareness (or consciousness), consequences for others, flexibility within moral reasoning, perspective taking and an area called "*priority to rules and consequences for others*" (ibid, p37). This provides a more rounded description of behaviours that may be useful for the development of guides to managerial practice (table 3).

Table 3: Ethical competence framework

Ethical competence framework (Schrijver & Maesschalck, 2013 p37)

	Knowledge	**Skill**	**Attitudes**
Rule abidance	Law, ethics code, rules and procedures (1)	Applying rules (2)	Importance of rules (3)
Moral sensitivity	Position in the organisation and society (4)	Defining a situtation as an ethical one. Seeing different solutions (5)	Empathy. Perspective-taking (6)
Moral reasoning	Moral arguments: - rules - consequences for others - consequences for oneself (7)	Using different moral arguments - rules - consequences for others - consequences for oneself (8)	Attitude of flexibility: - not only rules - not only consequences for others - not only consequences for oneself (9)
Moral motivation and character	Rules and consequences for others are more important than consequences for oneself (10)	Priority to rules and consequences for others in what you choose to do (11)	Autonomy Ego-strength (12)

Reprinted by permission of the authors.

Codes of conduct and codes of ethics have been developed for numerous professions in the western world including UK and New Zealand. Codes of conduct are described as "*an agreement on rules of behaviour for a group or organization*" (Collins English Dictionary 2013, online source). The Institute for Health Management in the UK has a code of conduct that covers areas including - managing self, managing the organization, managing

people and managing the service (Institute of Healthcare Management 2013, online source). There is currently no equivalent organization in New Zealand although there was one linked (in the 1990s) to an Australian organization called Australian College of Health Services Management. The Australian College of Health Services Management has a short code of conduct which has 6 points as shown below.

"Members of the Australasian College of Health Service Management shall:

- *Undertake their duties in the Health Service in an efficient, proper and responsible manner, having special regard for the well being of the consumers of the service.*
- *Support their colleagues and other health service managers as required and appropriate by providing assistance to other individuals and organisations.*
- *Contribute to the leadership of the organisation by recognising and developing the inherent skills of all health workers in order to achieve efficient and effective services.*
- *Seek to improve personal skill, knowledge and experience by undertaking appropriate study and being involved in the College's Continuing Professional Development program.*
- *Demonstrate a commitment to the development of other health service managers and interested persons in other health disciplines.*
- *Ensure that their position is used fairly and appropriately in a manner which must be neither to their personal advantage nor unjustly to the disadvantage of an employee or colleague "*

(Australian College of Health Services Management 2013)

Both the IHM (UK) and ACHSM (Australia) refer to general principles of good governance. They both appear to treat knowledge as objective – for example they both appear to presume that managers have some control over how they are perceived (in that what a manager intends – is what actually happens). My research would indicate that even with the best of intentions, there are behaviours that appear to challenge or liberate in times of change, that are not reflected in either of these codes of conduct. For example the following is a section from the Institute for the Institute of Healthcare Management (IHM) code of conduct (Institute for Healthcare Management, 2013)

"Managing people: to build and sustain trust, commitment and engagement between managers and who they manage.

Managers are expected to show:

Competence as a person, manager and leader

Attentiveness: non-prejudicial and non-discriminatory, accepting the diverse interests and backgrounds of people. Ability to actively listen and respond appropriately, motivate and encourage others in interactions

Honesty and trustworthiness: transparency in all actions. Working with integrity and able to make reliable judgments and act consistently and fairly when addressing performance and behaviour issues

Selflessness: humility and fairness

Politeness and courtesy in any interaction

Excellent communication skills, using the various communication channels effectively with appropriate non-verbal communication at all times. The ability to communicate clearly, effectively and openly is paramount

Empathy and sympathy towards individuals

Intellectual flexibility: emotional intelligence; ability to negotiate; mediate and deliver solutions that have buy in.

Support colleagues to fully understand their responsibilities, areas of authority and accountability

The ability to develop skills and qualities within individuals and teams and recognise achievements

Reliability: to deliver with honesty and clarity, acknowledging mistakes and misunderstandings. Apologising where necessary

An ability to resolve conflicts and disputes in a timely manner

A regard for the physical and mental health and well being of colleagues"

(Institute for Healthcare Management 2013, p2)

The descriptions of desired behaviour are high level and generally do not deal with the idea (or strategy) for when relationships, processes and perceived outcomes are poor. The reality is that relationships become conflicted, are constantly renegotiated and that leadership groups are perceived to do the wrong thing. Whilst codes of conduct are not intended to disclose specific ways for managers to behave, it is difficult to translate the described behaviours (above) to a complex, conflicted and political situations and achieve all of the aspirations laid out. Thus, it is highly likely managers will fail to meet the stated codes of conduct and be found guilty of poor conduct. It is of concern if codes of conduct are impossible to meet.

In contrasting the styles of codes of conduct it is clear that they come from a different belief in how knowledge is viewed ie the epistemology. The

IHM code of conduct would appear to subscribe to a manageralist (objective) point of view – it is rational, assumes that there is a single truth…

> "*that there's an external reality; that organizations exist as structures and systems; that norms and principles govern human behaviour; and that we can identify a set of universal managerial characteristics, roles and competencies that can be generalized across organizations and managers"* (Cunliffe 2009, p23).

Cunliffe proposes that there are a number of assumptions about managerialism including –

> *"managers are skilled experts who have the right to act as agents for owners and shareholders, are characterised by rationality and neutrality, pursue efficiency, the right to make decisions and give instructions to employees without seeking consent, act in line with the common good, use scientific management techniques*" (Cunliffe 2009, p19)

An alternative view which is reflective in the school code of conduct proposes that

- *"Reality is not what you think it is: the crisis of representation and the constructed nature of managing and organizing.*
- *Everything is political: ideology critique and the political nature of management.*
- *Suspicion is on the rise: reflexive approaches to managing."* (Cunliffe 2009, p24)

Followership

The word leader tends to imply a follower. Adair proposes that the "*discriminatory and determined colleagues are as important as good leaders*" (Adair 1989, p295). He goes on to suggest that "*good leaders today will tend to see people as colleagues, companions or partners, not*

followers" (Adair 1989, p295).

The idea of leaders being close to front-line activity is not new, it is however a move away for the distant heroic leader idea and the more technical approach to leadership and management (regarding tools and techniques). The relationship between the leader and followers/companions on a micro level would seem to be important. Chatterjee proposes that- *"empathy is the glue, the very substance that enables the leader and the follower to stay together on the same path"* (Chatterjee 1998, p3).

This implies a level of intimacy that involves risk and conversely trust and vulnerability (on both the leader and followers part). Chatterjee proposes that the relationship that a leader has with followers or companions needs to be based on credibility. An ally of credibility is "*transparency of action. Lack of transparency leads to lack of trust and this lowers the credibility of the leader*" (Chatterjee 1998, p122). He goes on to say that *"secrecy (i.e. no transparency) creates an artificial barrier between our inner nature and outer nature. The power of communication is reduced.."* (Chatterjee 1998, p 122)

Chatterjee also refers to a form of practical intelligence (such as *phronesis*) in leaders and he proposes that to have this quality is to have faith (or trust in their instincts).

> *"Faith is the ability to process one's intuitive intelligence – it is a knack for figuring things out even when there is inadequate data support…. His learning is not based on his intellect alone – he learns from his gut feelings and the gentle stirrings of his own heart"* (Chatterjee 1998, p99)

The engagement of staff has become an important characteristic of modern leadership and is in fact now a requirement for managers and leaders in the

NHS (ref). The definitions of engagement are generally about how the front-line staff are engaged in their work – their

> *"focus on motivation, satisfaction, commitment, finding meaning at work, pride and advocacy of the organisation (in terms of advocating/recommending either the products or services of the organization, or as a place to work)* (Executive 2007, p1)

This research is not just about front-line staff engagement but about engagement from managers in front-line work, engagement of front-line staff in complex issues (usually the domain of managers), engagement of patients and their families with complex issues, engagement of front-line staff with patient and family concerns. It is perhaps about the idea of leaders joining followers and taking on more characteristics of followers - given the view that leaders fall short of expectations. Kelley (1992) found that followers were very dissatisfied with leadership and found:

- *"Two out of five bosses have questionable abilities to lead.*
- *Only one in seven leaders is someone that followers see as a potential role model to emulate.*
- *Less than half of the leaders are able to instill trust in subordinates.*
- *Nearly 40 percent have 'ego" problems – are threatened by talented subordinates, have a need to act superior, do not share the limelight."*
  (Kelley, 1992 p201)

Kelley proposes that followership is the key to change and success. He describes one view of followership as

> "*… the people who know what to do without being told – the people who act with intelligence, independence, courage, and a strong sense of ethics." (*Kelley, 1992 p12)

There would appear to be a high overlap in the characteristics Kelley ascribes to followership – intelligence, independence, courage and ethics to

leadership and yet followership is seen as somewhat demeaning. Kelley suggests that it is important to "*embrace exemplary followers as partners or co-creators*" (1992, p203). He suggests that this element of partnership includes leaders sharing information, co-creating vision and mission, sharing the risks and the rewards. It also includes demonstrating what value a leader adds to followers' productivity by creating environments where followers flourish and being a hero maker. This is not about congratulating followers for a job well done but is about in-acting a leaders ability and willingness to follow the followers (or front-line staff) Kelley (1992 p203-226).

The concept of employee engagement is a relatively new term and has only become prominent from 2000 onwards (Scottish Executive 2007, p6). A report published by the King's Fund states that "*engaging staff and patients is not an optional extra, but essential in making change and improvement happen.*" (King's Fund 2012, p1). There is evidence that performance improves - Doctors make fewer mistakes and Nurses provide safer patient care if there are higher levels of staff engagement. (King's Fund 2012, p2).

Engagement has been described as a two-way interaction between parties. Whilst the characteristics of an engaged workforce focus on motivation, satisfaction, commitment, pride etc., there is an overall connection to the strategy of the organization (Alimo-Metcalf and Alban-Metcalfe 2008, p9).

The NHS Plan (Department of Health 2000) talked about shaping the services around the needs and preferences of the patients. A further paper (Department of Health 2008) places more requirements about engaging patients to include greater choice, better information, more control and greater influence. The NHS constitution (Department of Health 2013) stresses the involvement of patients full in their care, decision-making and achieving partnership with clinicians (rather than decisions being made by clinicians alone).

Robert Greenleaf proposes that servant leadership, servant institutions and servant trusteeship are vital to engaging followers on a large scale and thus achieve organisational engagement and change. Greenleaf proposes that

> *"a new moral principle is emerging, which holds that the only authority deserving one's allegiance is that which is freely and knowingly granted by the led to the leader…"* Greenleaf (1995, p 24)

Greenleaf goes onto suggest that this allegiance is achieved through servant leadership in that..

> *"they (followers) will freely respond only to individuals who are chosen as leaders because they are proven and trusted as servants."* Greenleaf (1995, p24)

This idea of servant first and leader second I believe fits with the public health system in terms of the stated reasons for organisations to exist "to provide health care" and individual reasons for being a "nurse/doctor/other health professional" – that is to help people.

Greenleaf also poses the idea that those that serve as a first priority are likely to show that overall they are more worthy than those who lead first – perhaps likening to the Aristotle idea of temperate and non temperate beings.

> *"The natural servant, the person who is servant-first, is more likely to persevere and refine a particular hypothesis on what serves another's highest priority needs than is the person who is leader-first and who later serves out of promptings of conscience or in conformity with normative expectations".* (Greenleaf 1995, p28)

Greenleaf proposed that there is a link between servant leadership and development of interdependent relationships which are based on conscience

and compassion (ibid, loc.153) –

> *Conscience also transforms passion into compassion. It engenders sincere caring for others, a combination of both sympathy and empathy, where pain is shared and received. (ibid, loc. 154)*

Compassion in practice became a major strategy for NHS in nursing at the end of 2012 in response to the failing at NHS hospitals. It poses that the '6Cs' are values and behaviours that carry an equal weight and are at the heart of the care patients are given. The 6Cs are care, compassion, competence, communication, courage and commitment (Department of Health 2012, p13). Compassion is described as

> *'how care is given through relationships based on empathy, respect and dignity – it can also be described as intelligent kindness, and is central to how people perceive their care*' (DOH, 2012, p13).

The idea that compassion has been driven out of healthcare and needs to be developed once again is an interesting conclusion for the leadership in the NHS to make (Flynn and Mercer 2013, p14). Is the cause of this only seen in nursing and because of nursing or are there other reasons – as suggested by (ibid, p14)

> *"Compassion is not a recognised feature of competition or market forces or privatised service cultures. If the NHS is suffering from a compassion deficit, then this is more likely to be due to the political ideology driving current health policy, and not due to any shortcomings in the caring values of nurses"* Flynn and Mercer (2013, p14)

Papadopoulos (2003) proposed a definition of cultural competence as *'the capacity to provide effective healthcare taking into consideration people's cultural beliefs, behaviours and needs'* (Papadopoulos 2003, page 5*)*. Papadopoulos has since changed this definition to include the word

compassion as she describes this as being hidden in the term of effective healthcare:

> *'the capacity to provide effective and compassionate healthcare taking into consideration people's cultural beliefs, behaviours and needs'*
> (Papadopoulos, I, 2014 video, 53 secs www.youtube.com/watch?v=ePkAqEv9OuI)

Smajdor (2013) proposes a counter argument to the proposal that compassion is the answer to the failings in the NHS by suggesting that compassion is not sufficient to prevent catastrophic failures in healthcare. She suggests that:

> "*reminders, routines and checklists offer alternative ways of ensuring that crucial healthcare tasks are undertaken independently of how people feel" (Smajdor, 2013, http://www.theguardian.com/healthcare-network/2013/sep/19/compassion-failings-nhs)*

If we accept that there is a lack of compassion in the NHS, is this at all levels including managers? Does lack of compassion in management describe some of the ethical shortcomings seen in management as well as front-line clinicians? The King's Fund cite that the development of the command and control, target-driven approach adopted by the NHS – referred to as the "*pace-setter*" approach has done so at the cost of too many NHS leaders and with little cognizance of the consequences to care (King's Fund 2012, p8). Does this rather fractured approach reinforce an absence of compassion? The King's Fund, like Lord Darzi (Department of Health 2008) emphasise a need for engagement of staff in leading change and service improvement.

Summary of how the literature influenced and shaped this study.

The literature review raised questions about the value of the technical approach when there are unpredictable outcomes due to the complex

change conditions (and poor cause and effect relationships). In my view the technical approach is utilised so often because it is about what the middle manager can control. They can control processes, plans and data analysis. I believe that managers become overly committed to a technical approach because they have been told it is their role and they have been given very few alternatives. Realistically there will be few opportunities to work for managers who observe a servant leadership approach. The idea of proposing an alternative to the dominant hegemony of management appeals because it is clear to me that the current practices for undertaking change are not effective.

Bad governance in the case of failing hospitals and bullying in the NHS may be as a result of intentional (highly unlikely) or unintentional actions. Understanding power relations in the real world and how easy or difficult it is to enter the realms of bad governance is seen as integral to developing engagement. The closer a leader is to the team (an aspiration of the dominant discourse on leadership), perhaps the more opportunity there is to unwittingly and unintentionally provide bad governance. Perhaps the quality and type of discourse that occurs between managers and staff working alongside each other (or at least theoretically working alongside each other) means that the opportunities into what Berne calls a *crossed transaction* is more likely (Berne 1996, p31). This may also suggest that their "theories in use" were not in line with their "espoused theories" (Argyris and Schön 1974, p6–7). Understanding how to build better and different relationships (perhaps based on compassion) between front-line staff and middle managers is a key component of this research.

The development of *phronesis* appears to be an important value to leadership. There is reference in the literature to the importance of reflexivity as part of a social process and reflection as part of a personal process. There is a move for leaders to be part of the real world and to have a clarity concerning the "right" thing to do – based upon higher ethical values and rational decision making. This almost spiritual foresight is

recognised but is largely not understood. The relationship between good decision making based on rational thought and virtue ethics has been explored and is important to the development of new knowledge. It would appear that escalating how to achieve *phronesis* is a key factor in achieving successful change and should be a key component of this research.

Finally, as an insider researcher, I had an understanding of the complexity of the environment and the intended actions of the middle managers in both case studies. Reflecting on the literature about what seems to go wrong in real life has raised key ideas which have influence my thinking.

I have identified that there may be considerable limitations to the technical/scientific approach. I became interest in why there is such a commitment to this approach when it does not appear to provide consistent outcomes. I became interested in seeking viable alternatives for everyday use.

The literature concerning bad governance concerned me greatly. As a result of this, my interest in what constituted ethical behavior, when making changes, was heightened. Once I became immersed in the data analysis, it became a key focus. As a result of this part of this I began to explore front-line perceptions of manager behavior, managers intended and unintended behaviours, universally positive strategies that work and universally negative strategies that do not appear to work.

Lastly I became interested in the idea of learning about the Aristotelian concept of *phronesis*. I have worked with many people undertaking change – I can tell you the ones that 'get it' and the ones that do not but I am unable to explain why. Toying with the idea that there may be a way to firstly escalate learning in this area and to also increase the number of people who may be able to develop *phronesis*, became a key aim in the

model that was to be developed. The literature suggested that increasing the rate and depth of experience may provide a means to escalate this area.

In the next chapter, I will outline and explain my research methodological approach to answer the research question.

Chapter 3: Project Design and Methodology

This study was located in the real world of the NHS in Wales and the public health service in New Zealand. Both environments are ever changing, political, stressful and complex. Consequently, the research aims and design reflects this epistemological approach. Epistemology being described as the "*theory of knowledge embedded in the theoretical perspective and thereby in the methodology*" (Crotty 1998, p3). The aim was to study the impact of change strategies (which were designed to enhance stakeholder engagement in two hospital settings) on managers and front-line staff and to develop a resource for NHS and other health service managers.

Research methodology for the study

It is recognised that the types of improvement strategies, the context of use and the method of introduction may affect the perceived outcome (Walshe and Freeman 2002). It is not conclusive from the literature, the degree to which each of these may affect the outcome. In complex systems where cause and effect phenomenon are difficult to construct and control for, the literature would suggest that to understand the effects of an intervention, more emphasis should be placed upon why and how changes occur and less on the technical details of the intervention (Walshe 2007). Walshe and Freeman go on to suggest that the effectiveness of many quality improvement interventions had a highly variable effect and depended heavily on context and the way they are implemented (2002). It is proposed that it may be more relevant to substitute a controlled experiment with the notion of a social situation which needs to be described and understood.

The theoretical framework (table 2) identified a range of underpinning theories relating to total quality management, change management and leadership theories. From these the constructs and concepts to be evidenced were developed.

The theoretical framework (in table 4) shows a qualitative evaluation from a constructionist perspective. The Constructionist approach provided a tenet that reality is socially constructed. In this understanding of knowledge, *"it is clear that different people may construct meaning in different ways, even in relation to the same phenomenon."* (Crotty 1998, p9).

This research acknowledges the importance of multiple realities (managers, patients/carers and staff) when a change has occurred. The constructionist approach places value on an individual's experience of an event or process. This research draws on individual experiences of similar events with the purpose of identifying similarities and differences between experiences. The constructionist approach incorporates the role of both the participants and the researcher in how it views data collected in a study -

> *"Because of the essential relationship that human experience bears to its object (or idea or event), no object can be adequately described in isolation from the conscious being experiencing it, nor can any experience be adequately described in isolation from its object*". (Crotty 2004, p45)

Table 4 has been constructed as a summary of the relevant literature informing this research. It articulates how the data gathered as part of this research links to the literature.

Table 4: Theoretical framework utilised for the study

Objective	Developing a model for National Health Service Managers to integrate quality improvement with operational management.		
Underpinning theories	Total quality management	Change management theories	Leadership theories
Constructs to describe the phenomena (case studies)	Human relation theories: Structural Framework	Symbolic interactionism Political framework	Interactions Effectiveness
Concepts that can be evidenced	Features	Perceptions	Behaviours

This study has used a qualitative research design using mainly non-numerical data. The theoretical perspective was interpretivist, thus acknowledging multiple unknown variables. It will be concerned with looking at *"culturally derived and historically situated interpretations of the social life-world"* (Crotty 1998, p67) and requires a flexible design. This approach recognises that knowledge associated with different views of the world depending upon your role and power, holds meaning for individuals and may be useful for developing theory. It also allows behaviours to hold different/multiple meanings for different individuals. This multi-perspective view was important to answer the research questions posed in the study.

There were multiple data collection techniques used in this study. In case study one where three strategies were developed and implemented, this utilised group consensus techniques, survey development, group meetings as well as data gathering from documents and interviews. In the second case study, data was collected from interviews with staff only. This was because it was felt that additional data collection from the second case study was not going to provide additional value to understanding and responding to the research questions posed.

Content analysis was used to verify the presence of features in documentation. The other technique used was thematic analysis – a tool within Grounded Theory methodology. Grounded theory "*seeks to ensure that the theory emerging arises from the data and not from some other sources*" (Crotty 1998, p78). The aim was to provide a rich thematic description of the data so get a sense of the predominant and important themes. This has been found to be a useful method when investigating an under-researched area or with participants whose views on the topic are not know (Braun and Clarke, 2006 page 88).

Case study methodology was utilised in this study. Two separate case studies were used to answer the research questions posed. This provided the in depth structure and focus required to view different phenomena from different points of view.

The study design

The design of this study was two case studies. The two cases were representative of typical healthcare teams working in environments where managers were actively working to introduce change. The cases were located in the NHS in Wales and in the public health service in New Zealand. One was located in a speciality hospital in South Wales, the other was a general hospital located in the North Island of New Zealand. Both were located in metropolitan areas.

Hartley proposes that case studies "*can be useful for exploring new or emerging processes or behaviours… and in generating hypotheses and building theory"* (Hartley 2006, p325). (2006, p325). The reason for using a case study design was to provide an in depth analysis using multiple sources to evidence the views and experiences of staff and the managers.

Eisenhardt (cited in Hartley 2006, p325) noted that although

> *"a common stereotype is that researchers find what they want to find (in case studies) in fact the opposite may be the case: the realities which conflict with expectations "unfreeze" thinking and allow for the development of new lines of inquiry."* (Eisenhardt cited in Hartley 2006, p325)

The usual reasons for using multiple-case studies have been described because they *"(a) predict similar results, or (b) predict contrasting results but for anticipatable reasons"* (Yin 2004, p54)

However Yin also proposes that it is legitimate for the data from a second case to *"fill a gap left by the first case or respond better to some obvious shortcoming or criticism of the first case"* (Yin 2004, p62).

He proposes that the two cases together could comprise a stronger case study. It is on this basis that a second case was added to this study.

Justification for adding a second case study is provided by both Yin and Eisenhardt. Because the research identified a "conflict with the expectations" from the first case study, a second case study was added to "fill a gap left by the first case study" (Yin 2004, p62). Following analysis of the data from the first case study, it was clear that further research was required to understand the conflict between what was said by managers, findings of the content analysis from documents (written by managers) and what front-line staff described as their perceptions and experience.

Figure 1 illustrates the relationship between the first case study and the second. The diagram outlines the different stages of my study areas and provides a high level view of the interaction of myself in the collection of data. A number of data items included in the first case study were not replicated in the second case study as the research became focussed on answering questions related to an emerging theme about the disparity in views of managers and front line staff.

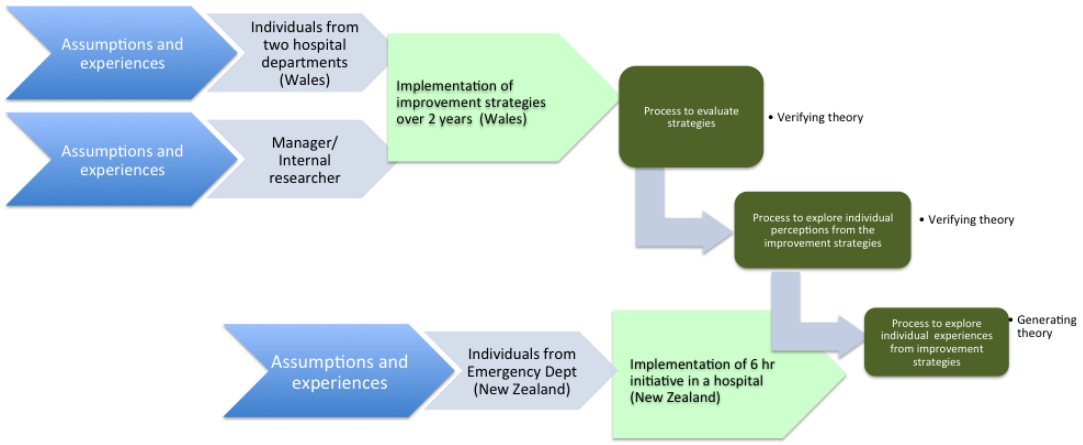


Figure 1: Outline of the two study areas showing the differences in the case studies.

Data collection timeframe

The study focuses on myself as manager and insider researcher studying the effects of change processes on front-line staff and managers in two case study areas. It included analysis of 22 documents (12 sets of minutes, 2 staff satisfaction surveys, 8 newsletters), 14 interviews (8 in case study one and 6 in case study two). Figure 2 outlines the data collection timeframes of the two case studies.

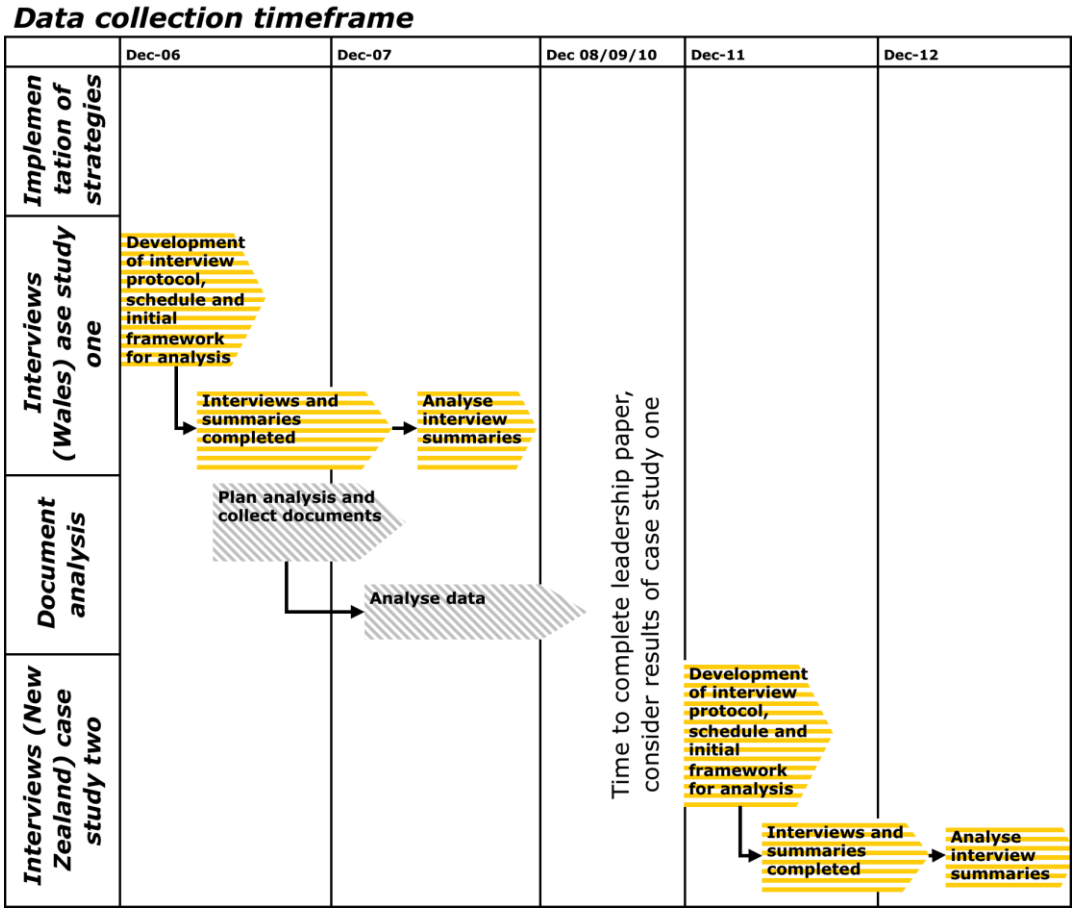


Figure 2: Data collection timeframe

Data collection from different sources, subsequent analysis and my personal reflections and insights as insider researcher, provide the sources of data for triangulation. It was intended that triangulation be used to obtain

> *"..different kinds of data on the same topic, which allow the researcher to see the thing from different perspectives and to understand the topic in a more rounded and complete fashion.."* (Denscombe 2003, p132)

In addition triangulation allows the findings from one method to be checked against the findings from another. *"Seeing things from a different perspective and the opportunity to corroborate findings can enhance the validity of the data"* (Denscombe 2003, p133).

Data Triangulation

Data triangulation was used to analyse the multiple sources within the first case and identify where there were non-convergent findings – thus highlighting important data requiring exploration.

The four approaches to data capture and analysis are shown in figure 3.

.

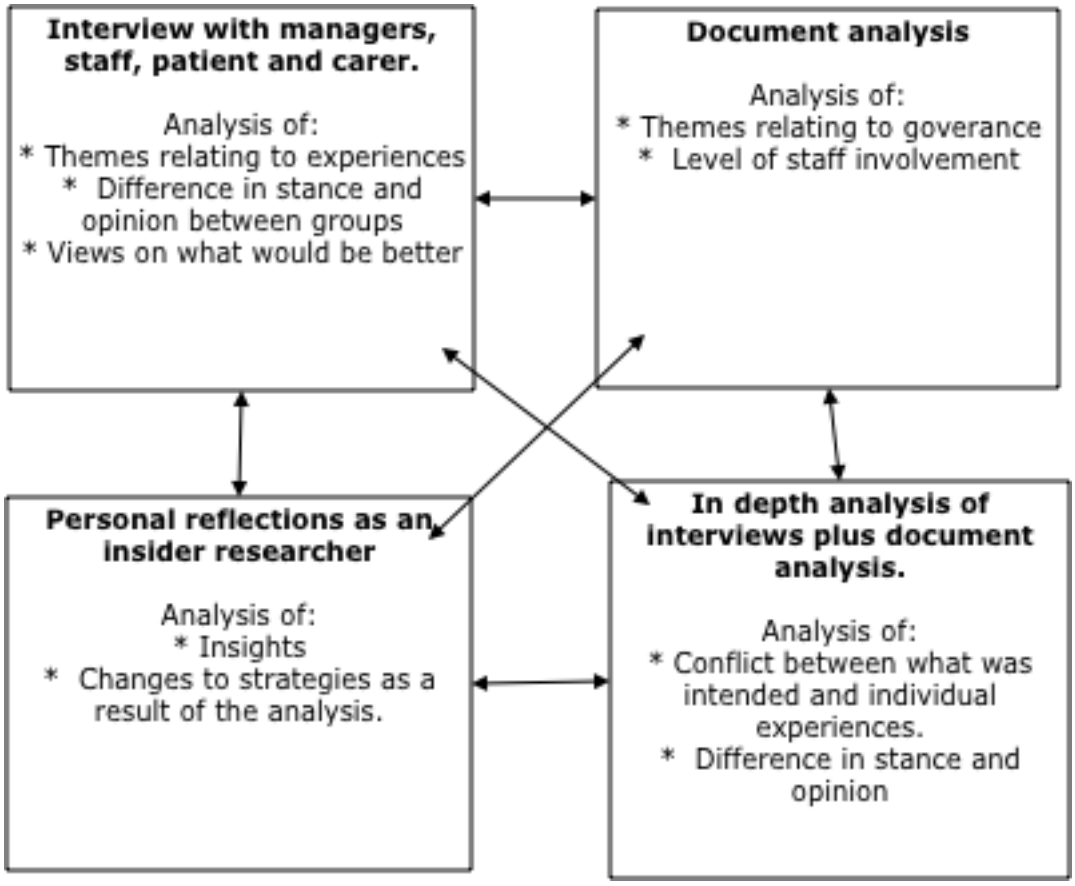


Figure 3: Data triangulation – four approaches to data capture and analysis developed for this study

Before analysis began (on case study one), an analytical framework (table 5) was prepared following the initial literature review. The analytical framework was based on drawing together a number of elements. The theory, potential findings in the data collection and reflection upon observations made from the real world (Trochim 2013). Therefore high-level indicators for the concepts to be explored are represented with the evidence sought to answer the research questions. The three areas that

were explored were total quality management, change management theories and leadership theories. For example, in the human resource, structural framework the data was analysed for the types of work being undertaken, the process implemented and who were involved with the work. There was also an interest in the interactions between the participants; were managers seen as honourable, trustworthy and legitimate by front-line staff and *visa versa*. The last area of interest was analysing the data for evidence of leadership for example were the managers seen as credible to front-line staff, did front-line staff and managers share agreed values and beliefs? What behaviours were seen as an aid and which were a barrier for either group?

Table 5: Analytical framework for case study one (based on the foundation literature review)

Constructs to be explored	**Concepts and code labels**	**Definition of code**	**Evidence Sought**
Total quality management			
Human resource, structural framework	Features	Type of improvement undertaken	Key themes
		Process of improvement	Structured approach
		Who is involved in the work	Range of staff, patients and managers
Change management theories			
Symbolic interactionism, Political framework, professional sub-cultures	Perceptions	Honourable	Intentions
		Trustworthy	Group harmony and resiliency
		Legitimate	Does the work meet a need
Leadership theories			
Interactions, effectiveness	Behaviours	Credible	Collaboration, group support

Total quality management was categorised under the human resource and structural framework. The aim was to explore the number and type of participants of the improvement work, the types of work undertaken: for example – was it clinical work, waiting times etc. and also examine the processes utilised. The second examined the personal views of the

managers, staff and patients/carers. What they thought about each other, what they thought about the work being done. The third section was looking at how behaviours were perceived by different participants.

In the second case study the analytical framework from case study one was considered in the analysis. The second case study was further analysed using thematic analysis and an adapted form of grounded theory. The questions asked during the structured interviews related to the gaps in data collected in case study one and focussed more upon theories of change management and leadership theory. The reason for selecting a second case study in New Zealand was three fold. Firstly, I recognised that the first case study raised significant questions that could only be answered with the addition of another case study. This was in the areas of change management and leadership theories. Secondly, my personal circumstances changed part way through my study; my husband and I had decided that we would return to New Zealand. Thirdly, there arose an opportunity to look into the questions from case study one in a completely different cultural setting (of another country), though relevant and comparable (as the New Zealand Public Health Service is very similar to the UK NHS in being free at the point of delivery).

Thematic analysis was selected in case study two because it placed more emphasis on the presence of tacit (informal and sometimes unknowing) knowledge as well as explicit knowledge. Thematic analysis was used so that maximum conscious and unconscious tacit knowledge could be identified and coded in the data. It is proposed by Hannabus that tacit knowledge which is conscious

> *"hovers about explicit knowledge providing a personalised, impressionistic, metaphorical and symbolic hinterland for the many transactions and choices made.."* (Hannabuss, 2000, p403)

Recognising unconscious tacit knowledge is described by Hannabus as the "aha" experience or epiphany. We don"t know what we don't know until it is perhaps presented in a new way that offers a new explanation for a phenomenon. The structured interviews were designed to illicit tacit knowledge to allow insight as to how participants made sense of their changing world. How they described and talked about the chronology of events, the perceived cause and effect and connections become important in understanding multiple views of the work environment and relationships. With use of the adapted repertory grid technique it was aimed to give the interviewee the opportunity to reflect on their own assumptions out loud (Fransella, Bell et al 2004, p69) as well as allow me to compare any difference between front-line staff and managers.

Overall the interviews would be considered semi-structured because although the interview questions were predetermined the wording and explanations could be changed (Robson, 2005, p270). There were open-ended questions contained in the overall structure. Each interview was replicated in the same way. The use of the adapted repertory grid technique, which contained fixed response questions, was used in both case studies.

Thematic analysis was the main strategy used in the first case study however some content analysis was also utilised. The first case study concentrated on eliciting explicit feedback concerning the strategies implemented. Some themes were identified and searched for in proceeding documentation. Case study one was focussed on the views and opinions of participants to verify or establish a benefit using the strategies and to amplify the differences in perceptions of the different staff groups (if they existed).

The data collection and analysis for case studies one and two occurred one after the other. The key milestones of the project are described in table 6. Ethics approval was sought from the two case study Hospitals and Middlesex

University Health Ethics Sub-committee (approval letters are shown in Appendix 1,2 and 3).

Table 6: Project milestones -

Milestone	**Date**
Approval from Velindre NHS Trust Research Risk Review Committee	Nov 2005
IPH 4014 Programme planning and Rational approved by Middlesex University.	Jan 2006
6 months maternity leave	Feb 2006
Case Study one Letter from the South East Wales Research Ethics Committee confirms that an application for ethical approval is not required due to the project regarded as a service evaluation and management survey (appendix 1).	Feb 2007
Interviews with staff, patient and carer	Apr – Dec 2007
Framework for analysis of written documentation developed	Sep 2007
Content analysis of written documentation completed	Feb 2008
Research study stopped for two years on moving to New Zealand. Resumed Explorations in Leadership module.	Sep 2009
Completed Leadership "D" Level module	May 2011
Case Study two Letter from the Northern Ethics Committee confirms that a expedited ethics approval has been granted (appendix 2), approval from Middlesex University (appendix 3)	Oct 2011
Interviews with staff	Nov 2011
Analysis of interviews completed	Aug 2012
Writing for final project started	Aug 2012
Final project submitted	August 2014

Prior assumptions

This project was started with a number of assumptions which I recognised may create potential bias with a risk of compromising the validity of this project and the intended findings. The prior assumptions were:

1. That the literature had provided evidence of management shortcomings including: inability to sustain and spread improvement, inability to engage front line staff consistently in clinical governance and quality improvement activities and the presence of high profile failures in patient care in the NHS.
2. That more in-depth knowledge of the experience of change by participants could assist in the development of a model to assist leaders/managers and other stakeholders in facilitating change.
3. That the case studies selected were representative of common healthcare teams working in the NHS and the New Zealand public health system.
4. That the management strategies implemented in both case studies were contemporary and typical of both health systems.
5. That I had provided sufficient mitigation to minimise my influence (as an insider researcher) to allow participants to speak freely in interview by co-opting an outsider to undertake interviews in case study one (where I was the manager) and undertaking the interviews in case study two (where I was not the participants manager).
6. That developing knowledge about a more collaborative leadership and followership approach could enhance approaches to organisational learning and change.

By recognising these assumptions there are a number of risks to the validity of this study. The two areas of most significant risk were – insider researcher and the selection of the case studies (Costley, Elliott et al 2010, p25).

The role of manager and insider researcher

My dual roles as manager and insider research of this multiple case study have implications for the framework of the study – the design of the data collection, the way data is collected and the analysis and interpretation of the data.

Costley et al (2010, p25) outline a number of issues for consideration for the insider-researcher which I have elaborated on in the following tables 5, 6 and 7 which show how the information has been transparently handled.

Interpretation of what is seen by the researcher in the data collection is particularly important. For the insider-researcher the data is laden with local knowledge. "*you determine which behaviours are observed, which are ignored and how the information is interpreted but, as an insider, you have detailed knowledge of the particular context.*" (Costley, Elliot et al. 2010, p33)

The above quote is specifically relevant to the interviews conducted in this study. Appendix 4 contains a copy of the information given to the participants prior to agreeing (and signing) a consent form. Table 7 describes how this aspect was carried out in case study one with the use of an outside interviewer. In case study two (table 7) where the researcher conducted the interviews, transparency in data analysis was addressed through the choice of using grounded theory and the fact that the researcher was not an operational manager of the area where the participants were employed. This was meant to reduce the influence that the interviewer may have on what staff said due to not having an on-going relationship with the participants.

Power dynamics involved in requesting subordinates to be involved in the research is seen as another key consideration for insider researchers (Costley, Elliot et al. 2010, p31). Recruitment of participants in the

interview is described in the following tables; there was a clear process for voluntary participation and informed consent.

To address issues relating to potential manipulation by the interviewer or participants in the interview process and ensure clarity in roles and in purpose, interviews in both case studies utilised an adaptation of reperatory grid (Kelly 1979).

Table 7: Increasing transparency as manager and insider researcher in interviews (case study one)

Increasing transparency as a manager and insider researcher (case study one) – interviews	
Risk	**Mitigation**
Interviewees maybe fearful that their future employment or care could be affected. This may result in biased responses.	Interviews were not carried out by myself but by a person external to the departments. Whilst the interviews were taped, this was not available to me. A verified (by the participant) and annonymised account of the interviews using direct quotations in a template were presented to me for analysis.
Interview content and emphasis could be biased by the interviewer.	The interviewer used an adaptation of repertory grid[2]. This provided additional structure and clarification around key aspects of the interview. The structure of each of the interviews was similar (between all participants in both case studies).
The selection of interviewees could bias the types and range	The interviewees were stratified and randomly selected from staff lists. The

[2] Repertory grid is described further on page 118

of responses ie insider researcher could select staff that are sympathetic to management ideas.	individuals were provided with participant information illustrating their rights and voluntary status.

Planning for the data collection from written information (for case study one) posed particular problems for the insider researcher as some of the documentation for analysis had been written by the insider researcher therefore was potentially biased and colluded with the my view point. I have attempted to address this potential for bias with careful development of themes via content analysis and detailed recording of clustered ideas.

One aspect of the "researcher as an employee" is the acknowledgement that the research may be undertaken in an overt or covert way (Vinten 1994, p31). Whilst this research was undertaken in an overt way – bound by specific approval from ethics committee and voluntary participation, there were elements of the research that were not for example written with the intention to include in a research study. Whilst permission was given to review documents, as it was deemed by the chair of the ethics committee to be a "*service evaluation and management survey*" (appendix 1) the authors of the original documents were unaware that the documents were to be used in research (although the documents were in a public domain). Of course this matter does provide a significant mitigation to research bias as well however it should be noted that the documents were not written as part of a research program at the time.

To make explicit the issues of researcher involvement in case study one, again the analytical framework included a review of the data and a protocol for coding the written information was designed. The two main elements requiring transparency are described in table 8.

Table 8: Increasing transparency as manager and insider researcher – a summary of content analysis of written documents (case study one)

Increasing transparency as manager and insider researcher – content analysis of written documents (case study 1)	
Documents could have been written with the knowledge that they would be analysed for certain themes and outcome.	The documents selected were only those that were written before the decision to include them in retrospective study was decided. This means that at the time of writing the authors did not know the documents would be analysed.
The researcher wrote the documents from certain perspective and will analyse them in that same perspective	The insider researcher coded the data according to criteria identified in the literature to verify presence or absence of data items thus attempting to provide a broad critical treatment of the documents. The analysis process used triangulation to provide a multiple perspective to emerging themes thus reducing insider-researcher bias.

I could have sought external review of the analysis of written information process however I determined that this potential influence could be managed through providing transparency in how decisions were made and utilisation of triangulation. The aim was to check out the consistency of findings and to ensure that my account of the findings was rich, robust, comprehensive and coherent.

To reduce the insider research influence in data collection in case study two, consideration was given to the freedom of the participants to speak openly and also my influence in the thematic analysis (see table 9).

Table 9: Increasing transparency – identification of key areas considered in the case study two

Increasing transparency- interviews (case study two)	
Participants may not feel that they could speak freely because I was a colleague of the manager of the Emergency Department.	It was explained at the interview and in the participant information documentation that I was leaving the organisation and what individuals said would not be ascribed to them and was confidential to the study.
Thematic analysis of what was said at the interview could be misinterpreted or biased by the researcher.	A structured approach to the thematic analysis was undertaken – where possible data was authenticated with other interviews or within the interviews by counting data points. Analysis used a grounded theory approach which was intended to transparently show how the data informed the selection of the categories.

I felt that a mixed method approach was appropriate to enable me to balance my insider researcher status with a combination of qualitative and quantitative data.

The selection of the case studies:

Yin (2004, p27) refers to five components important in the design of case studies. These include the nature of the study questions, propositions of the study, unit of analysis, the logical linking of data and the criteria used for interpreting findings.

The nature of the study questions means that a flexible study design was required. The study proposition was that the interactions and behaviours of managers leading to a change may or may not be effective in delivering the changes intended. The unit of analysis for this study were groups of staff who have had experience of working together during a 1-2 year change process. The types of data required for this study, based on the study propositions required various sources and modes of analysis. Thus, the linking of data to propositions required triangulation using the multiple sources of data with elements of the data collection design allowing flexibility to explore new and emerging themes.

Critical evaluation of the case studies

Case study one was undertaken in Wales (a small specialty hospital treating cancer patients). There were two teams involved in the research (59 staff in total). Team one was made up of clerical staff including secretaries, appointment schedulers, hospital receptionists and clinical coders (44 staff). Team two was made up of 15 nursing staff (including phlebotomists, registered nursing staff and untrained nursing staff). The two teams in case study one had both experienced improvement strategies which were introduced over a two-year period by myself.

Case study one was selected because I was the manager of the areas, I had access to healthcare teams where I had introduced a change process. The change involved the introduction of three strategies, each had an aim to improve the process of communication and working between the managers, patients/carers and front line staff. The change strategies included – a staff satisfaction survey, a staff newsletter and a front-line quality group.

Case study two was undertaken in New Zealand – a large district general hospital Emergency Department (130 staff). Participants were drawn from nursing, management and medical professions. This Emergency Department had experienced an improvement strategy (and achieved a government target) which focussed on meeting the 6 hours initiative (ie 95% of patients will be in the Emergency Department less than 6 hrs.) (Ministry of Health 2014)

Case study two was selected because of the significant change that front-line staff had to make in their work. Whilst it utilised a different strategy for change (from case study one) it was similar in that it used a common management led approach to change. The process for change included the collection of data and improvement cycles internal and external to the Emergency Department. It utilised a mixed approach to change using what is known as "*A3 problem solving*" (Jimmerson, 2007:p5). The change strategy involved staff at all levels in the department including clerical, nursing orderlies, doctors, managers, and allied health.

Similarities between the two case studies –

1. Both case studies employed change strategies that were driven by staff in middle management positions and were typical contemporary approaches in the NHS and NZ public health service.
2. Both case studies are in health services that were free to the public, they have similar training for nurses, doctors and allied health.

Differences between the two case studies

1. There are known differences in professional sub-cultures between the two case study countries (Degeling et al 2003)
2. The healthcare teams work in different areas. One is in the acute field and the other is in a more planned service.
3. Case study one had slow, low impact change compared with case study two.

Case study one data collection and analysis broadly focussed upon verifying theory. Through review of the literature the researcher developed a set of items that were verified as being present (or absent) in the data collected from the case study. Glaser and Strauss propose that within verifying theory:

> "*a touch of generation may be included, but the researcher's focus is on verifying; he generates theory only in the service of modifying his original theory as a result of the tests.*" (Glaser and Strauss 2011, p27)

Initial analysis from the first case study identified that there were areas of study which could not be explained (or verified) and further study would be useful to understand the conflict in experiences of the participants.

The second case study area was chosen because the healthcare team had experienced a significant amount of manager led change than the first case study and it was felt that the issues that had emerged from the first case study would be replicated and amplified. The second case study data collection was designed to generate theory specifically focussed upon a study area exposed through data analysis in the first case study.

Trustworthiness

The epistemological approach of this research is constructionism. Constructionism claims that '*meanings are constructed by human beings as they engage with the world they are interpreting*' (Crotty 1998, p43). Constructionism would suggest that objective, valid and generalizable conclusions are never realisable (Crotty 1998, p13). Crotty also suggests that at best they will be

> "… plausible, perhaps even convincing, ways of seeing things – and to be sure, helpful ways of seeing things – but certainly not any "one true way" of seeing things." (Crotty 1998, p13)

The focus therefore here is to lay out the process of design and provide detailed data capture methods and analysis for scrutiny. Feast and Melles (2010, p4) maintain that to do constructionist research the researcher must place all "*meanings, scientific and non-scientific, on an equal basis"* ; they are all constructions and none is truly objective or generalisable. In addition to transparency there is also a need to look at transferability or generalisation from the constructionist point of view.

Proponents of naturalistic generalisation assert that evaluation should be carried out in a way which – *"provide(s) maximum of vicarious experience to the readers who may then intuitively combine this with their previous experiences"* (Stake and Trumbull 1980, p1).

Stake asserts that whilst the naturalistic researcher must attend to one or two major issues, they will present the data in a way which leaves the "*richness and ambiguities and conflicts which are part of daily experience" (Stake and Trumbull 1980, p4)*, thus allowing the reader to identify relevant previous experience and develop personal understanding and internal conviction from which a change in practice can occur. Thus the presentation of rich narrative to illustrate key concepts is important for transferability and transparency. The degree of transferability is a direct function of the similarity between the two contexts… (Lincoln and Guba 1985, p124). Lincoln and Guba propose that how this is done is for

> *"an inquirer to provide sufficient information about the context in which an inquiry is carried out so that anyone else interested in transferability has a base of information appropriate to the judgement"* (Lincoln and Guba 1985, p124)

There are, however scientific generalisation conventions which illustrate transparency particularly related to the manner in which data is collected.

Elements present in the study to increase transparency included:

- Selection - the invitation to front-line staff who participated in interviews in the first case study was stratified and then randomly selected. Thus avoiding only interviewing a selected group of front-line staff.
- Selection – documents were excluded which were written after the start of the study to avoid manipulation by the researcher or other staff with a certain stance.
- Selection – volunteers were asked to participate in the second case study. This had potential to have front-line staff with a certain stance for example a negativity to the process of change that occurred. As this group of staff are in fact a focus for the study – this was determined to be an appropriate recruitment process.
- Logical analysis – a transparent outline for all of the data collection and analysis has been provided given the issues with an insider-researcher and potential bias given the familiarity with the context and environment as well as the researcher personal views.

It is hoped that the findings will be recognised as immediately relevant and transferable due to a fresh perspective on easily recognisable, yet hard to fix problems of management and leadership. In other words readers will recognise patterns, components, meanings and similarities with other cases.

Transparency

The key risk to the quality of the data is confusion as to how the data was collected and how I, as the insider researcher, may have influenced the data. Points of clarification are outlined in table 10. The table also includes actions taken to understand and treat the risk.

Table 10: Transparency in data collection – examination of the key areas

Risk	Actions
Documents for analysis – interference from manager/insider researcher (case study 1)	Only documents written before February 2007 were used. At the time of writing it was not known that these documents were to be used for analysis of written information
Biased analysis in analysis of written information undertaken by the insider researcher (case study 1)	Systematic approach to coding of themes based on explicit criteria for inclusion and exclusion. Documentation of all processes.
Effect of manager/insider researcher on participant responses (case study one)	Use outside interviewer with no operational responsibility for interviewees
Effect of manager/insider research on participant responses (case study two)	Researcher/ interviewer not operationally responsible to the area
Over generalisation of findings	Clear research questions, awareness of risks, clear process for analysis of data.

The main risks associated transparency in the data collection are covered above.

Ethical considerations

Issues concerning recruitment and consent were addressed as part of the ethical approval process. The participant invitations included information regarding confidentiality and informed consent options for declining and leaving the study (appendices 4 and 5).

Data collection in case study one was carried out by a third-party interviewer. This was to address concerns that staff may have in providing feedback to their line manager (i.e. myself). This was to preserve anonymity in feedback (i.e. I as their line manager and researcher could not attribute data to individuals). The person selected was a neutral party who had a quiet, gentle approach. He had no direct responsibility for staff which I felt was important both to enable staff to speak freely and protect them from any repercussions of their views on line managers.

Costely et al (2010, p25) pose a number of considerations regarding research ethics which relate to being a work-based researcher. Whilst all researchers are presented with a number of ethical issues relating to confidentiality and consent, they propose that there are issues that relate to the nature of the research question itself, the methodologies and the way research is conducted, analysed, the range of stakeholders and the outcomes.

The choices a manager makes in one setting provide a context for how their motives, role and agenda will be viewed by front-line staff in another setting. I believe that the ethics of managers are always under scrutiny and how they facilitate change is a key area of concern. The purpose of this research is to develop understanding and model ways in which middle managers can work more collaboratively with front line staff. The aim is to move from an autocratic, ill-informed and sometime benign director of change, to a player with shared responsibility for engaging front-line staff in well thought through change processes. From a unitarist to pluralist management perspective (Fox, 1966). This stance is supported by the development of new guidance for NHS and New Zealand health managers (see chapter 5, page 218).

A key component in this inquiry is for the researcher to develop an approach that is reflexive and conscious of the different cultural backgrounds of the participants and myself as the researcher. This is not only relevant for the experience of the participants but also the assumptions made in the

findings. It is proposed that four areas should be considered; cultural awareness, cultural knowledge, cultural sensitivity and cultural competency (Papadopoulos 2006, p87). I shall go through each area described in turn to demonstrate how this study approached cultural competence.

Case study one was carried out in a country that was not native to me. I had been working in Wales for a period of 2 years prior to starting the study in 2004. I had previously recognised a number of cultural differences which were relevant to the position of researcher as well as the position of operational manager. The main difference related to how topics of conflict and change were discussed as well as perceptions of manager authority. In New Zealand there appeared to be a more straightforward preamble required before raising issues of concern (by the manager), in other words the process of raising issues was done at a low level. It was my impression that in New Zealand issues were more likely to be discussed and there appeared to be less discussion and socialisation before actually describing what the problem or issue was. In my role as operational manager in Wales, it appeared that more attention was given to how issues were discussed and there was a high level of concern expressed when issues were raised both by the giver and receiver. In Wales, staff in general appeared more sensitive to criticism. A point of interest to support this finding is that on Hofstede's (2014) power distance index (PDI), New Zealand is ranked at fourth lowest at 22 PDI (after Austria, Israel and Denmark).

> *"New Zealand scores very low on this dimension (22). Within organizations, hierarchy is established for convenience, superiors are always accessible and managers rely on individual employees and teams for their expertise. Both managers and employees expect to be consulted and information is shared frequently. At the same time, communication is informal, direct and participative".* (The Hofstede Centre, 2014:online)

The United Kingdom has a power index of 35 (10th lowest).

> *"At 35 Britain sits in the lower rankings of PDI – i.e. a society that believes that inequalities amongst people should be minimized. Interestingly is that research shows PD index lower amongst the higher class in Britain than amongst the working classes. The PDI score at first seems incongruent with the well established and historical British class system and its exposes one of the inherent tensions in the British culture – between the importance of birth rank on the one hand and a deep seated belief that where you are born should not limit how far you can travel in life. A sense of fair play drives a belief that people should be treated in some way as equals".* (The Hofstede Centre: 2014:online)

The power distance index is said to measure the extent to which the less powerful members of organisations and institutions accept and expect that power is distributed unequally. The assumption is that the lower the index the more likely members of an organisation will challenge those higher in the organisation. My assessment was that I had to tailor my approach (both in my work and in my research) and seek more feedback in Wales when communicating and undertaking change, than I may have needed to do in New Zealand (where people were more used to providing feedback to their managers). The attributes of the 3rd party interviewer was a key strategy in providing a safe and supportive interview process for front-line staff.

Cultural knowledge and cultural sensitivity were important factors in designing the research and were particularly relevant to the change in design for the second case study. Cultural differences as described by Degeling (2003) assume that different professional groups have different perceptions of work. Thus values concerning systematising care versus clinical autonomy become part of the research area of interest. Whilst compliance with ethics committee procedures regarding participation, information and rights of the participant were observed and addressed a number of issues, a significant effort was made by the interviewers to show

they were genuinely interested in the participant's story and that their story would be held in confidence.

My approach to cultural competence, as described by Papadopoulos (2006), has been carefully described at each level from design, how participants have been treated and in observance of particular cultural features in analysis. This included consideration of perceptions of power, inquiry and discussion into the nature of participant beliefs and values. I have also honestly and transparently exposed many negative aspects of my own short-comings and others where this has been raised.

The ethics concerning the methodological approach are well supported in this study as it was presented to two local ethics committee chairs in Wales and New Zealand. These were both approved as not requiring full ethics committee review due to the evaluative design of the research – appendices 1, 2 and 3. Confidentiality, privacy and security of data have been observed as part of this process.

My personal reflections as an insider researcher have been described at the outset so that scrutiny of the possible influences are transparent, reflection on the overall research experience is contained in chapter seven.

Consideration has been given at each point of data collection (as to the impact and influence from the insider researcher). It is hoped that by addressing ethical issues in collected data, in the form of interviews, information from staff has been open and honest. In order to transparently represent the findings of my research I have, where possible, used the words and phrases of the participants in quotes.

An area of which was not taken into account in planning the interviews for case study one and two was participant distress. Whilst both the interviewer for case study one and myself in case study two aimed to provide a 'caring listener' demeanour in our interactions with participants.

One participant in case study two expressed considerable emotion during the interview. Whilst the participant did not become emotionally distressed and stated that she was pleased to be able to talk about what she thought and how she felt, I did not have a pre-planned approach to dealing with distressed participants. I could have provided a 'check in' phone call from myself or offered an EAP (employee assistance programme) which provides free counselling for staff (if I had negotiated this). I also did not have a plan for how I would handle information that was shared with me in confidence that breached codes of conduct or referred to criminal actions. Both of these issues were overlooked because of my naivety in undertaking interviews. However, in retrospect, and in line with good ethical practice as promoted by Middlesex University Health Studies ethics committee, I would have sought guidance from the ethics committee.

Conclusion

This study used change strategies in two case studies with the aim of examining the intended and unintended consequences of middle manager behaviour.

The aim in case study one was to develop strategies that would address perceived gaps in the current application of quality improvement in operational management. It focussed on engaging managers, front-line staff and patients/carers in shared activities to improve services. It aimed to assess outputs from this implementation in the form of documentation analysis and interview. The analysis focused upon identification of improvement outcomes, the level of engagement with managers, front-line staff and patient/carers and compared front-line staff and manager priorities. Case study one also explored these same areas with follow-up interviews.

Data triangulation was used as a framework to view data from interviews, documentation, personal reflections as an insider researcher and data collected from the available documentation.

A second case study was added to provide further data to address gaps raised in the analysis of the first case study. Case study two collected additional data from managers and front-line staff as to their experience of an intensive change programme to meet the New Zealand Emergency Department targets. It compared the espoused priorities of management to the experience in practice of front-line staff. It used an adaptation of grounded theory to identify themes from the interviews.

In the next chapter I will be discussing the actual project activity including the real life problems and issues encountered in undertaking the study.

Chapter 4: Project Activity

Introduction

As stated earlier this project spans 8 years of activity and includes data collected in two different countries. It has three main phases of project activity:

Case study one, Welsh Hospital, UK

Phase 1: Implementation of three strategies (ie newsletter, quality group, staff survey)

Phase 2: Development of data collection methods including document analysis and interviews

Case study two, New Zealand Hospital, NZ

Phase 3: Development of data collection methods including interviews.

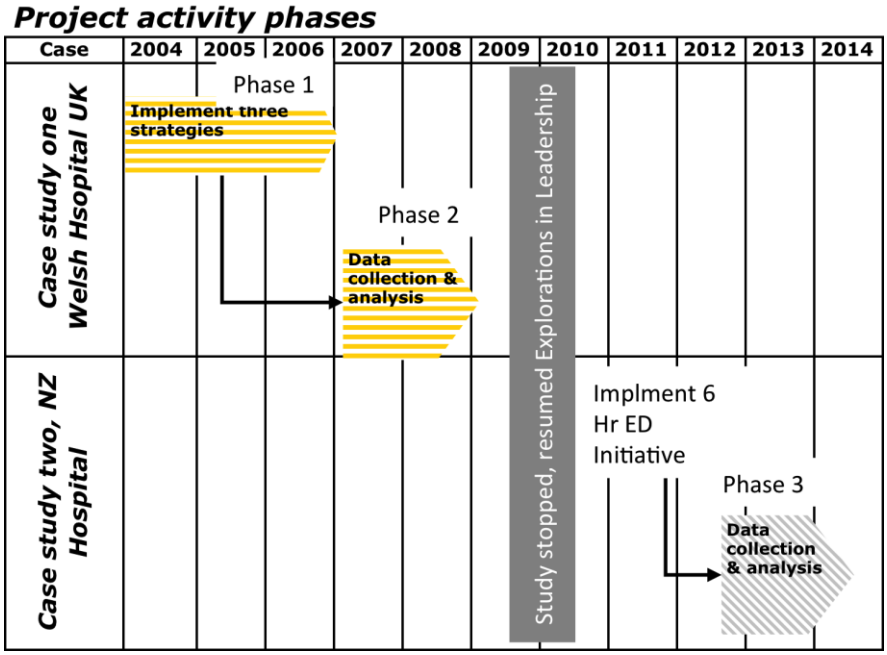


Figure 4: Project activity phases

Phase one and two occurred when I was employed at a Welsh Hospital as a quality improvement and operational manager for 3 years. Phase three

occurred when we moved back to New Zealand and I was employed as an operational manager for 3 years.

Phase 1

Case study one - implementation of three strategies

The Medical records department had 44 full and part time staff. The Medical Records department employed staff to manage the retrieval of the paper (hard copy) medical records, update a sophisticated electronic medical record via medical secretaries, provide reception facilities and provide clinical coding. The Medical Records Department was led by a Manager and below this position were three team leaders one each for clinical records, clinical coding and medical secretaries. I was the manager with overall responsibility for medical records and the outpatient department (see figure 5)

The Outpatient department had 15 full and part time staff. The Outpatient Department employed staff to support the running of outpatient clinics by working with doctors and specialist nurses. The Outpatient department was led by a Nurse Manager who managed a number of roles. This included registered nurses, health care assistants, phlebotomists (taking blood) and clerical staff (figure 5 shows the managerial role that I held in case study one).

Structure of participant roles in Case Study one

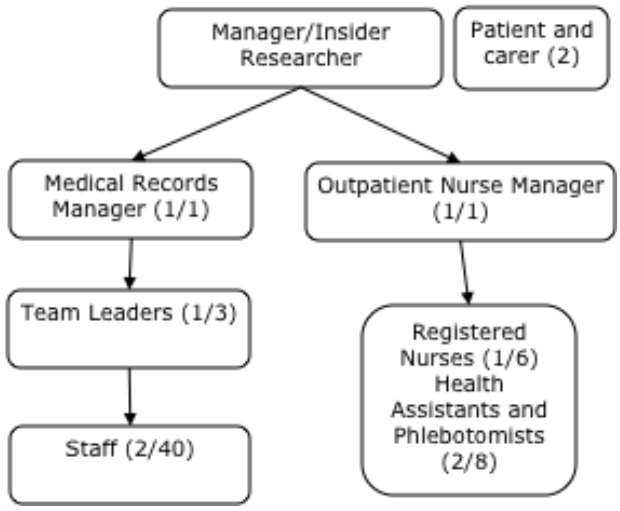


Figure 5: Role of researcher, number of interview participants and number in staff/patient/carers in each group.

The selection of strategies implemented in case study one was based on my previous experience as the manager in developing strategies to transparently deal with the challenges of engaging staff in change and improve services. The three strategies were selected because they were thought to be effective in providing feedback and a commentary for all stakeholders involved in ordinary everyday work as well as identifying areas for improvement (see figure 6). The implementation of the strategies is based on a realist approach and an understanding that healthcare delivery is complex and heavily embedded in social interactions.

Robson describes a realist view of doing experiments –

> "*Through theory and observation, and as a result of previous experiments, they* (the researchers) *develop knowledge and understanding about the mechanism through which an action causes an outcome, and the context which provides the ideal conditions to trigger the mechanism"* (Robson 2002, p31)

Whilst managers may genuinely believe that there has been a service improvement it is imperative that this is corroborated with front-line staff and patients/carers. The same can be said of front line staff delivering services to patients, patients need to agree that the change is an improvement.

The strategies assume that there may be a miss match between managers and front-line staff (and patients) thinking about quality and aims to solve this problem. The three strategies when applied together provide feedback loops between patients, staff and managers.

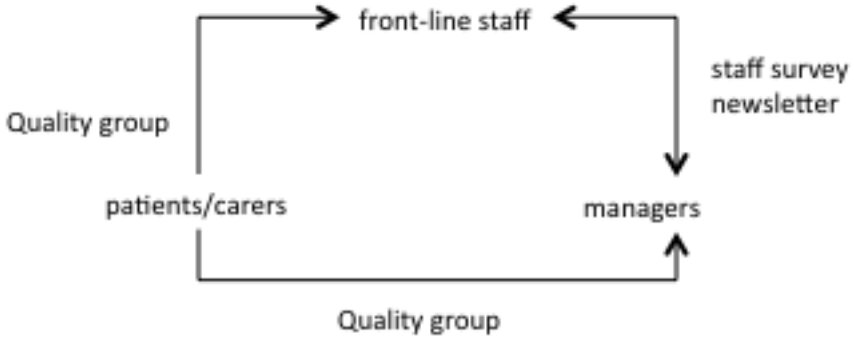


Figure 6: How the three change strategies provided feedback to each stakeholder group.

An example would be - if we take the staff satisfaction survey – it provided feedback to managers about general themes of satisfaction from staff, it also provides feedback to staff about what their colleagues think. The staff newsletter provided feedback from managers to front-line staff. The quality group provided feedback (and a discussion forum) for managers and front-line staff. There was no return arrow for feedback to the patients/carers. This was because although feedback (in the form of communication) was provided to the wider patient advocate group, the strategies were not set up to change the behaviours of patients (only of front-line staff and managers). Feedback through the wider patient group however did provide positive communication about staff efforts to the patient group (even though this was not an intended outcome).

In addition, the three change strategies were selected because they were thought to work with mechanisms and/or monitor mechanisms that may be useful to identify improvement work in the normal operational management arena. Each of the three tools played a part in feedback loops and providing foci for staff and managers.

The staff satisfaction survey identified staff issues with their work and with management. The manager's response to this may enhance or block the

opportunity to show concern for staff, thus increasing or decreasing trust. Trust is thought to be integral to developing shared understanding and collaboration. The newsletter may provide a number of ways to demonstrate consensus of a priority improvement to the wider group. It may provide a forum for exposing conflict based on data published, actions documented, feedback and progress on projects (appendix 6). The quality group may provide a discourse for openly aligning views directly with staff and patients (or a venue for airing conflicts). Robson (2002, p31) refers to an action leading to an outcome when mechanisms are triggered. In order to trigger mechanisms, conditions need to be supportive within the context.

The development of the staff newsletter (case study one, Welsh Hospital, UK):

The newsletter was adapted from a monthly report which I had submitted each month to the general manager (whilst I was working at a NZ Hospital prior to April 2004. I had arrived in Wales to join my soon to be husband (a New Zealander born in UK). Although I had previously worked in England clinically as an Occupational Therapist, I had not worked as a manager in Wales before. I designed the newsletter to provide information to my managers (not always required) and to staff that worked in the directorates that I was responsible for. It was designed to ensure that front-line staff were being well informed of any issues and celebrations. Beckhard and Harris (NHS Institute for Innovation and Improvement 2005a, p14) pose that there is a change equation which requires that each of the four element in the change equation be positive (ie one not zero). The elements proposed were 1) a vision, 2) an element of dissatisfaction, 3) a capacity to undertake change and 4) what the first steps were. If there was a neutral or negative element, resistance will not be able to be overcome. The equation assumes that resistance to change must be overcome and the staff newsletter was a strategy to describe what processes had been used to agree a course of action and demonstrate a level of consensus where this had been achieved.

The newsletter was initially written by myself (as the manager for the departments) – sample in Appendix 6. It was designed to be friendly and informal whilst providing important information for staff. It covered the main areas of work and topics of conflict and dissatisfaction (as gathered by informal discussion and the staff satisfaction survey). These were aired in the newsletter. The headings for the newsletter included:

- *Have you heard?* Commentary, social information, congratulations etc.
- *Risk* – incidents, delays, key performance indicators.
- *Highlights and lowlights* – things that went well, things that didn't go so well.
- *Money, money, money*! Financial spend for month and year to date, sickness, supplies
- *Comings and goings* – changes to staff, updates on role changes
- *On-going issues* – updates on projects, issues to be resolved.

The newsletter was emailed out to all of the staff individually. It was intended that a similar and separate newsletter was also produced for the outpatient department and several attempts were made to produce it. Due to late inclusion in the project - only two newsletters were distributed to the outpatient staff over the two-year period. The outpatient department were not originally included because they had set up the Quality Group which already had a means of providing feedback through the minutes of that group.

No formal feedback was requested by myself or the managers of the department during this time. There was some limited feedback from front-line staff and as a consequence of this, the newsletter remained the responsibility of myself and the enthusiastic manager for medical records.

The development of the staff satisfaction survey (Case Study one, Welsh Hospital, UK):

The staff satisfaction survey methodology was originally developed as part of a group of quality improvement projects at a previous hospital in New Zealand in 2000. At the time of development, I was a facilitator for projects on the Critical Care Nurses course in which the first survey was developed. I then became the manager of the area (Surgery), where the survey was used over a two-year period. Originally the survey was developed and implemented on two surgical wards in a Hospital in New Zealand. It was originally administered to all nursing staff at six monthly intervals over two years. The strategy was found to be a useful way to prioritise areas requiring improvement work in an otherwise poorly performing service which had high staff turn-over and was difficult to recruit to.

The surveys (for both of the areas in case study one) were developed using the same process (appendix 7). Likert scales for item selection and levels of staff satisfaction (Robson 2002, p293). The actual survey questions are shown in appendix 8. It should be noted that the survey was conducted prior to the start of this doctoral study. As with the other improvement strategies, the survey was not originally designed to form part of a formal research study. The questions however were developed using a Delphi technique. Analysis of the development has been carried out retrospectively. The Delphi technique is considered useful if there are a number of factors present regarding the make-up of the group and what other alternative mechanisms are useful to assist the group in making decisions. There were 4 out of 7 properties to indicate that Delphi was appropriate:

- *"The problem does not lend itself to precise analytical techniques but can benefit from subjective judgments on a collective basis*
- *Time and cost make frequent group meetings infeasible*
- *The efficiency of face-to-face meetings can be increased by a supplemental*

- *The heterogeneity of the participants must be preserved to assure validity of the results, i.e., avoidance of domination by quantity or by strength of personality ("bandwagon effect")"* (Linstone and Turroff, 2002, p4)

Unlike Weller et al (2011, p165), this research was set up as an insider inquiry and assumed to be a component part of the normal evaluation that the NHS would undertake. We did mitigate anxiety by staff regarding giving full and frank feedback by providing anonymity. Anonymity was achieved by planning for an independent outside administrator to collate the surveys each time thereby reducing identification of hand writing in any written comments.

The development of the quality group (case study one):

The quality group was introduced to case study 1 (Outpatient Department) in April 2004. The idea of having patients involved in a staff forum came from a national programme (Implementing the Guide to Good Practice) running in Wales at the time (Cumming 2005). The key points for building partnerships in this programme included:

- *"Patients must be involved at every stage of the change programme, as a fully integrated and valued member of the team.*
- *Effective patient partnerships depend on good communication*
- *It is important to have robust strategies in place to find out the views of the patient population.*
- *Maintaining communication with patients means that patients should receive as a default, copies of all letters written about their care."* (Cumming 2005, p86)

Whilst the hospital had an active Patient Liaison Group with membership of 10 patients and carers and 10 senior managers, nurses and doctors monthly, groups undertaking improvement work had limited contact or input directly from patients.

As a means of gaining support for recruiting appropriate patient involvement, I asked the Charge Nurse of outpatients what she thought about inviting patients to join the anticipated quality meeting (initially specifically to look at waiting times in outpatients). The Charge nurse agreed that we could try it and we decided to put the question to the front line staff at the next staff meeting. I attended the staff meeting and explained to the staff that I wanted to invite two members of the patient liaison group to attend the then quality group meetings (in which all staff were invited to attend). The staff voiced concern that they would not be able to speak freely in the group if patients were there and they were not enthusiastic. I suggested that it be trialled for 6 months to see if it was useful to which the staff agreed to the trial.

I telephoned the chair of the then hospital patient liaison group (which involved ex patients, current patients and their carers) to ask if there were two members of the group that would be interested in attending a monthly lunch time meeting with staff in the outpatient area with the view to improve the way outpatients worked. After consideration at a Patient Liaison meeting, the Chair said that he would be delighted to join the group and that his wife (as a carer) would also be keen to attend. Consideration was given by myself, the nurse manager and the wider outpatient team as to the dynamics of a husband and wife team. It was agreed that two would provide better support for participation than a single patient.

I then discussed with the Charge Nurse potential problems with the group dynamics but in the end we decided to keep the group informal without documenting terms of reference. Before the first quality meeting the Charge Nurse and I met the patient (Chair of patient liaison group) and his wife, gave them a behind the scenes tour explaining some of the treatment pathways, introduced them to staff and had a discussion about the experimental nature of the group. Many of the outpatient staff knew the patient representative and his wife who would be attending through being a patient at the centre. It was agreed at the first meeting that minutes

would be made and distributed via email and the notice board. It was agreed that the focus was primarily on solving waiting times, but other issues as they arose in the clinical area or from the Patient Liaison Group could be put on the agenda. The meetings were chaired by either myself or the Charge Nurse manager.

Despite my intention to set up the three strategies of the newsletter, quality group and staff survey in each area (ie medical records and outpatient department); the staff satisfaction survey was not set up in the outpatient department until 2006 (two years after starting the first strategy). This was due to prioritising the work from the quality group (which was considerable) over starting a new strategy – ie the staff survey. The Quality group was not replicated in medical records department. This decision was made following a discussion with managers, the patient representative and carer and finally the outpatient quality meeting group. It was felt that there was sufficient cross over from medical records to outpatients and that separate meetings were not beneficial therefore one of the medical records team leaders joined the quality group. Table 11 shows the starting period of each strategy in each department, each continued until I left the organisation in 2007 (I understand that the strategies continued after I left).

Table 11: Case study one – start dates for the three strategies

Date strategy started	2004	2005	2006
Quality Group	April 2004, Outpatient Department		
Staff Satisfaction	August 2004, Medical Records		August 2006, Outpatient Department
Newsletter	December 2004, Medical Records	January 2005, Outpatients	

The table shows the quality group being implemented in outpatients only. The other two strategies were implemented in both however they did not occur in outpatients until years two and three.

Phase 2:

Case study one - development of data collection methods

Data was collected using semi-structured interviews (with front line staff and their managers, see appendix 11) and from three types of written documentation (newsletters, minutes from the quality group and staff satisfaction surveys).

Case study one – development of semi-structured interview schedule

A semi-structured interview protocol was developed and used in three separate pilot interviews. The pilot interviews served to test firstly a unique facilitation technique using an adaptation of Kelly's (1979) repertory grid. I thought that this would provide a structured way to cover a number of topics within a short space of time (one hour). I hoped that this approach would allow data to be collected regarding staff views both of the strategies implemented but also on more general areas regarding relationships between managers, patients and front-line staff. The second reason for the pilot was to test types of questions which provided data about perceptions of engagement and thirdly the specific wording for the specific topics covered in the interview.

Initial questions posed were developed by myself from themes that had emerged from my experience in working with the three strategies and informal feedback from staff and managers about the process of change we had implemented (over the previous 2-3 years),see Appendix 16 . Questions also focussed upon some of the problems I had experienced in keeping strategies moving forward. For example I asked for participant views on "staff are encouraged to improve their service" and "managers work with staff to improve services". With regard to specific statements used in the

repertory grid, these were developed over several months by myself based upon themes derived from the literature survey and initial interviews in case study 1. For the purposes of the interview the statements were printed onto cards and examined as individual statements, discarded or tested within the pilot interviews. The repertory grid was developed by Kelly in 1959 as part of his Personal Construct Theory, to elicit understanding of participant preferences based on their personal constructs (Fransella and Bannister 2004, p5). However this research used an adaptation of the Personal Construct theory repertory grid in order to understand participant preferences. Where a question was not understood by a participant in the pilot, it was reframed/reworded or discarded. The three people involved in the pilot included a project person (who then became the interviewer for all the interviews in case study one in Wales), a manager (my line manager) and a person from front-line staff (a Physiotherapist). None of these people reported to the researcher. The pilot also determined the maximum number of questions to ask for a 40-50 minute interview. Modifications were made as to the best introduction and explanation of the repertory grid adaptation. This process informed the questions for the interviewer and the script for setting up the room, table and questions on the table. The questions were not substantially modified through this process however the numbers were reduced from 14 to 7-10. It was found that there was quite a lot of repetition of the questions plus the interviews were taking over one hour to complete. The feedback from the pilot interviews and the data collected seem satisfactory for the purpose of getting staff to talk about the issues of interest ie relationships between managers and front-line staff and the strategies that had been implemented.

A template was developed to summarise the data collected from the interviews by the outsider interviewer (see Appendix 16). The summaries were emailed (or hard copies given) to the interview participants to check accuracy as a form of respondent validation. The templates were made anonymous and then forwarded to me by email. Whilst I could see whether

the person was one of the two managers, I could not identify the front-line staff from the interview templates.

Repertory grid was used because it provided an opportunity to elicit a frank or contentious description of how a person may view the world (or part of it). Jankowicz (2004, p14) refers to four basic constituents of a grid – including topic, elements, constructs and ratings. He offers a number of definitions of a repertory grid including –

> *".. a set of rating scales which uses the individual's own constructs as the subject matter on which ratings are carried out."* (Jankowicz 2004, p14)

This research adapted from the pure form of repertory grid by providing the topic which was asking participants about the views on the relationships and responsibilities of managers and front-line staff, elements were the consistency with which managers and front-line staff were seen to undertake roles and responsibility and the constructs which were selected by the interviewer as "never, sometimes, mostly, always". The participants were asked to rate each topic against the constructs. This provided a replicable structured interview (across two case studies) and a technique which focussed views on issues thought to be important. It also provided an opportunity to discuss the meaning of the topic, elements and construct which a written survey would not have allowed.

The interview structure that was used allowed for comparisons in ratings between interviewees; however the main reason for ratings was to explore the gaps between current and desired states. Unlike repertory grid (part of personal construct theory methodology), the topics (statements) and constructs (never, sometimes, mostly, always) were pre-determined by myself, based on criteria derived from guidance on responses related to frequency/length of time responses (University of Nottingham 2013). This was designed to focus the interviewees on contentious and possible "back

stage" talk. Back stage refers to the Erving Goffman's Dramaturgical perspective from 1959 on social interaction where front stage and backstage are concepts used to describe roles people play at any given moment. He describes the self as "exposing separate components" "*back region control; team collusion; audience tact*" (Goffman, 1959, p253). The aim of the interview was to find out what staff "really" thought about the strategies- not what they might say at a formal meeting (or espoused). It also may provide an insight into tacit knowledge and deliberation. The adapted repertory grid was designed to encourage the participant to deliberate. Whilst individual deliberation is described as a discussion with oneself (Eraut 2000, p127), the process of asking participants to rate statements could be viewed as asking them to undertake reflective deliberation (Dewey 1998, p1). Its purpose being to make sense of and/or evaluate one's experience, including what one has heard and read (Eraut 2000, p127). A more open interview was considered, however as the researcher felt the need to use an outsider to carry out the interviews and the focus was on "back stage" talk, it was decided that this novel adaptation may prove useful in eliciting responses as well as drawing some comparisons between participant responses.

The participants were asked to rank pre-prepared constructs and then discuss their selections. Part two of the interview asked questions regarding perceptions of the changes that had been implemented (the final structure of the interviews is outlined below).

The intention of the interviews was to verify content by receiving specific feedback regarding perceptions of relationship between staff and front-line staff and what staff thought of the strategies implemented.

The list of potential interviewees was split into three groups – managers, patient/carers and staff. Table 12 outlines how the interviewees were stratified and selected.

Table 12: Case study one – interviewee selection

Interviewee group	Selection criteria
Managers x2	As there was only one manager for each case study, each was invited to be an interview participant .
Patient/Carer – Outpatient Department	There was only one patient and one carer involved in case study one, – both were asked to participate in the interviews.
Staff from 2x Departments – Medical Records and Outpatients	The process in Appendix 10 was used to stratify within the four front-line staff groups and to randomly select interviewees. Team leaders were classified under front-line staff as they all were involved in delivering services to patients and other staff.

An external interviewer carried out the interviews, collected the data and collated it for me. As all of the staff to be interviewed reported to me, I determined that this was a barrier to open disclosure and I selected an alternative interviewer. Training was prepared for the interviewer and included; a) being interviewed himself using the same process that he was to carry out in the real interviews, b) being provided with a written script to use during the interview and c) practicing the interview script several times over several days with myself prior to the interviews starting.

Each interview participant was given a set of statements typed onto card which they were asked questions about. Table 13 outlines the statements that were presented to each of the selected interviewees. Statements were based on the role that each of the interviewees played therefore not all questions were asked of each interviewee. The statements were selected by myself and were adjusted before each interview. The interviewer was informed.

Table 13: Repertory grid statements presented to each group of participants in Case study one

	Case study one questions by group	Managers	Medical Records Frontline staff	Outpatients Frontline staff	Patient/Carer
Actor involvement	Improvement work should involve front line staff		Y		
	Managers work with staff ot improve services				
Confidence	Staff fix problems				Y
	Managers fix problems				Y
	Managers know how to improve things			y	Y
Goal alignment	Staff want to improve patient care				Y
	Staff are encouraged to improve their services		Y	y	
	Manager and staff work together to make improvements	Y	Y	y	
	Staff see the need to improve their work	Y			
	Staff see improving their work as part of their job	Y			
	Staff are committed to improving care		Y		
	Managers want to improve patient care				Y
Knowledge	Staff know how well their unit/department is performing	Y			
	Staff get feedback on quality issues	Y		y	
Priorities	It is clear what managers see as priorities	Y		y	
	manager and staff priorities are the same				
Trust	Staff trust managers	Y	Y	y	
	Managers trust staff	Y	Y	y	
	Patients trust NHS staff				Y
	Patients trust NHS managers				Y
	Managers do what they say they will do	Y		y	
	Managers are concerned about the views of their staff	Y	Y	y	

Column one is the broad topic area which includes who is involved, goal alignment between the different groups, assessment of knowledge, priorities and experience of trust. The second column is the actual statements given to the participants. The remaining columns indicate which statements were given to which groups of participants.

The demographic details of the interviewees are summarised below in table 14. All participants who were interviewed were female. Of the 59 staff in case study 1 only one was male. This was representative of the hospital staff, which had a much higher proportion of female staff than male.

Table 14: Demographics of interview participants in case study one

Case Study One	Pseudonym	Demographics
Manager/Leader	Shelley	40-50 year old female, working in organisation for over 10 years
Manager/Leader	Susan	50-60 year old female, worked in organisation 4 years but 20+ years of experience
Front-line - Med Recs	Tina	50-60 female worked in organisation 3-4 years but 20_ years experience in clerical
Front-line - Med Recs	Stella	20-30 yr female with professional training, worked in organisation 1-2 years but with 5-8 years experience
Front-line - OP	Valarie	50-60 yr female, unregistered care staff, worked in organsiaiton 20+ yrs
Front-line - OP	Marther	30-40 yr old female, registered nurse, worked in organisation 1-2 years but with 5-8 years experience
Front-line - OP	Megan	50-60 yr old female, unregistered care staff, had worked in organisation 20+ years
Patient/Carer	Mark	50-60 year old male, retired, member of the Patient Liaison Group
Patient/Carer	Julie	50-60 year old female, retired, member of the Patient Liaison Group

Case study one – development of document data collection

The three strategies implemented in case study one meant that there were multiple sources of written documentation by which data could be collected. This included 22 documents in total ie 12 sets of minutes, 2 staff satisfaction surveys and 8 newsletters.

Document analysis was undertaken using a mixture of verifying content and identification of themes.

Table 15 outlines the data collection and thematic analysis focus for each of the documents in case study one.

Table 15: Case study one – data collection and thematic analysis

Document	**Case study one - data collection and content analysis**
Staff **newsletters**	Thematic analysis of the staff newsletter was

	undertaken (and themes subsequently used for other documentation analysis). Where data did not fit an already identified category – a new category was made. Each Newsletter was reviewed and where there was evidence that an item existed this was marked/coded on the paper newsletter (appendix 9 – sample of newsletter coding). Each coded element was logged onto an Excel spread sheet under the date of the newsletter. Analysis was undertaken by taking each of the items (pieces of paper that described subjects) and clustering like with like. Each heading was broken down to sub-headings as shown in appendix 9.
Staff **survey** questionnaires	Each question in the staff satisfaction survey was to be coded thematic analysis and clustered under single or multiple themes – the broad categories that were used, were identified in the newsletter analysis. Where there were data items that did not fit with the original 3 broad categories – new categories were generated. Because there were only 19 questions in each survey, each one was examined for links with a theme.
Quality group **minutes**	The quality minute analysis was expanded to enable possible examination of social processes as well as topics/subjects and included: • staff analysis – number, attendance • thematic analysis including subject range and thematic analysis., • analysis of the goals, methods, actors and conflict.

Phase three

Case study two – development of interview schedules

The Emergency Department North Island Hospital, NZ (pseudonym) had 130 FTE nursing staff and 20 FTE Doctors plus support staff including clerical, orderlies, Social Work. It was located in a large district general hospital in a metropolitan area in New Zealand. The Emergency department was led by a triumvirate structure – Clinical Leader/Doctor, Nurse Manager and Service manager. The department saw on average 160 patients per day. Similar in size / service to a District General Hospital in Wales.

The aim of the research was to understand the experiences of the staff that were involved with a major change programme - achieving the 6 hour initiative (Ministry of Health, 2011). Appendix 19 outlines the aims for this national programme in New Zealand. The interview structure was designed to encourage interviewees to give their personal and professional views on the changes that had occurred.

Eliciting participants – data collection strategy

A convenience sample was sought from those within the Emergency department. This was achieved with the help of the nurse manager (who did not report to me) who agreed to circulate a group email to all nursing staff inviting volunteers to be interviewed as part of this study. Each person received a ethics participant information sheet (and a consent form to sign) and the list of questions that were to be asked at the interview (Appendix 5). Two volunteers were sought from the front line staff group, however as three Registered nurses responded, it was decided to conduct three interviews. Three Manager and Clinical Leaders were also invited to be interviewed due to their leadership positions within the department (see Table 16). Unlike in the first case study where an outside interviewer was utilised, as I was not involved in direct line management, I undertook the interviews. The participants that were managers, were known to me, the front-line staff were not known to me.

Table 16: Demographics of interview participants in case study two

Case Study Two	Pseudonym	Demographics
Manager/Leader	Annabell	40-50 year old female, working in department for 3-5 years
Manager/Leader	Vicky	30-40 year old female, working in departmetn for 5-10 years
Manager/Leader	Daisy	50-60 year old female, working in the department for 30 years
Front-line, Emergency Department	Sarah	30-40 year old femae, working in department for 5-10 years
Front-line, Emergency Department	Lucy	30-40 year old femae, working in department for 5-10 years
Front-line, Emergency Department	Steve	50-60 yr male, working in department for 10+ years

The first interview was used to pilot the questions and structure. As this interview yielded high volume data it was decided to utilise this interview as part of the data source. No modifications were made to the questions, however I modified my technique to ensure that the questions posed were clearly understood and answered more fully. Part two of the interview was also piloted at this time. This part of the interview replicated the adapted repertory grid used in interviews case study one. After the first interview, I decided that no modifications were required for this part of the interview. This was based on the respondent of the first interview finding the technique acceptable and it generated considerable discussion focussing upon the research questions.

In part one of each interview, participants were asked what changes had occurred in their work areas over the last 18 months, from their personal, professional and organisational perspective. They were asked what differences the changes had made to their clinical practice and the experience of patients.

Part two of the interview used the same structure as in case study one where a set of statements were typed onto a card (see table 17). The participants were then asked to place each statement on the word that best reflected their answer.

Table 17: Repertory grid statements presented to each group of participants in Case study one

	Case study two questions by group	Manager/leaders	front-line staff
Goal alignment	Staff are encouraged to improve their services	Y	Y
	Managers and staff work toghether to make improvements	Y	Y
Priorities	Managers and staff priorities are the same	Y	Y
Trust	Mangers trust staff	Y	Y
	Managers are concerned about the views of their staff	Y	Y

The interviews were transcribed by myself using voice recognition software called Dragon Dictate (Nuance 2012). The process for transcription was to listen to small sections of the recorded interview and repeat the exact words into a digital microphone which was then processed through Dragon Dictate into written text in a Microsoft word document. This process allowed me to undertake a fast transcription process without using a professional transcriber. It also allowed me to listen to the interviews in detail and become immersed in the data. For example 50 minutes of interview took 90 minutes to transcribe (including simple sentence editing - comma, full stop and voice part labelling). As I use a touch typing technique, I tried to transcribe straight from the interview. This process was not as fast as using the voice recognition software. It was necessary for me to verbally transcribe (speak) into the voice recognition software because the software requires training to a voice. The software cannot transcribe from an interview speed of conversation and the software being untrained to all the voices. The downside to this approach could be that important inference and meaningful intonation was lost, however, in order to note this form of data, the actual audio file was reviewed again as part of developing thematic ideas – non verbal expression was captured in the thematic part of the process. In order to understand the data and underlying inferences I went back many times to listen again to the data in order to immerse myself and glean new meaning.

Following transcriptions I reviewed the typed manuscript searching for data elements that were related to questions like - "What's going on?" and "What is the main problem of the participants and how are they trying to solve it?" (Glaser and Strauss 1967). Once a data element was identified it was given a footnote (with the statement, a reflection or insight in italics).

As the elements were identified in each transcript, they were recorded as a footnote. Each of the data items/footnotes were turned into endnotes and copy and pasted into an exel spreadhseet (one set of foot notes for each participant). These individual data items were printed out and cut up into individual pieces of paper (and each piece of data from the interview was kept separate at this stage). Data items that were similar in theme were placed together into piles. Each pile was reviewed and given a title related to the data that it described. Items were moved around until they fitted with the theme title.

Each item of data was identified with the participants name, profession and footnote number (so that each data item could be tracked back to the context of the individual interviews if required) appendix 20. This meant that the coding and tracking back to the interview was efficient and tried to maintain links with the context including the prescence of non-verbal cues which can be missing or discarded (Silverman 2005).

The constant comparitive method was used to analyse the data. This included:

> *"comparing incidents applicable to each category, 2) integrating categories and their properties, 3) delimiting the theory and 4) writing the theory* (Glaser and Strauss 1967, p105)

The three interviews from the front-line staff were analysed followed by the three manager interviews. This was carried out to allow front-line staff data to emerge before the manager data was considered. As a manager, I was aware that I carried significant bias and felt that I needed to study the

front-line staff data which carried significant negativity to the change before analysing the more positive manager data. Once all data had been entered into a spreadsheet a further analysis was undertaken to compare between interviewees and within interviews searching for themes which may be constructed and provide explanations as well as abstracted features of the data related to labels or states, behaviours and processes.

The second level of constant comparison involved developing large clusters of similar data items which may start to describe phenomena and themes. This involved filtering and sorting spreadsheet categories multiple times, going back to the original transcript to see if other data could be utilised to describe links to the data. I repeatedly revisited the original transcriptions and audio tapes to check and look for any missing meaning.

Reflection on project activity

The project activity had two distinct phases which largely followed the timing of data collection of the two case studies. The impact that the interviews from case study one had on my understanding of my rather 'technical' approach to change cannot be underestimated. Detailed analysis focussed on documents that I had hoped would validate the work we had undertaken. Analysis of the interviews occurred after the document data had been analysed. The interview data in many was disappointing because it did not show what I thought it should show. I thought that staff would concur with my understanding about our success. What it raised was a large number of concerns about my abilities as a manager as well as staff that I worked with to undertake quality improvement activity. This created more of a 'confirmation' rather than an 'aha' (seminal) moment. The data from the interviews aligned with what I had suspected might be the case, thus fuelling my interest in social factors involved in change. The second case study was ideal for looking in-depth at social factors of a department making big changes. Whilst I was surprised once again by the level of negativity held by some of the participants, I was heartened by others who had doggedly keep working to make meaning out of what they were doing and create a positive environment for themselves.

Summary

The project activity was based on three phases of activity. Phase one was the implementation of three strategies in case study one – a quality group including patient/carer, a staff newsletter and a staff satisfaction survey. The implementation occurred over 3 years (2004-07). Phase two included data collection in the form of analysing written documents from the implementation (minutes, newsletter and surveys) as well as interviews with front-line staff, a patient and carer and managers from the departments. A semi-structured process was undertaken to identify data in paperwork related to staff and manager activity. Nine semi-structured interviews were conducted by an interviewer external to the department (as I was the line manager). The interviews utilised an adapted repertory grid and investigated staff, patient/carer and manager views on relationships between staff and their experiences of the strategies implemented (anonymised examples of interviews and thematic analysis in Appendix 20).

Phase three gathered data via interviews from staff within the emergency department. Interviews explored personal and professional views of the changes that had occurred. The same adaptation of repertory grid as used in case study one, was used to explore staff views on relationships between front-line staff and managers. Interviews were transcribed and analysis of the data included use of constant comparison analysis.

Chapter 5: Project Findings

Introduction

The first section in chapter five outlines the findings from the two case studies. It includes the data gathered from the written documentation and the semi-structured interviews. The second section presents how the thematic analysis informed the development of a model.

The first set of data is from content analysis of the Newsletter strategy. This includes thematic analysis of the written newsletters as well as interviews with staff on the same topic.

The second set of data was collected from the written staff surveys that were developed as well as interviews with staff on their views about the strategy. Themes identified in the written newsletters were used as a starting point for the analysis of the newsletter data. Additional themes were identified in the staff survey data which were thought to be significant. Further data was gathered in the staff and manager interviews about their experiences and views receiving and contributing to the newsletter.

The third section of data from case study one was analysis of the minutes of the quality meeting strategy. This analysis expanded from thematic analysis to also explore type and frequency of staff involvement, topics of the meetings covered, how often subjects were discussed and what the range of topics were. It also looked for specific data concerning conflict, actors involved. Presentation of data from interviews is also included in this section.

Conclusions from the findings of case study one are drawn together and presented. The findings demonstrate a justification in the change of focus for case study two.

The second case study data is presented in the form of emerging themes and identification of theoretical concepts. Concepts/theories are then presented for further testing and verification in the interview data. Conclusions regarding case study two are presented in terms of how the theory builds using the findings of case study one and presents new concepts.

Part two of this chapter is primarily focused upon drawing together the findings from both case studies and present unified findings which justifies the presentation of a new model for transformative engagement.

Findings from case study one

Findings from Newsletter – (case study one)

Eight newsletters were retrieved from a 27 month data collection period. Each newsletter was between 500 and 750 words in length and contained 4 to 6 graphs. Each newsletter was co-written by me (prior to designing the data collection to include the newsletter). At the time they were written it was not known that they would be analysed as part of a later research study. The other co-writer was the manager of the department. The newsletters were available within the public domain and so do not breach confidentiality.

The headings in the newsletter included – news, risk, projects on the go, comings and goings, money, and on-going issues. Each topic was dealt with briefly and there was space around each heading (ie not dense writing). Each newsletter also contained 4-6 clip arts and made up 3 to 6 pages of A4 9 see appendix 6 for an anonymised example copy.

Each newsletter was reviewed and where there was evidence that a theme (category) was present, a code was entered onto the paper copy by hand. If a new category was identified, I went back through the previous newsletters searching for data items that may fall under the new category. The constant process of verification of the data theme required further

verification in all documents. Appendix 9 is an example of how each of the newsletters were annotated with the categories. The themes were grouped together into three high level headings including Human Resources (HR), performance and risk. The categories for the content analysis were derived from the data – ie as each item was identified – it was categorised with either a previously identified theme, or a new theme was generated. Appendix 13 shows how the themes were developed.

The outpatient newsletter was late to be implemented due to work undertaken with the quality group – which also provided information a forum for quality improvement. The newsletters were written and distributed as a shared task between the manager for the area and myself. Whilst it was planned that there would be staff input, this did not occur and the newsletter was management initiated and driven. The purpose was to share information with staff and monitor how initiatives were going – therefore providing feedback.

Summary of Document Analysis for the Staff Newsletter (case study one)
Thematic analysis revealed a strong focus on human relations (relationships and sickness) and performance (productivity and risk identification) – see figure 7. A second level of analysis was carried out for recurring themes within the newsletters. These were clustered with related items in terms of content.

The three themes of human relations, risk and performance are no surprise to a largely manager driven newsletter. With no front-line staff contribution we focussed on the things that "kept us up at night" that we felt it important to share with staff. In retrospect the coded elements demonstrated a negative and critical stance by management on front-line staff. Whilst there was reference to action plans and people being involved in projects; the most frequently cited subjects related to risk. The theme of risk was considered to really be about problems with what staff were doing; risk was defined as identification of problems and monitoring.

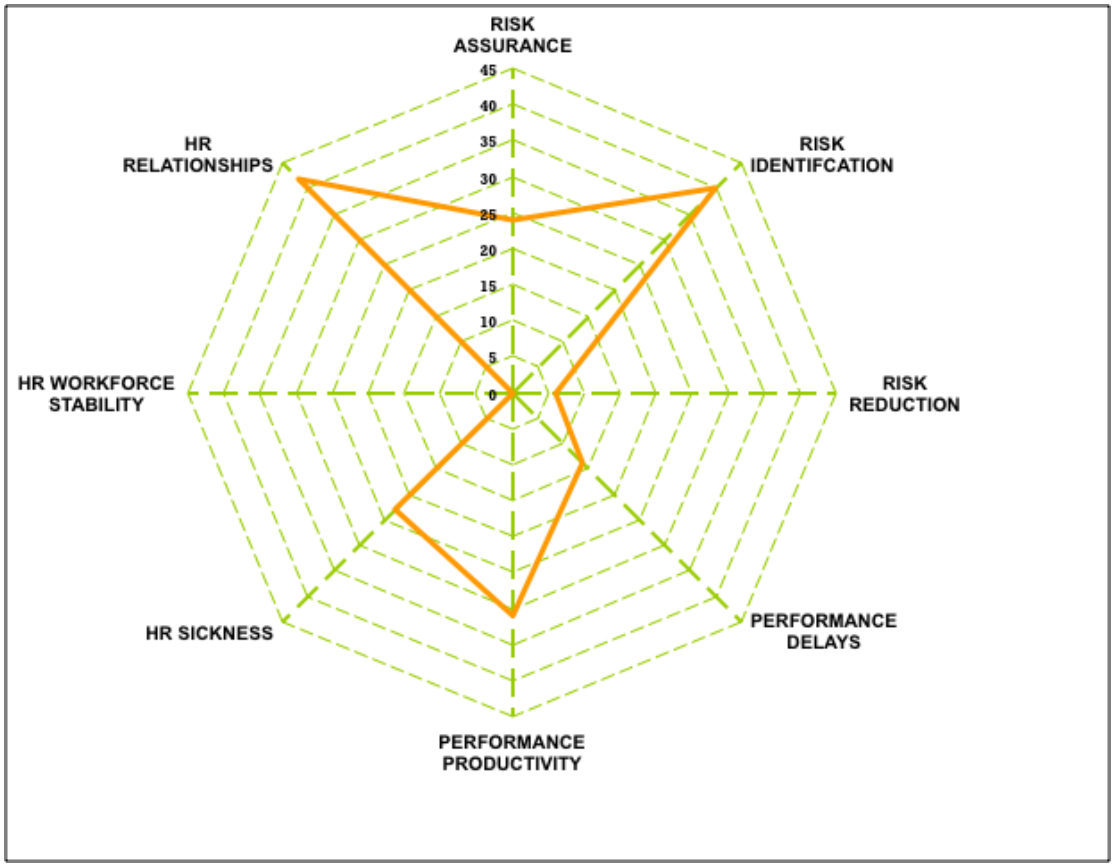


Figure 7: The number of categories identified in the thematic analysis for the staff newsletter (analysis of case study one)

Summary of Interview Analysis for the Staff Newsletter

The newsletter was viewed positively by the front line staff member and managers who were interviewed. Feedback on the newsletter is found in appendix 13. The newsletter was reported to be a positive communication tool for spreading information. The two main negative reports were that it needed to be more frequently published and that it was too time consuming to produce.

Findings from quality meeting – (case study one)

A search was carried out at the NHS Trust for the minutes from the Outpatient Quality Group (from April 2004 to December 2006). This involved searching the files on four different staff computers. All notes that were retrieved were included in the document analysis (ie none were

excluded). Twelve sets of notes were retrieved out of an estimated 15 meetings. As a centralised database for storage of minutes and notes for meetings was not in operation at the time (plus two members had left the department) – the minutes were not stored in easily identifiable locations to be retrieved easily.

Table 18 shows the date the meetings were held (for the 12 sets of minutes extracted) the number of attendees documented at each meeting and the proportion of the meeting made up of front line staff i.e. Staff Nurse, Assistant, Clerical and a Phlebotomist. The maximum total number of staff employed in the department at any one time was 15.

Table 18: Dates of quality meetings where minutes collected.

Meeting date	Staff	Managers & Patients/Carers	Total	% Front line staff
04/21/04	8	3	11	73%
05/19/04	7	3	10	70%
07/21/04	5	4	9	56%
08/18/04	5	4	9	56%
09/20/04	4	4	8	50%
01/19/05	6	3	9	67%
05/04/05	6	2	8	75%
08/31/05	4	4	8	50%
02/15/06	3	4	7	43%
05/17/06	3	2	5	60%
10/18/06	6	4	10	60%
11/15/06	5	3	8	63%
Total	62	40	102	61%

Table 19 shows how often each of the identified staff members attended the meetings during this time period. This table shows that the highest regular attenders were the patient/carer and managers.

Table 19: Frequency each person attended

Attendee by category	Number of attendences (maximum 12)
Patient/Carer A	10
Manager A	10
Manager B	10
Staff Nurse A	9
Patient/Carer B	8
Assistant A	7
Clerical A	7
Phlebotomist A	7
Assistant B	5
Staff NurseB	5
Staff Nurse C	5
Assistant C	5
Staff Nurse D	4
Phlebotomist B	3
Clerical B	2
Manager C	2
Clerical C	2
Staff Nurse E	1
	102

Over this period only 2 members of front-line staff worked full time in the department and barring holidays were routinely available for the quality meeting. Other staff were offered additional payment for attendance (in addition to their rostered hours). 6 staff attended more than 7 times and both patient/carers attended more than 7 times indicating a core group of regular attenders. In summary there appeared to be a core of staff that attended regularly and they were a mix of managers, front-line staff and patients/carers.

Thematic analysis, whilst predominantly used in mass communication has been used for other documents including diaries, speeches, minutes of meetings (Robson 2002, p353). The constructs used in the content analysis were selected because they could be linked to answering the original research questions.

Table 20: Justification for construct categories in content analysis

What knowledge do health sector middle managers require to undertake transformative engagement with staff and patients?		
Constructs described by Robson (2002) as: *Subject matter – what is it about?* *Goals – what goals or intentions are revealed?* *Methods – what methods are used to achieve these intentions?* *Actors – who is represented as carrying out the actions referred to?* *Conflict – what are the sources and levels of conflict?* Source: Robson 2002 pg. 355		
Research questions	**Construct categories selected for analysis**	**Why these constructs were selected**
Are there changes to the team as a result of the implementation of change strategies?	Actors/conflict/method	Were there a few people involved or was engagement widespread
What features of the strategies were important for managers and front line staff?	Actors/Subject/Goals	If there was engagement (as seen by attendance at meetings), what sort of subjects or goals were described.
Were the strategies perceived as useful and sustainable?	Conflict	Was there open discussion or was it closed.
What "governance" themes emerge following implementation of the strategies?	Subject matter/method	What was the discussion about – could it be judged as important, relevant or trivial and of no value

Table 20 provided focus for analysis linking the analytical frame (outline in table 3, chapter 3) with specific interrogation of the data from the written

documents. Appendix 14 shows the full analysis of the quality group undertaken. Whilst this analysis is a proxy for "what actually happened", it provided data regarding the effectiveness of the strategies employed.

Summary of document analysis for the quality group

There was evidence that there was a mix of front-line staff, managers and patient/carers in attendance at the Quality Meeting. There was evidence of regular discussion of some subjects. The subjects that were most commonly discussed were the clinics. Performance and risk were the highest categories of topics to be discussed.

The most common methods identified from the minutes were; information sharing, discussion/opinion, plan to change work processes and review of data/information.

The actors identified as most commonly raising issues were the managers and patient and carer. Those with responsibility to resolve issues at the meetings were recorded as myself (manager) and the Charge Nurse Manager. This would suggest that this group was largely driven by the managers and the patient/carer and not the front-line staff. Whilst in many respects this was expected, it was disappointing to me as a manager that the meetings appeared to be so reliant upon the managers to instigate next steps for projects. Front-line staff did not "take over" the running of the group which was albeit unstated aim of the quality group.

Conflict was identified in the minutes – although there was limited understanding as to how this was dealt with. A number of conflict issues appeared related to meeting the expectations of patients and identification of new problems.

Case Study one: Front line quality meeting – interview analysis

Six participants were interviewed about the quality meeting; three staff, two patients and one manager. Each participant was asked three questions

about the Quality Group – "what is good about the quality group?", "what is bad about the quality group?" and "if you were to form a quality group would there be anything you must do to ensure its success?"

Positive responses from participants included that the group was inclusive, provided a forum for discussion and debate, allowed face to face communication and ensured accountability of the managers.

> *"Because it"s face to face it's all very real and is less easy for managers to ignore patient views especially as the patient representative is sitting in front of them"* Mary, front-line staff member in outpatients (case study 2).

> *"Initially I felt that there was a little bit of scepticism from staff as to why patients/carers were attending "their meeting" however this quickly dissolved when they realised that we weren"t there to criticise but to help and to provide constructive ideas and feedback from our and other patients' personal experiences. I now feel very comfortable attending the groups and feel that we are listened to".* Joanne, patient/carer representative in outpatients.

> *"The other good point was that it was a very open environment and we got to talk about issues that I would imagine within other departments were only discussed at Senior Management level"* Jane, front-line staff member in outpatients

Negative response from participants included that the group was controlled by the chair (myself) which the participant did not think allowed enough discussion, had poor attendance leading to poor continuity, not frequent enough, patient/carer were not representative of all patients and many staff had to turn up as an extra duty.

> *"… I felt the chair always drove the agenda to suit them… also I thought that the chair of the meeting was a bit controlling and didn't give us sufficient opportunity to discuss issues that we wanted to."* Jane, front-line staff member in outpatients

> *"The worst thing about the quality group is that there is never a very good turn out by staff especially as our manager often expects us to turn up in our own time when we are not getting paid"* Mary, front-line staff member in outpatients.

> *"… we tended to talk about the same issues every meeting and often these were issues that we couldn't do anything about such as lack of space, lack of rooms."* Joanne, front-line staff member in outpatients

Suggested improvements in the quality group included trying to achieve more regular attendance increase regularity of meetings back to monthly and improve timeliness for minutes and actions.

Appendix 20 provides more detailed quotes from the views of participants. This information is split between staff (front-line and manager) and patient/carers. It demonstrated the diversity and conflict in views which meant that I found it difficult to ascertain whether the quality group generally good or generally bad. The need and goals of the quality group were generally thought to be good however the execution appeared to be weak or flawed. This was a familiar theme from the previous approach (of the newsletter) and was a recurrent theme in case study one.

Summary of interview analysis for the quality group

A summary of the positive points concerning the front line quality group included – the mix of staff and patients was liked. It was reported to be viewed as an open environment in which staff could contribute. It was

viewed as a vehicle for managers to be made accountable for actions and listening to patients. Staff and patients/carers suggested that they needed to be held more often. The patient and carer interviewed were very positive about the Quality Group and felt reported improvements had resulted from the group, they reported that they were able to make a good contribution to the group and felt comfortable working with staff in the group.

There was some concern by staff that patient views may not represent all patients and that there was too much control from the chair. There was concern that the same issues were discussed each meeting and that these were not things that could be solved. There was concern that there was frustration as to how quickly recommendations could be acted upon. The patient and carer reported some frustration regarding poor continuity of the meetings and actions not carried out in a timely way.

Summary of findings on quality group

The findings from interrogation of the documents would suggest that the quality group achieved what it set out to achieve – ie to engage front-line staff and patient/carers in improving services and specifically waiting times in outpatients. Interviews with participants involved in the quality group however suggests that this group was largely driven by the chair (me) in that agenda items raised and actions carried out were largely actioned by myself (or the charge nurse managers). This would suggest that participants in the group may have been described as willing participants as opposed to equal partners fully engaged in a process of change. To this end it would appear that this group whilst focussed on important issues for patients and front-line staff and included representatives from both, failed to achieve the level of engagement desired.

Findings from Staff satisfaction (case study one)

Case Study one: Staff satisfaction survey – content analysis

There were two satisfaction surveys developed, one for medical records one for outpatients. Each survey was developed using a semi-structured approach to gain a consensus over the items/questions to include (appendix 7).

Each survey was analysed separately and the detailed analysis is shown in appendix 15. The items identified in thematic analysis were strongly linked to risk, performance and HR. The two quality improvement areas without strong links were sustainability and innovation. Further analysis regarding characteristics associated with integrative (and innovative) cultures revealed that there were a number of items that were not selected to form part of the survey content. Omitted items included rate and spread of change, level of autonomy, attitude to new ideas, type and frequency of feedback, satisfaction with how staff contributions are received and actioned and resolution of problems.

Case Study one: Staff satisfaction survey – interview analysis

Front-line staff from both departments (2 from medical records and 3 from outpatients) were asked what they thought of the locally developed staff satisfaction surveys. There was significant negativity from front-line staff about the surveys. Appendix 23 provides a summary of quotes related to the main questions. Below is data collected as part of the interview regarding front-line staff views on the staff survey.

> *"... my experience at …. is that every time I have completed a survey I have had no feedback whatsoever as to my comments and I have never witnessed anything actually change as a result of people completing a staff survey."* Mary, Outpatient front-line staff

> *"The staff surveys that I have completed have been a waste of time as nothing positive has changed following them. This is because we give our opinions and then nothing is introduced as a result of these opinions and therefore nothing ever gets better."* Sharon Medical Records, front-line staff.

The staff did not find the Staff Survey to be a positive experience mainly because they did not see any change following the survey findings. Whilst there was acknowledgement that staff views could be raised anonymously (and this was viewed as helpful) there was over whelming criticism of a lack of perceived follow up action.

The conclusion that one may make at this time is that the managers didn't follow-up on the findings of the survey, either the problems were too great or perhaps they became distracted by another priority. One of the benefits of being an insider is that this interview information is extremely interesting and valuable because there were a number of initiatives that were generated and kept alive as a result of feedback from the staff satisfaction survey. For example the question concerning "tracking of notes" which appeared in the medical records survey (see appendix 6). This involved a whole body of work about why medical records went missing, where they went missing, after what activity. It was reported extensively in the newsletter and additional equipment was bought to make the tracking of notes using a bar code reader easier as it was thought that this was a barrier. Another example would be the change in cover for the secretaries. There was a lot of dissatisfaction from the secretaries about the cover that was provided when they went on leave – this made for a stressful environment particularly when secretaries returned from holiday. We (as in myself and the manager of medical records) worked with staff to try and solve this problem and we came up with a shared solution that involved changing the "cover" secretaries from the most junior to the most senior secretaries. In other words the more experienced secretaries were more able to provide cover for multiple consultants than the more junior staff.

This solution was suggested by staff and was welcomed by the staff who agreed to change roles.

Feedback from the staff surveys (from the managers) was more positive. Appendix 24 includes more detailed statements from the two managers interviewed. One manager reported a positive view of the staff survey and the other held a more negative opinion. The second manager reported concern that front-line staff would focus upon complaints and indicated that she did not think this would be helpful.

> *"The results of the survey can demonstrate whether or not changes that have been implemented by managers for example, have actually worked or not. Finally, staff surveys can help to motivate managers as obviously you want to get a "better score" from staff from each survey."* Margaret, Manager

The first manager, whilst more positive about the survey, felt that perhaps external factors (outside her control) could be reflected in the survey and felt that this was not necessarily fair.

The contrast in data gained from interviews creates an interesting and clear line in views between front-line staff and managers. Front line staff were unanimously opposed to the staff survey because they didn't see change in relation to the survey. The managers generally supported the survey because they said that it gave them additional information to work with.

Summary of interviews for the staff satisfaction survey

Staff reported that they did not find the staff satisfaction survey useful in that they did not see any follow up from managers to address the issues raised as part of the survey. Most staff acknowledged that it was an opportunity to provide views and opinions however they expressed disappointment that this information was not used by managers. There was

a strong feeling from staff that managers should follow through with actions following staff giving their opinions/views

One manager voiced concern that the survey focused upon negative aspects – complaints. The other manager said that the survey could reflect how staff felt in reaction to aspects of the department outside her control. There was not an overall positive view of the staff survey

Interview data concerning repertory grid (case study one).

Appendix 16 shows the findings of how the nine interview participants responded to the statements given to them i.e. they were asked to place them on the continuum of never, sometimes, mostly, always. Some questions were asked of only one group about another group. The questions were grouped under confidence, goal alignment, knowledge, priorities and trust.

The patient and carer reported that they had a higher confidence in staff being able to fix problems over managers being able to fix problems. Front line staff and patient/carer reported that managers know how to improve things sometimes and between sometimes and mostly.

In goal alignment patients and carers reported that both staff and managers want to improve patient care "always". Staff views were wide ranging when it came to staff being encouraged to improve services and working with the manager to make improvements. Some thought this was in the "always" category and others placed it in the "never" category. Managers reported that they felt this was to be located in the "mostly" and "always" categories.

Managers reported that staff received feedback on how their department was performing at the "always" category. However, staff reported this was only in the "sometimes" category.

With regard to issues of trust – frontline staff, patient/carer and managers agreed that manager and staff trust was between "sometimes" and "mostly". Frontline staff responses were split regarding management concern for the views of staff. Managers reported that they were mostly/always concerned about the views of their staff.

Whilst the number of responses was small, there was quite a split between how managers were perceived by front-line staff. The three questions in which managers were positive (always) and front-line staff were negative (sometimes) were "managers and staff work together to make improvements", "staff get feedback on quality issues" and "managers are concerned about the views of their staff". This dis-connect in perceptions became a focus of interest and was explored further in the second case study.

In addition, participants were asked to assess if any of the three strategies would be useful to improve performance against each statement.

Front-line participants were asked *"which of the tools/strategies do you think may be helpful to improve each of these gaps?"* (if they have identified gaps in their work related to the statements).

For example if the participant had classified a statement as "never" they were asked if in their view, any of the strategies may be helpful in improving this situation.

Table 21 identified that the quality group was identified the most appealing in addressing almost all areas of discontent.

Table 21: Which strategy addresses which gaps – what participants thought

Case study one	Case study one questions by group	Quality group	Staff newsletter	staff survey
Actor involvement	Improvement work should involve front line staff	3	1	0
	Managers work with staff to improve services	4	2	3
Confidence	Managers know how to improve things	1	0	1
Goal alignment	Staff are encouraged to improve their services	4	3	0
	Staff are committed to improving care	2	2	1
Knowledge	Staff know how well their unit/department is performing	0	1	1
	Staff get feedback on quality issues	2	2	0
Priorities	It is clear what managers see as priorities	1	1	1
Trust	Staff trust managers	3	0	4
	Managers trust staff	3	2	0
	Managers do what they say they will do	1	1	2
	Managers are concerned about the views of their staff	3	1	5
		27	16	18

The quality group was identified as the most useful in addressing a high number of issues. The staff newsletter and the staff survey were seen as useful strategies but clearly were not seen as useful as the quality group. Staff also gave additional feedback on their experience of the strategies. In the response from Tina who identified the staff survey was useful for "managers to show concern about the views of their staff –

> *"The fact that managers give staff the opportunity to give their views demonstrates that they are concerned about staff views and opinions. However staff will only feel that their concerns are really genuine if they then act upon any issues identified by staff. If they don't actually act upon any concerns expressed by staff then this can actually prove to be detrimental as staff will feel that the survey was just a "token effort" and a way of ticking a box to say that it had been done"* Tina, front-line staff

Conclusion of the findings from case study one

The aim of this work was to study the impact of three strategies on quality improvement work and participants involved with the strategies (managers, front-line staff and patients/carers). When the data was collected from thematic analysis (from Front-Line Quality Group minutes, the Newsletter, and copies of the staff satisfaction survey) and interviews, it was examined according to the analytical frameworks developed for the areas of study and ultimately to answer the research questions.

Appendix 17 provides a high level summary linking findings from documents and interviews back to the frameworks explored (as outlined earlier, see page 78). For example total quality management provided three areas of interest for this study – the type of improvement undertaken, the process used to do the improvement and who was involved in the work. Document analysis and the interviews support that there was evidence of important quality issues being worked on, there was also evidence of a structured process (use of Plan Do Study Act cycles) and evidence of managers working with front-line staff and patients/carers.

The framework for change management included honourable, trustworthy and legitimate concepts for exploration. The data particularly from the interviews demonstrated that there was a significant miss-match between the data collected in the document analysis and what front-line staff reported in interview. Feedback about leadership showed a similar miss-match between the findings from the relatively positive documentary data and findings from the largely negative interview data.

The three strategies were not effective in getting front-line staff, managers and patients/carers to focus upon service improvement – this was evidenced in the difference between the document analysis and the interview data.

Documentary evidence was more positive about the nature of the strategies than the feedback from staff. Managers were more positive about the strategies than front-line staff. The dis-connect in the views between managers and front-line staff provided the basis for the addition of the second case study.

Figure 8 shows the original plan for triangulation of the data from case study one (referred to on page 95). It also shows where I have concluded that there is a failure to cross-validate. The documentary analysis evidence is not supported by the in depth analysis of interviews – I have therefore

shown this as a red line on the triangulation diagram – i.e. there was evidence of a dis-connect between what front-line staff said and what managers said and documented. In addition, my personal reflections as an insider researcher are also in conflict with the in depth thematic analysis of interviews.

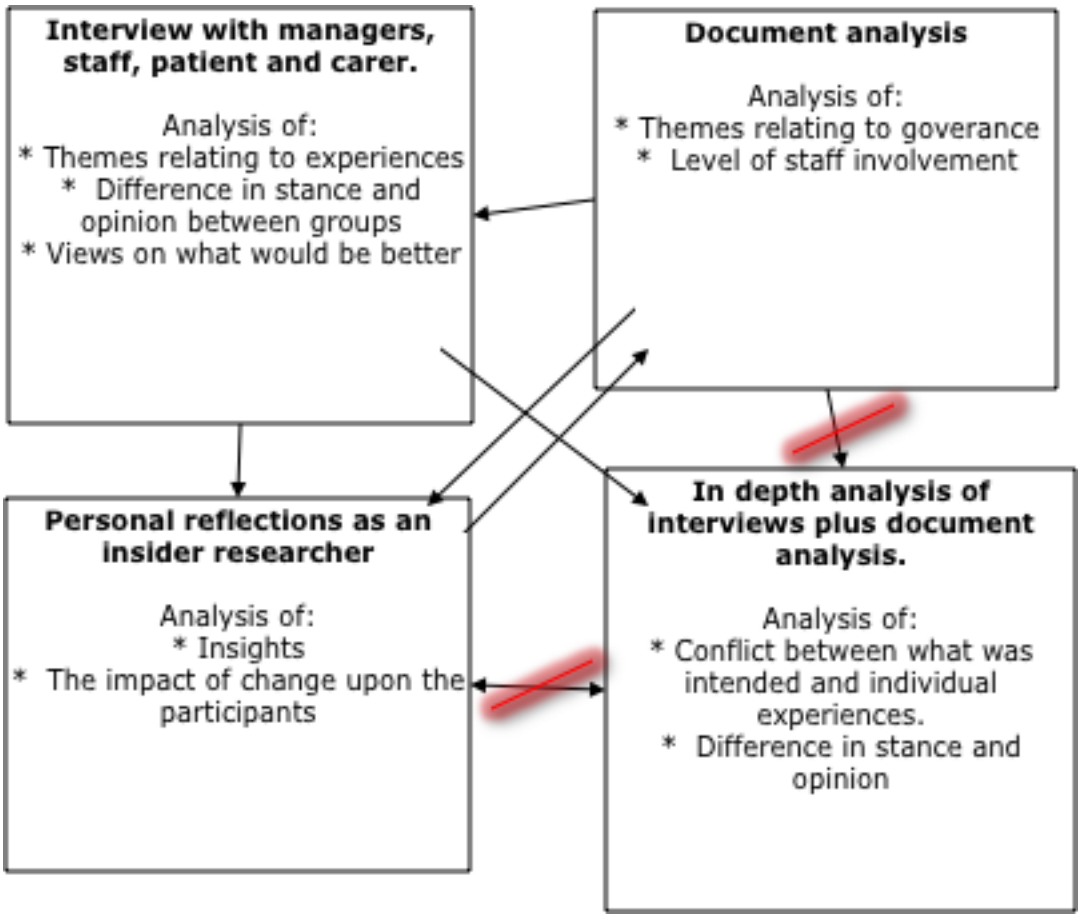


Figure 8: Triangulation of data from case study one (including red lines where the data failed to cross validate).

From this analysis three key themes emerged for further discussion and exploration. These were

a. Data analysis suggested that front-line staff identified a number of shortcomings in management behaviour with regard to follow-up and accountability,

b. Data analysis also indicated that front-line staff did not see that managers were responding appropriately as a result of front-line staff feedback.
c. Data analysis also suggested that managers a) were not aware that there were major failings in their implementation of the strategies and b) did not deliberately seek to sabotage the strategies.

The strategies failed to deliver on the level of engagement desired. Front line staff were positive in theory about the strategies (as evidenced in the interview regarding benefits of the strategies) however they reported that their experience was different to what they thought it should be. Front line staff reported that the strategies were poorly implemented and managers did not meet their expectations in terms of the follow-up from the strategies. Front-line staff did not recognise the changes that had occurred (that from the managers point of view were put in to address the front-line staff concerns). Front line staff did not believe that managers were working in their best interests. Managers on the other hand perceived that they were working with staff, had good strategies in place and were working hard to achieve engagement.

Findings from case study two

Case study two participants were from a large district general hospital in New Zealand. They were all from an emergency department who had undertaken a change process to achieve "shorter waiting times in the Emergency Department (ED) (appendix 19).

The interviews followed a similar format to the first interviews and again lasted between 40-60 minutes. The interviews involved a section adapted from a repertory grid and semi-structured interview questions (see appendix 5 for participant information and questions asked). Volunteers were invited to participate via a letter to all staff (by email) via the Nurse Manager of the department - participants volunteered to be interviewed. The manager

and medical participant (referred to as manager/leader) were asked by the researcher to be interviewed due to their unique positions.

Each of the individual interviews was held face to face with myself, audio recorded and transcribed by myself. There were 6 interviews in total. Three interviews were with front-line staff (registered nurses) and three with staff in management (one clinician who was a clinical leader (doctor), one service manager and one clinical charge nurse.
It was explained to each interviewee that the interview information would be made anonymous before publication and that it would be held in confidence by the researcher to encourage each participant to speak freely.

All of the participants explained that they were supportive of the shorter waiting times in the Emergency Department in principle, although this was not known at the outset of the interview (by myself) and in some interviews was not apparent throughout the interview as there was quite a lot of negativity towards the target from front-line staff. Whilst this seems contradictory it is similar to what was found in case study one. The strategies were generally supported but parts of the implementation process were not. Appendix 26 shows a sample transcript of an interview.

Following transcription, all interviews were subjected to a thematic analysis and were reviewed and annotated with footnotes. Footnotes for each interview were then copied and pasted into a separate document and analysed separately for emerging themes. Each notation/footnote was cut up and like items were clustered with other like items. This occurred interview by interview at first. Each cluster was named/classified and entered into a spreadsheet. Because there were so many clusters, I was unable to remember all of the labels from previous interviews therefore renaming of groups between the interviews occurred on the spread sheet – by sorting and re-sorting the data until duplication of similar themes were removed. All items in the spreadsheet were linked back to the original transcript (Appendix 20 shows a sample of this).

Thematic analysis

Initial analysis was undertaken and yielded 41 minor categories (once duplicate categories were removed). Table 22 shows the categories ordered by the most common items first ie loss of control. Each cluster was re examined again to identify over arching themes if apparent. This process of examining and re-examining the data occurred several times before major categories were identified and settled on.

Table 22: Minor themes from managers and front-line staff, case study two, n=484 data items.

Count of Themes from Case Study 2 interviews (minor themes)	Telly
Loss of control	32
Change in traditional role of nurses	31
Conflict with process	27
Helping others to understand	26
Agree with the aim	24
Building alliances	24
Changing what consitutes care	21
Conflict with priorities	18
Powerless	18
Agree with the process	17
Helping with strategy	17
About barriers	14
Skills and resources	14
Associations with trust	11
Loss of confidence	11
Sadness	11
conflict with aims	10
Getting and giving feedback	10
Interventions	10
Positve outcome	10
Applied positive input	9
Balancing pros and cons of what is good	9
Change in traditional role of managers	9
Rapport	9
Chastised/hurt	8
Feeling that noone is listening	8
Getting the aims across	8
Institutional memory for where people have been	8
doubts	7
A change from basic assumptions	6
Ideas about patients	6
Positive outcome	6
About speed	5
Cheating	5
Pride	5
Aspirations for the future	4
Bullying	4
A line in the sand	3
About clarity	3
Blame	3
Short-cut nursing	3
Grand Total	484

Appendix 20 provides an example of each notation (from the transcript) which was then categorised into an interim category (which was "draft"), a minor category and then the final key conceptual category (called major category). This example also shows how the minor category "loss of control" became classified under two different major categories – ie some items related to loss of control were grouped under "emotional" as a description of what was being felt and some were grouped under "challenging roles" which appeared more to do with uncertainty about what was being asked of them and with little or no distress expressed. The audio files were also reviewed to consider how dialogue was expressed ie intonation, emotion.

This analysis utilised an inductive approach where data was linked to other data without trying to conform it to a pre-existing coding framework. It was also examined at a latent level to examine the -

> "*underlying ideas, assumptions and conceptualisations - and ideologies - that are theorised as shaping or informing the semantic content of the data"* (Braun and Clarke, 2006, p90).

This use of analysis fits with the constructionist paradigm – it seeks to theorise the socio-cultural contexts and structural conditions rather than focus on motivation of individual psychologies (ibid, p91). Below shows a list of major items under which the minor categories were clustered and 11 major key conceptual categories were identified.

1. Alignment with goals
2. Challenging roles
3. Conflict
4. Concern for the function of the team
5. Emotional
6. Power differences
7. Social support/valued contacts
8. Insights
9. Communication

10. Concepts of care
11. Ethics

Table 23 shows how the minor categories were clustered and 11 key conceptual categories were identified. The minor categories are ordered from most frequently identified in the interviews.

Table 23: Major categories, case study two, n=484

Count of Themes from Case Study 2 interviews (major themes)	Total
Alignment with goals	
Agree with the aim	24
Agree with the process	17
Positve outcome	10
Applied positive input	9
Balancing pros and cons of what is good	6
Positive outcome	6
Aspirations for the future	4
A line in the sand	3
Challenging roles	
Change in traditional role of nurses	31
Loss of control	16
Skills and resources	14
Change in traditional role of managers	9
A change from basic assumptions	6
Short-cut nursing	3
Conflict	
Conflict with process	27
Conflict with priorities	18
Associations with trust	11
Loss of confidence	11
conflict with aims	10
Concern for the function of the team	
Helping others to understand	26
Helping with strategy	17
Balancing pros and cons of what is good	3
Emotional	
Loss of control	16
Sadness	11
doubts	7
Pride	5
Blame	3
Power differences	
Powerless	18
Chastised/hurt	8
Feeling that noone is listening	8
Bullying	4
Social support/valued contacts	
Building alliances	24
Rapport	9
Insights	
About barriers	14
Institutional memory for where people have been	8
About speed	5
About clarity	3
Communication	
Getting and giving feedback	10
Interventions	10
Getting the aims across	8
Concepts of care	
Changing what consitutes care	21
Ideas about patients	6
Ethics	
Cheating	5
Grand Total	**484**

Table 24 shows the major categories identified in alphabetical order (major categories) and frequency with which the theme emerged in the transcripts. The most commonly occurring themes related to alignment with goals and challenging roles. This was closely followed by conflict.

Table 24: Case study two, 11 major categories, n=484

Count of Themes from Case Study 2 interviews major themes)	Column1
Row Labels	Total
Alignment with goals	79
Challenging roles	79
Conflict	77
Concern for the function of the team	46
Emotional	42
Power differences	38
Social support/valued contacts	33
Insights	30
Communication	28
Concepts of care	27
Ethics	5
Grand Total	484

A large volume of emotional items were identified in each of the interviews and a high number came from one of the Registered Nurses who expressed negative emotions with the change that had occurred. The emotional elements were closely associated with some of the power difference elements such as loss of control and blame. The category for "communication and social support" referred to interviewees identifying current and new social elements which appeared to be important during the change process. The "concepts of care" category related to beliefs about the care they provided. The category "insights" were items where a change in thinking was described by the interviewees as a result of the process that was undertaken. Ethics, whilst only a small group of items in number, were left as discrete items due to their significant negative impact on the views of frontline staff of managers. With changes that were described by both front-line and manager/leader staff it was interesting that there was not

more consideration for ethics both as they related to doing right thing by the patients and related to other stakeholder expectations around a code of practice.

Figure 9 represents all of the data elements of which 181 were attributed to the managers and 303 attributed to the front-line staff. Figure 9 shows the proportion of elements. For example under conflict the front-line staff data relating to conflict was 13% compared with 21% of the managers.

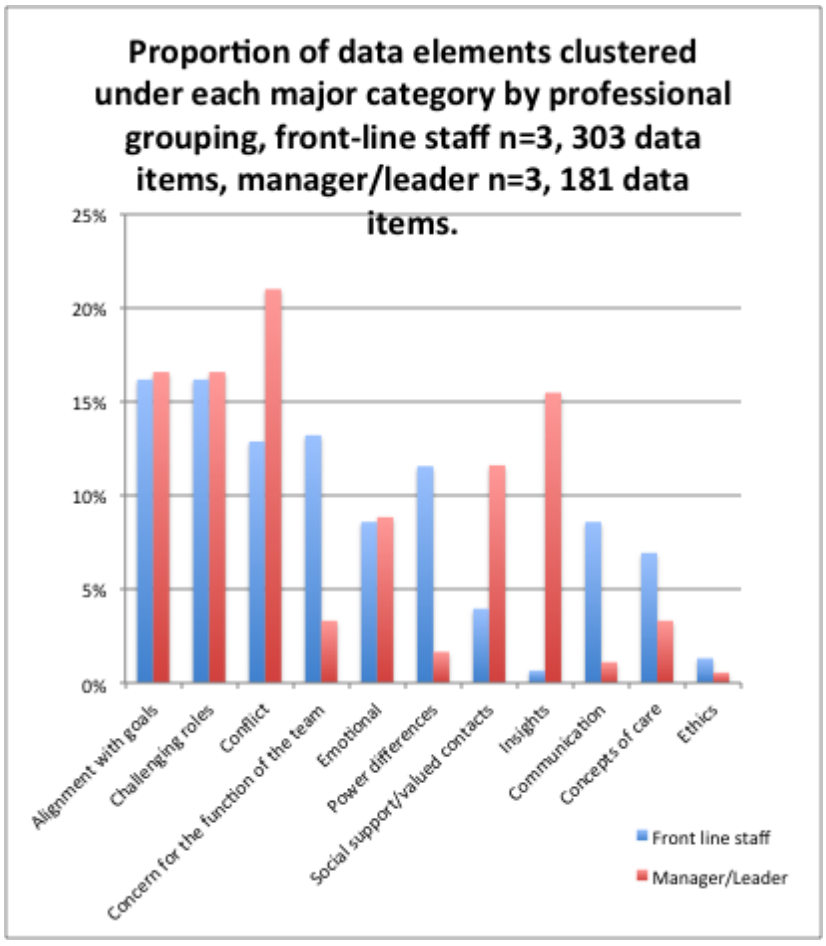


Figure 9: Case study two, proportion of data items categorised by participant group

The highest number of items for the managers related to the major categories (in addition to conflict) of alignment with goals, challenging roles and insights. For front line staff the highest groups were alignment with goals, challenging roles, concern for the function of the team, conflict and power differences.

Development of categories

1 Alignment with goals

There were a high number of data items related to the aims of the ED target. Sub categories were identified under the themes of "agree with the aim", "agree with the process", "applied positive input", "aspirations for the future and a "positive outcome".

All of the participants stated that they believed there was a positive outcome from the initiative. The department was described as being:

> "*better now because patients aren't in the corridors", "less people in the department, care remains the same", "on a positive note it's fabulous and flow is good, all (patients) have rooms*". Sarah, Registered Nurse, ED

One of the participants called Steve stated he was supportive of the change and stated he had insight into the problems that the level of uncertainty created for the 130 staff involved. He acknowledged that whilst the process was flawed at times, overall, it had achieved a positive outcome.

All of the participants voiced their support for providing care to patients in a shorter time span in the Emergency Department. All participants identified how they personally had contributed to make a better process and how they had applied themselves to some aspect of the change. This aspect highlighted the complexity in delivering the changes; the findings appeared to be good and bad at the same time.

> *"On a positive note it's fabulous. Because they are here for a limited time and the flow is good. And they all have rooms. But I do think overall the patient care has gone down".* Lucy, Nurse, ED

The slip in nursing care was reiterated in another interview as well.

> *"It's huge. Thinking about the 6 hour your nursing care slips?. So in many ways I think it's fantastic because patients aren't waiting round and back in the day they would-be all the corridors spaces. It was full so there was no privacy. If you are lucky you would get a curtain to put around (them) but your initial assessment, when we used to go there was right in the middle of the corridor. But looking at me you go and do your assessment as per normal and you know they are in heaps of pain, and you get it sorted. And then you might be busy doing your other assessments (other patients) and when you come back the patient has gone!" Sarah, Nurse, ED*

Daisy expressed her alignment with the "6 hour target' goal due to the previous unacceptable situation.

> *"Well for me, because I've been there now for 30 years, I kind of knew that I couldn't continue to work in that environment unless there were some dramatic changes. In 2003 we basically spent all our time fighting to improve things for patients and we weren't getting anywhere. So when the ministry came with the target, the six-hour target, it really, for me, it was really like someone is going to tackle it and we will change, and it can happen. So it gave me a lot of hope and for me... although the changes were difficult for a lot of people, I just realized that we couldn't continue doing what we were doing day by day"* Daisy, Manager/Leader

Alignment of the target appeared to be an extension of a belief that the target was designed to address the issues that she had become concerned and frustrated about as can be seen in the following quote:

> *"The reason the targets are there is so you can give good care, ultimately that is what it was all about in the first place"* Daisy, Manager/Leader

Motivation to overcome the problems of uncertainty in the change process and to change from an unacceptable situation was evident in the interviews for all of the front line staff and the managers.

2 Challenging roles

All of the participants described experiencing a change in their roles and the roles of the different members of the team. The changes were described as occurring at every level.

A number of areas of change for nurses were described by each of the registered nurses. These included *"(nurse) coordinators have become computer watches to manage the flow of patients"* Lucy, Nurse, ED, *"other people interfering with your patient care was brought in – moving patients"* Sarah, Nurse, ED, *"don't really care what is being done to your patient because – not your responsibility?... it's not nursing anymore its just numbers and paperwork"* Lucy, Nurse, ED.

One of the registered nurses spoke of a loss of control - how patients would be moved to another area by other nurses. Comments such as *"the patient moves without my knowledge", "we found people were moved without things being done"* Sarah, Registered Nurse, ED. The need to move patients to areas to accommodate other patients was associated with descriptions of being under pressure and being rushed.

There was reference to certain skills and resources which included one nurse suggesting that skills such as *"time management", "willpower", "being able to prioritise and handle the pressure"*, (Steve, Registered Nurse ED) were now essential skills as a result of the initiative.

A manager/leader explained that how nurses were traditionally trained was a problem:

> *"All through our training I think you were always taught to focus on what's coming in. And to make sure that they're (patients) safe and it's always the priority the people coming in. And (the Manager) really taught us that you can't look after those guys until you make space and to make space you need to concentrate on the ones going out and getting them to where they need to be"* Daisy, Manager/Leader

A manager/leader described the reaction from the then clinical leader (Dr) when she first started as a manager in the department and had ventured out into the clinical area to see what was happening. It was explained to her

> *"That I should just be in my office and that if I wanted anything to change I should talk to him and (the Nurse Manager) and they would make change and to just get off the floor. "* Annabel, Manager/Leader

The manager/leader explained that she had been employed to meet the initiative target and did not see her role as working from an office area. She explained that she monitors what is happening in the department throughout the week and the Nursing Manager, Clinical Leader (Doctor) and her will phone on weekends if things aren't going well in the department (they can view an emergency department electronic whiteboard remotely).

A further example which expressed different attitudes to both the role of nursing and standards of practice is given below. In this example Daisy suggests that she felt like an alien.

> *"And like I saw a patient the other day who had a bandage around his head and it had blood on it and it had dried and there was like concrete blood down his face and he was about to go up to the ward. There was no way (in the old days) you would be sending a patient to*

> *the ward with blood visible on them. You would never let a patient leave and I just saw him being wheeled out and I just thought "oh no". So then I went and found the nurse and said now you've got a patient with blood on him and she was like "yeah, so, he's been hit on the head with a bottle, what do you expect?" Well I said, "you have got to clean that up before he goes up to the ward". It was like being an alien…* Daisy, Manager/Leader

The challenges to roles described cover challenges to what constitutes care and compassion, what is nursing, and what are the roles of management. Change processes involve changing what we all do therefore how challenges in roles are identified, viewed and handled would appear to be an important aspect of successful change.

3 Conflict

Conflict was described by all participants. The sub-category themes identified included "associations with trust", "conflict with the aims", "conflict with priorities", "conflict with process", "loss of confidence". The registered nurses described a lot of conflict within the care process from arguments with other units, to frustration with not enough staff and feeling like patients were being moved too quickly from the department or end up in inappropriate places. The manager and Clinical Leader identified that staff may perceive that they are not concerned about what staff think and thus exacerbating the conflict, as illustrated in the following quote:

> "*We are concerned but not able to act on everything – staff may perceive that we are not concerned about what they think." …. "a place for hearing and listening and place for getting on with it"* Annabel, Manager/Leader

Loss of confidence was a theme that emerged from the registered nurses from experimenting with processes in the department and use of PDSA (plan do study act) cycles. The speed at which things were introduced and then

subsequently changed or abandoned was described in a way that suggested staff had lost confidence that good judgement was being used in the change process. A second loss of confidence was raised by the manager and clinical lead as they felt that they weren't always supported by other senior staff in the organisation.

The conflict with priorities was evident and there was acceptance from all those interviewed that it was inevitable that managers and clinical staff priorities would be different.

Quote from Annabel, manager - "*my underlying ethos is about providing the best care I can with the resources that there are*".

Quote from Sarah, RN - "*Manager and staff priorities are completely different – they have their aims and we have ours*".

Another quote from Lucy provided some reconciliation for the conflict with priorities:

> *"Because our priorities are totally different, for us to understand where they are coming from, it can help us change in doing a different kind of nursing. You can join up in the long term as long as you're on the same page you definitely are going to be 2 branches - 1 being patient driven and the other numbers and target times (driven) I guess we join up at some point. So it's like a triangle eventually you meet up."* Lucy, RN, Emergency Department

Conflict with the aims appeared to be more about different views of the same thing. The RNs perceived that managers were focussed upon the numbers only because that was what the managers talked about. The translation of the target into what it had achieved for patients and their care was spoken of by all of the participants – but more so by the Manager and Clinical Leader.

> *"And then we had new staff, so they don't really they don't know why we are sort of strictly adhering to the six-hour time. They don't really know the background to that and so for them it's probably just the target. And if you don't know why you're doing it or doing something it makes it really hard and it kind of got misinterpreted as well"* Daisy, Manager/Leader

The initiative aim in itself was not contentious however the many faces of the initiative were highly contentious.

4 Concern for the function of the team.

There were three sub-category groupings under "concern for the function of the team". These were largely split between "helping with strategy" i.e. the espoused goal of the programme and "helping others to understand" which could be seen as the actions and behaviours associated with the espoused goal. The third smaller category related to balancing the pros and cons of what is good for the team and the work of the team.

One of the RNs described taking on a role as a go between (between front-line staff and management). Part of this role appeared to be helping others to understand the meaning of the initiative in language and terms that they understood.

> *"I have been around a bit I saw opportunities to talk to x and y and z and Q (managers and leaders). I would say, I think we need to talk about this thing, we need to talk today on this one. Or we should talk tomorrow on this one and put a timeframe on some things. …. I think I was lucky enough that I had the rapport with those people and that they respected me and gave me the opportunity. And I think it helped everybody"* Steve, Nurse, ED

Steve was then asked if he saw this as being part of his role as a senior nurse on the floor?

> *"Probably yes, and probably from the point of view that I could see something that we could keep the goal but we just need to fine tune it a bit and talk things through. We needed to have a way of discussing this while it's happening instead of leaving it for a meeting. You know some things you can leave to a meeting, but sometimes we need to get a hold of this now, rather than later, in case it goes out-of-control then we don't get the advantage."* Steve, Nurse, ED

This participant contributed most of the data related to concern for the team. Whilst a front-line staff member, this participant appeared to act as a "go-between" (between the managers/leaders and the front-line staff). This participant described ways to protect the leadership team from being misjudged and misunderstood by trying to address issues as they arose and in a timeframe that appear appropriate to the priority of the problem. This participant demonstrated "good will" to the leadership team – and his concern for the team spanned both the leadership and front-line team.

Vicki (manager/leader) also expressed concern for the team but in a way that was about improving the performance of the team by mixing the right team members so that staff who perhaps didn't seem to cope well with pressure had a combination of staff that supported them.

> *"So we have that role (coordinator) but some people are just better at it then others and some people are more engaged in it than others and some people just can't handle there it… I think there is a change when those people are on but we normally have more than one person on anyway so often the second person will provide support towards the first".* Vicki, Manager/Leader

Concern for the function of the team was expressed by front-line staff and manager/leader participants. Translation of the changes appeared to be an important component of this theme – this appeared to be done within professional groups – by key staff and by presence of manager/leaders in the clinical areas.

5 Emotional

The sub-categories identified under emotional included "blame", "doubts", "loss of control", "sadness" and "pride".

Blame made up a small component of data collected and was related to blaming the target of "things being missed" and being shocked by staff judgements of patients.

Doubts were expressed mainly by manager/leaders. Uncertainty about achieving the changes required, seeing that the solutions were going to be so difficult to implement so how could it be achieved. Front-line staff expressed doubt that the outcomes could be achieved.

There were a number of data items related to loss of control including feeling angry:

> *"So sometimes you think oh I don't like that and you let a bit of steam, breath in then count to ten, refocus, remember what you're here for."* Steve, Nurse, Emergency Department

A sense of alarm/or panic:

> *"… then the charge nurses start getting really upset and they feel they don't get trusted so then they start throwing it at us and it just goes in a big circle…"* Sarah, Nurse, ED

A sense of the situation being unfair

> *"…like you only have 2 or 3 patients in monitored as a nurse or like instead of having one there they have 3"* Sarah, Nurse, ED

Data categorised under sadness was collected from manager/leader and front-line staff interviews. The manager/leader reflected a view that others in the organisation did not understand the process of change and this had resulted in feedback which the participant found knocked their confidence.

Front line staff reflected upon instances where staff displayed extreme signs of stress through being under pressure and perceptions of bullying:

> *"But the abuse, I wouldn't say abuse it is a big word, but sometimes it has been. We've had some nurses cry here a lot over the last couple of years. From being bantered about getting patients out. I don't think it's particularly nice at all.* Sarah, Nurse, ED

In reflecting upon what has been required of front-line staff, this quote demonstrates an emotional response to the changes that have occurred

> *"It feels like we're not doing nursing like we're not caring for a patient and the problem we are caring about is a percentage and a number rather then going and spending time with the patient to explain what is wrong… do a decent assessment… you know do things properly with them…. we are doing things a bit half arsed in just rushing out because we've only got a limited amount of time. And that's quite sad."* Sarah, Nurse, ED

This appears to be a concern for a change in the level of nursing compassion that is required and expected in working with patients and the target. There appeared to be a proposal from two of the front line staff that time was a critical ingredient of nursing compassion – and lack of time meant that it was difficult to be compassionate. The target was being blamed for being unable to deliver the care that they thought was necessary. The department of health report published in 2010 regarding expectations for nursing and mid-wifery described nursing compassion as:

> *'...we respond with humanity and kindness to each person's pain, distress, anxiety or need. We search for the things we can do, however small, to give comfort and relieve suffering. We find time for those we serve and work alongside. We do not wait to be asked, because we care."* (Department of Health, UK 2010 p 12)

In addressing issues of nursing compassion, Straughair identifies five strategies including: recruitment and retention, role modelling, leadership, support and service user involvement (Straughair 2012p 240-244). None of these strategies however specifically mention the impact of time on delivery nursing compassion or refer for example to nursing ratios etc. One of the other front line staff (Steve) spoke of the changes that were required to be made- *"Oh everybody had to think about time management, priorities…..Because it's proven it can be done, it just needed a bit of willpower" (*Steve, Nurse, ED)

This suggests that there were challenges around individuals organising their time. It could be supposed that if staff were unable to speed up or find new ways of working (or stop doing other activities) in their non face to face work, then their time with patients would be under pressure. If staff were unable to reduce time on non face to face activity ie time for lab results, finding equipment, doctor consults) time – this will have put pressure on the time spent with patients. In other words, the emphasis to reduce patient times in the Emergency Department would have had to have focussed on changing the behind the scenes (non face to face) work in order to preserve the face to face assessments and communication with patients and family. It is expected that this is the case, however this remains unclear if this occurred or if the focus was to reduce nursing time with patients.

The report called putting patients first (Department of Health 2013) states that *"Blind adherence to targets or finance must never again be allowed to come before the quality of care*." (DOH 2013, p10). This study analysis would indicate that some participants felt there was "blind adherence to targets". The complexity of a single patient visit to an emergency

department includes the input of multiple computer systems, processes and front-line staff. When is adherence to the target blind? Is this when all of the systems and staff doing the tasks "take too long" and consequently one person is under pressure to speeds things up or to cut corners? Does cutting corners always apply to the same profession group or activity therefore there are groups of staff that are more vulnerable than others in "cutting corners" thus accused of blind adherence (or conspiring to). The position in the process of care means in an Emergency Department, the nursing staff are the most at risk and may have the least control over the entire system. If they are unable to influence the "package of care" which includes the non face to face activity required (e.g. delays for the x-ray booking, the orderly to pick up the patients, the priority of the phlebotomist in taking blood, the priorities of the doctors), then the only other way to reduce time for the patient is to reduce their own face to face interactions. If for example the non face to face care takes so long to carry out and is so onerous this will also influence the feelings of the nurses in how good their face to face nursing was. None of the participants talked about the non face to face delays that may occur and influence their feelings of providing good nursing care.

One of the manager participants suggested that "short-cut" nursing started before the 6 hour initiative.

> *"I think it's got so busy and I think it was part of me thinks it was before the 6 hours. It's not the 6 hour targets fault, it happened before that because you never had time. Like we used to make sure all patients were changed because they are going to need X-rays or the doctor is going to listen to their chest or look at their ankles. If you've still got shoes on it's really annoying. So for me it was always, get your patients changed, put their clothes in a bag with a label because those things mean something to that patient and if you loose them it's horrible. But we got so busy that people weren't even getting changed, we were constantly pulling them out of that*

> *room and putting them in the corridor. "Don't bother getting changed because you will be out of there in a minute". And we started nursing using short cuts*" Daisy, Manager/Leader

The blame for how nurses were having to work from front-line staff was on the 6 hour target and yet Daisy suggested that "short-cut" nursing was already occurring prior to the target being introduced.

Sadness was expressed by a manager/leader regarding a breakdown in the wider teamwork and feeling of togetherness not because of anything to do with the clinical work but because of the loss of a shared tea-room.

> *"The other big thing, and I know that no one else sees it as a big thing - we lost our tea room. The tea room was not just a place to get a cup of tea but it is where everyone went from our clerks, doctors, consultants, nursing and we could sit in there … When you wanted help you would just ring the tea room. There was no like, "I'm on my break that it's it for half an hour"… We would be laughing about things or crying about things. You were all together… I think it was a lost opportunity to keep the nurses, doctors, clerks phlebotomists and everyone together*" Daisy, Manager/Leader ED

Data elements of pride were collected from manager/leaders and front-line staff.

> *"I don't think it's perfect yet. I think if you come in here and you are really really sick you'd get a gold star service"* Annabel, Manager/Leader, ED

Data categories under 'pride for front-line staff' were about pride in achieving the target and also pride in their role in the process of achieving the outcome.

"… overall it benefits everybody including the patient and staff." Steve, Nurse, ED

"Because it's proven it can be done, it just needed a bit of willpower and I think what happened was a definite plan with a definite goal and off you go"… "And I certainly was appreciative of the times I could say to the people in management look we need to sit down and talk. And then took time out." Steve, Nurse, ED

6 Power differences

Sub-categories related to power differences included bullying, chastised/hurt, feeling that no one is listening and feeling powerless.

Power difference data was gathered solely from front-line staff.

"In monitored (a section of the emergency department which has patients continuously monitored) your charge nurse can come up and giving you absolute nonsense in front of everybody about getting patients out" Sarah, Nurse, ED

"But once again it does annoy me and upset me when they are nowhere to be seen for 2 or 3 hours and then you get horrendously busy and they rushed over and start yelling at you. Well where have you been for the last couple of hours you're supposed to be working with me but they disappeared into the office for a couple of hours without telling me" Sarah, Nurse, ED

The sub category referred to as chastised/hurt was where front-line staff described instances of being told off.

"His blood results were completely off the chart and it was 'get him out get him out' … "I was pulled up… I got pulled out but nobody would listen to me... Because I got pulled into a room about it and I

> *got slammed… but I was not listened to. It was like talking to a brick wall"* Sarah, Nurse, ED

Data collected under the theme "no one is listening" was related to not feeling like there was an ability to give feedback to senior management on what it was like in the front-line.

> *"The posters and staff were good but we were getting feedback from them but they weren't letting us give them feedback"* Lucy, Nurse, ED

Data collected under the theme of "powerless" depicted a sense of limited options for change and disappointment that plans changed frequently.

> *"We came in to hand over one day and it was just thrown at us and then everything just got thrown at us bit by bit there was no feedback forms or advice on ways we could improve it"…* Sarah, Nurse, ED

> *"Sometimes there are changes and we don't get time to get used to them. They're trying to do the visual handover thing at the moment. We had PowerPoint, I did the presentation 3 times and it lasted 2 weeks and it's now out the window. You can guarantee next week they're going to throw something else let us and we're just getting confused"…* Sarah, Nurse, ED

> *"We are trying to improve our care but it's hard when we are forced to"* Sarah, Nurse, ED

The feedback from Sarah was very negative regarding the way that the changes were undertaken (and the speed). Sarah expressed feelings of powerlessness that were more extreme (and out of balance) than either Lucy or Steve. Avelina and Rotmans (2009) propose that there is

dependency between A and B for example if A is management and B is Sarah (or Lucy or Steve). The type of dependence perceived determines the degree of power in play and level of negativity towards that power. Table 25 illustrates 6 outcomes from different levels of power resulting in balance – mutual dependency, co-existence/cooperation or synergy. Imbalance is said to lead to one-sided dependency, competition and /or antagonism.

Table 25 Typology of power relations

Type of power relation	*Balance*	*Imbalance*
Having power 'over'	A depends on B but B also depends on A, so A and B have power over each other = mutual dependency	A depends on B but B does not depend on A, so B has power over A = one-sided dependency
Having 'more' or 'less' power	A mobilizes more resources than B, but A and B have goals that are collective or co-exist = co-existence/ cooperation	A mobilizes more resources than B, while A and B have mutually exclusive goals = competition
Having a 'different' power	A exercise power in such a way that it enables and enforces the power exercised by B = synergy	A exercises power in such a way that it disrupts or prevents power exercised by B = antagonism

Reprinted with permission [awaiting] from Sage publishing (Avelino and Rotmans 2009, p557)

Using the typology outlined above, the manager (A) and Sarah (B) are out of balance because they have "different" powers which leads to "*antagonism*" in this typology i.e. "management" exercises power in such a way that it disrupts or prevents power exercised by Sarah. Other quotations suggest that other front line staff found a balance of power. The power themes presented here concern the negative aspects of power where there is an imbalance. There are examples clustered under "social supports and valued contacts and "communications" of where there appear to be "mutual dependency", "co-existence/cooperation" and "synergy". For example Steve reveals that he provided advice to the managers about when to speak to staff "*I could say hey look I've talked to the charge nurses but I think you*

need to talk to them" (fuller extract on page 200). This would appear to be synergist is typology. Steve reports a good rapport with management so this allows Steve to "use" the power that A has to influence the situation. In another example, Lucy describes how front-line staff and managers have different priorities but share the same goal *"I guess we join up at some point. So it's like a triangle eventually you meet up"* Lucy, Nurse, ED. This would appear to be an example where the goals are collective and are in balance "co-exist/cooperation" (fuller extract on page 205)

7 Social support and value contacts

There were two groups under this category – the first has been classified as building alliances both within the department and within the wider hospital, the second was related to building rapport within the team.

Annabel (manager/leader) talked about another member of the leadership team that she found to be a complimentary team member.

> *"So what we end up by doing as I push and she pulls me back slightly and I push and she pulls me back slightly and that is perfect because if I had somebody next to me who was pushing at the same pace as me because I am very much a pusher and the mover and shaker then maybe we would be a bit more destructive."* Annabel, Manager/leader

Steve described a number of ways that he worked between front-line staff and managers including senior nursing staff.

> *"You will get better rapport with some charge nurses than others. Sometimes you wait until a certain one is on and then you have a chat with them. And I might say we were talking about this the other day what you think. Sometimes I know some people carry information well and sometimes people don't. It doesn't go past (ie reported through to a higher level) especially if they think oh we*

> *don't need that. And I think well why don't we."* Steve, Nurse, Emergency Department.

Steve used the term "some people carry information well and sometimes people don't". This appeared to recognise that some people in the team could filter important information from unimportant information. Steve also went on to say that filtering information was difficult.

> *"I always remind myself - be careful don't carry gossip, don't carry people's grievances. Is this a real concern or is it 'I just I don't like this' you know…"* Steve, Nurse, Emergency Department.

Daisy as a middle manager also referred to a role sitting with front-line staff and in management.

> *"And so you really are the messenger and you have to be able to sit in both camps and it's very difficult sometimes…. You are in the middle - you are a buffer between the two camps."* Daisy, Manager/Leader

This sifting filtering of information – relevant from irrelevant – was evident in each interview as the staff reflected on their roles and what had occurred. The rapport with the manager/leaders was also discussed.

> *"And that's why sometimes with the initiation of the six-hour thing I'm very thankful to have a rapport with the likes of Annabel, Claire and Anika because I could say hey look I've talked to the charge nurses but I think you need to talk to them. So I think these are the issues but I think it is more appropriate that you speak with him. I could say like I've talked to them but I think they need a little help."* Steve, Nurse, Emergency Department.

It would appear that an ability to go around the usual hierarchy when undergoing change may have provided assistance to both manager/leaders and front-line staff.

8 Insights

Themes about "insight" or "learning" were found under four different areas – barriers, speed, clarity of purpose and institutional memory (for where people have been).

The manager/leaders identified areas that I have grouped under "learnings" to countermeasure barriers. The first term "learnings" refers to gaining an understanding that making "lots of changes" and "talking/engaging with lots of people is important to the process of change" (Vicky, Manager/Leader). The second "insight" was about revisiting old ideas with new people. The participant reported that she found that this was a way to keep people engaged. She also found that the idea that because it didn"t work last time – it just may work the next time. The third quote is about front-line staff making changes and managers and leaders not quashing ideas. This also shows that if it doesn't work, it doesn't matter, something else can be tried.

> *"So if you want to make change you have to make lots of changes and you have to try different things and you also have to engage a lot of people."* Vicki, Manager/leader

> *"So when we get new people and when they go 'oh why don't you do this, why don't you do that', I go well we tried to do this and that last time and it didn't work. So it can be sort of like I don't really want you to tell me what we've already tried. But on the other hand it's something that we've obviously tried before because we weren't happy with it and it was a good idea at one point, we thought was a good idea, and maybe it didn't work that time but maybe it will work this time."* Vicki, Manager/leader

"I think that one of the biggest changes in the ED is that people feel empowered to make changes. This is the biggest change that we have made. And I think that historically they were in a situation where change or ideas were squashed, whereas I actually feel like I like to think that people feel like we can try anything because if it doesn't work we'll just change it again." Annabel, Manager/leader

The fourth insight related to firstly the impact that a positive attitude a workforce has on the ability to make change. Secondly, the impact of improving small things, which in the end turns out to make a big impact.

"They (nurses) were feeling more empowered and we were also able to move things forward and get more positive with small gains which made big gains which enabled people to feel more positive if that makes sense." Vicki, Manager/leader

One of the manager/leaders was invited to a meeting because of staff concern for what was happening in the Emergency Department. The experience of attending the meeting appeared to provide a moment of clarity for this individual on what the target of achieving 95% of patients out of ED within 6 hours for their emergency department.

"because I came back to a meeting (with people high up in the organisation) "saying oh we need to talk to you about your style". And they were fairly vague about the whole thing and they sort of said that it's a bit like a bus and we are going on a journey and we don't know what is happening and we don't know where we are going. And I remember thinking "what do you mean you don't know where you are going?" I know exactly where I'm going and I said "I know where we are going, we're not going to have any corridor patients, we are not having any patients in the ED longer than 6 hours and we are going to give these people more space to work!

> *And by doing all that we're going to improve patient care." I couldn't understand how they could be so vague about it because I was really clear that this was what we needed to do"* Annabel Manager/Leader

The managers appear to translate the target to what it meant for their own situation. Annabel identified that it gave an opportunity to improve the environment and provide dignity for where patients were treated (no patients in the corridors) it provided a meaningful goal for staff (enough space to work) and for both patients and staff it was going to improve patient care by improving the timeliness of care. This appeared to give direction pointing which was referred to throughout the change process. The "no patients in corridors" became an important marker for when the emergency department was becoming over loaded. Direction pointing is one of the four ways to create an environment where innovative complex behaviours can emerge to deal with the zone of complexity (Plsek and Wilson, 2001, p747). The other three include boundaries, resources and permissions. These three can also be seen to have been developed at this seminal moment for the manager.

The senior staff that requested the meeting appeared to be concerned and uncertain that the leadership style that Annabel displayed was going to be appropriate for the changes that needed to occur. The value of challenging Annabel at this time could be construed as useful as Annabel was asked to/able to reflect and reconfirm the important strategies of the change.

Daisy spoke a lot about what it was like before the 6 hours. This was similar to Steve – perhaps because they were the longest serving members of the team interviewed. The memory of past situations appeared to be important to accepting change and a personal fear of going back to the "old days" – which related to nursing patients in corridors

> *"This is still very vivid in my mind. I remember coming on one day*

while it was happening every day. Instead of having 25 patients we would have 50 and of course they were all jammed in the corridors and every little crack was used to see patients. So in the end, like the doctors from the specialties wouldn't come and see the patients because there was no way physically they could see them. So we used to have those portable screens on wheels and we would put them round so that patients could have some privacy. But of course you could see through those cracks." Daisy, Manager/Leader

9 Communication

Data gathered and themed under communication was split into three subcategories including interventions, getting and giving feedback and getting the aims across.

Interventions were characterised by front-line staff who took it upon themselves to shape the improvement process by canvassing the views of staff, gathering information that might be useful for managers to consider, prioritising what managers/leaders need to address now, acting in some ways as an informant, sometimes an advocate and sometimes and advisor.

"I could say hey look (managers/leaders) I've talked to the charge nurses but I think you need to talk to them. So I think these are the issues but I think it is more appropriate that you speak with him. I could say like I've talked to them but I think they need a little help" Steve, Nurse, ED

Getting and giving feedback data was generated from the proximity of managers/leaders to the front-line work and the available avenues for discussing the changes that were planned or had happened. Front-line staff concurred that managers/leaders were very visible in the work place.

Interviewer – do you see them around in the department much?

> *"At the time of the change, definitely, definitely and they are always approachable, even if they don't like what you have to say"……"Yes. Manager/leader X and I agree not to agree sometimes. We agree that we're both here for the best outcomes, we don't see eye to eye, but we still talk."* Steve, Nurse, ED

Data was collected which indicated feedback to the wider organisation helped with relationships outside of the department

> *"we're not phoning up to annoy you, we realise you're busy too, we've been there we appreciate it. But we have to approach it together and I think it got the awareness out and I think it probably really helped."* Steve, Nurse, ED

Front- line staff data concerning "getting the aims across" demonstrated an understanding about the uncertainty of predicting the changes. The first quote describes a legitimacy in managers and front line staff having different priorities but suggests that these need to be recognised and meet up at some point. The second provides an insight into the hesitancy and uncertainty about starting a change process.

> *"Because our priorities are totally different, for us to understand where they are coming from, it can help us change in doing a different kind of nursing. You can join up in the long term as long as you're on the same page you definitely are going to be 2 branches 1 patient driven and the other numbers and target (driven) .. I guess we join up at some point. So it's like a triangle eventually you meet up" Lucy, Nurse, ED*

> *"… it's not because you don't want them to know it's because you need to think through (it) yourself, so that you know how to lead people through it…."* Steve, Nurse, ED

10 Concepts of care

Concepts of care appear closely linked with challenging roles. They have been treated separately to differentiate between internal thinking (around concepts of care) and challenging roles (which is more related to interaction between people). There were two minor categories identified under concepts of care. The first had only a few data items and related to how front line staff spoke about patients. In the interviews one front-line staff member referred to patients as "them". It appeared to be "them and us". The same staff member also mentioned that patient's don't "linger" in the department or "lounge around" any more. This could be taken that patients were deliberately staying longer than necessary (thereby absolving staff from the responsibility of causing delays?). It was stated that the reason that patients were not lingering now was because of the changes staff had made to the department because of the 6-hour initiative.

The second area regarding concepts of care was related to new roles (in the same profession), new accountabilities and different definitions of care. Vicki talked about changes made in her thinking about the definitions of care.

> *"I think more about the broader issues of care rather than just the patient in front of me… But for me I think now I am more about-they shouldn't just be staying here, they should be going on to more defined care, that is what is happening in the whole department. I shouldn't just accept that someone is stationary there (in ED)…* Vicki, Manager/Leader

Vicki described a time-based accountability which appeared to be implicit in providing good clinical care but which through the 6 hour initiative became explicit and part of discussions about what constituted good clinical care.

> *" … but we started to think about more efficiency of delivery of care. So how quickly we get pain relief, there have always been*

certain ones expected-such as thrombolysis for PCI (percutaneous cardiac intervention), that has always been measured. But we just started to try to get an idea of how efficient we were in the first couple of hours, versus the length of stay. … Vicki People are always a bit sceptical but people are always a bit surprised too. Does it really take 45 min to get some pain relief in renal colic? Well yes actually it does - because we have looked at a whole lot and by the time the nurse makes the assessment and the line is put in, that is actually how long it takes." Vicki, Manager/Leader

Prior to the 6-hour initiative only some pathways were timed. The wider use of time-based care to include all processes whilst implicit in good clinical care, appears to become a management driven target when it becomes explicit in the standard of care. Many of the changes to concepts of care related to a focus on time – as with many improvement strategies.

"… you know there was a push to move people quicker without things done as per usual and we found that some people were moved without things being done. Steve Nurse, ED

Changes in how care was negotiated with other staff was described by Steve. He referred to the new way of working as being less driven by individual personalities and more driven by processes

"You know now we don't have to take the high pressure approach. There still is a bit of that but it has taken the heat out, because if we do ring them (Doctors) up they know, the odd one or two who think they are living in the dark ages. And we let the system take hold of it." Steve Nurse, ED

11 Ethics

Two front line staff spoke of patients getting swiped out of the department before they had actually moved from the department.

"And there is also the issue of moving patients on the computer without physically moving them, which is a bit dangerous. …They move patients from assessment and the short-stay on the computer without physically moving the patient. So if we have a fire within half an hour of moving the patient, the firemen are not looking for patients in the right place because it sees it's empty." Sarah, RN ED

"…and what I don't like all so is if they are getting close in time and the orderlies are busy or whatever, they get swiped out so it looks good on the computer but the patient is still sitting there. I totally disagree with it" Lucy RN, ED

This element of cheating to achieve a target is of concern. To gain an understanding about what was reported through the interviews I went to speak with the manager/leader following the interview. There was huge pressure to perform especially when the patient may only be a few minutes over 6 hours, this meant that some of this behaviour of moving the patient on the computer emerged. There remains a problem when a nurse has completed work with a patient and has moved on to the next patient, the original patient however is waiting for someone to move them to a ward or to the short stay unit. To all intents and purposes, their care in the emergency department has been completed. The pressure on the senior members of the team (from managers and leaders) meant that the behaviour of clicking on a patient (via a computer screen transfer to the next ward destination) when they had finished with them emerged. This issue had been reviewed several times by the leadership team and it was recognised as wrong. It had been made clear on several occasions that it should not occur. Individual performance of senior nurses and doctors looks at how well the department runs under their "watch" therefore there remains considerable incentive to achieve the target through whatever means.

The Francis inquiry referred to target driven cultures and target driven nurses. It found

> *"The culture driven by the leadership of the Care Quality Commission is target-driven in order to maintain reputation, but at the expense of quality"* Department of Health (2013a, p982)

The report also referred to the organisation as a whole "… *prioritised targets not patients and focussed on finance not quality"* (Department of Health 2013a, p 695)

Two of the front-line nursing participants referred to the focus of more senior staff on the targets timeframes for the Emergency Department. One participant in particular (Sarah) reported that her views were not able to override the priority to meet the target.

Mid Staffordshire inquiry also documented the pressure from the top of the organisation – *"as chief executives, we knew that targets were the priority and if we didn't focus on them, we would lose our jobs"* (Department of Health 2013a, p 713).

An adaptation of the "6 hour" campaign that was made at the District Health Board (DHB) - where the participants worked, was that if there were clinical reasons for a patient needing longer in the Emergency Department, these patients were excluded from the target. The most common exclusion criteria were patients whose condition deteriorated during their stay and required a change in treatment thus delaying their move from the acute area of the Emergency Department. These patients were reviewed by the clinical leader and accounted for under 1%. This was a variation to the national policy which stated that 95% of patients will leave the emergency department in 6 hours (Appendix 19). In this review, the entire patient journey was reviewed. If for example the patient waited 3 hours for a CT scan and then there was a deterioration in the last half an hour of their

stay, this may not have excluded the patient from the 6 hour target due to the delay at the beginning of their stay.

Interview data concerning repertory grid.

A smaller group of statements were used in case study two. Each participant was asked to read the statement and place it next to the answer that best reflected how they felt (with options never, sometimes, mostly and always). Table 26 provides a visual summary of the answers that participant selected. There was quite a lot of consistency between front line staff and managers/leaders. The one area where a difference was noted was in manager and staff priorities. Managers/leaders and front line staff generally indicated that staff were encouraged to improve their services and worked together to make improvements. Mostly managers trusted staff (between sometimes and mostly); managers were concerned about the view of staff.

Table 26: Repertory grid responses in case study two.

Participant Group	Case study two - results of adapted Repertory Grid	Goal alignment		Priorities	Trust	
		Staff are encouraged to improve their services	Managers and staff work together to make improvements	Managers and staff priorities are the same	Managers trust staff	Managers are concerned about the views of their staff
Front-line staff	Never			✔		
	Sometimes		✔	✔		✔
	Mostly	✔	✔	✔	✔	✔✔
	Always	✔	✔		✔	
					✔	
Front-line staff	Never					
	Sometimes		✔	✔✔		
	Mostly	✔	✔	✔	✔	✔✔
	Always	✔✔	✔		✔✔	✔

Table 26 shows where the responses were positioned for front-line staff and manager/leader. The statements given to both groups are in the vertical columns.

Developing theory

A theme that emerged in the data from case study two was that of loss, grief and high emotion – from all participants. All participants expressed uncertainty, anxiety about the future and all reflected upon their experience from a very personal point of view.

Each of the front line staff referred to the abstraction of "loss" as associated with the change that had occurred – loss of role, loss of interaction with patients and what they could do for patients, loss of control over the environment and control of the patient, loss of confidence

and a loss in status as a nurse. Interviewees described situations where loss was more pronounced than others. In contrast participants also described how much better the department was, better for patients, better for staff and better for them personally. The next section of analysis was to explore patterns associated with negative and positive aspects of change and staff reaction to it. The first exploration of this data was to add another dimension to the data to classify positive and negative aspects of change. These are described as challengers and liberators and these are stratified by the major categories identified and by participant group (manager/leader or front-line staff). The word challengers referred to the more negative data items whereas liberators referred to the more positive actions that were undertaken. Table 27 shows how the data was stratified.

Table 27: Data stratified by participant group, major category and challenger/liberator

Count of Themes from Case Study 2 interviews major themes)	Column Labels		
Row Labels	Challenging	Liberating	Grand Total
Alignment with goals			
Front line staff		49	49
Manager/Leader		30	30
Challenging roles			
Front line staff	43	6	49
Manager/Leader	16	14	30
Communication			
Front line staff	5	21	26
Manager/Leader	1	1	2
Concepts of care			
Front line staff	4	17	21
Manager/Leader		6	6
Concern for the function of the team			
Front line staff	1	39	40
Manager/Leader	1	5	6
Conflict			
Front line staff	39		39
Manager/Leader	32	6	38
Emotional			
Front line staff	24	2	26
Manager/Leader	13	3	16
Ethics			
Front line staff	4		4
Manager/Leader	1		1
Insights			
Front line staff		2	2
Manager/Leader	9	19	28
Power differences			
Front line staff	35		35
Manager/Leader	3		3
Social support/valued contacts			
Front line staff		12	12
Manager/Leader	3	18	21
Grand Total	**234**	**250**	**484**

The above table indicates that both front-line staff and managers identified challengers and liberators (i.e. negatives and positives). There were four data clusters which posed the most challenging for both groups of participants – challenging roles, conflict, emotional and power differences.

In order to look at relationships between positive and negative aspects of change I focussed upon what front line staff said about managers. From the data I wrote two lists of statements - one focussed upon items identified under challengers and the other liberators (Appendix 27 shows the draft list of statements and how these were modified and combined). I then estimated how significant the impact of this statement on a change process. This may provide a way to deal with multiple realities and conflicts in the data – where conflicting beliefs co-existed – i.e. the change was good but it was also very bad. Some activities were described to be positive but may have a low impact on achieving a change, some things may be seen as negative but have a high impact on change. The aim at this point was to categorise themes based upon reported perception of negative/positive and high impact on change/low impact on change – without making a judgement as to how ethical the outcome may have been. This was an exploration to uncover unintended consequences of change. Each of the front line staff identified positive and negative aspects of the changes. Two of the participants talked about the challenges (one front-line/one manager/leader). I selected this as a descriptor because in the interviews it was used in different ways – for example Steve used the words challenge as a goal “a fantastic challenge” as a verb ‘it challenged us” and as a state in the future “the next challenge”. In order to avoid a passive antonym to challenge such as acceptance, sanction, willingness etc. I referred to one of the interviewees who identified what she had learned during the process of change.

Vicky (manager/leader) in particular talked about what she had learned from this process including things like – the importance of the team, using data, making lots of changes, trying different things, talking to a lot of

people. These insights were described as if they were a key to the success of the programme of work and were "liberating". So, whilst the participants did not describe them as challenges and liberators, for the purposes of linking both aspects to enhancing learning about change, I selected these titles because they presume that there is no single truth. When presenting the themes under positive and negative, it presumes that because someone doesn't like something that it is negative that it is wrong or needs to be turned into the polar opposite of negative. Etymology of these terms: A challenge "*an objection or query as to the truth of something, often with an implicit demand for proof*" (Oxford Dictionaries 2013. [online]) describes two sides of a situation in which there is a challenge to someone else's ideas. The term liberator "*n - a person who liberates a person or place from imprisonment or oppression*" (Oxford Dictionaries 2013) has generally been used in political campaigns to demonstrated actions which can address a power difference between groups.

Examining the views of front-line staff on management led to polarising positions – positive views and negative views. How important are the views of front-line staff? So what if staff don't like the changes, if they are making them anyway? Transforming leadership is said to result in "*a relationship of mutual stimulation and elevation that converts followers into leaders and may convert leaders into moral agents*" (Burns 1978, p4). The link between leaders and followers is critical and linked so therefore it is important what staff think about the changes and their experience of undertaking the change. What are the problems with what managers are doing? The themes from case study two dominant in the data were conflict, challenging roles, power difference and emotional. Examination of this data demonstrated a high negativity because of what I have described as management "interference". The change agents (in this case the managers) require me (as a nurse) to behave differently, do a different kind of nursing (which I don't feel is ethically appropriate) and I feel bad about this. Not all of the things that management did were negative and there were many

data items that for example related to "*having a good rapport with manage*ment", "*management were always listening*", "*I could always speak with them"* Steve, Registered Nurse ED. From the data I started to estimate the level to which front-line staff felt that managers "interfered" – or changed what they did. In this case managers may not have "interfered" but colleagues had changed how they were doing things (not necessarily the managers) – this was still referred to as "management interference". Because the positive and negative data had already been identified I felt that this polarised view may be useful in providing an estimate of negativity and positivity.

I also estimated a "level of impact of change" (to achieve the target I believe that it is valid to acknowledge that some data items were perceived to have a low, medium or high impact on the ability to make a change, ie they were on a continuum. In order to estimate this level, I defined the term change very simply as "how differently work is done today compared with what was done prior to the change". I have also made an assumption that a "change" is equal to a measurable improvement. It should be noted that this change occurred over 2 years and was incremental in nature. Of course some changes do not result in an improvement and some of the data would suggest that participants did not ascribe to all of the ideologies of the improvement. Nevertheless, to examine different phenomenon that appear important from the thematic analysis, I have stripped away some of the complexity and focussed on two things that appear important – level of change in the work and level of management interference in how work gets done. This has been done with the ambition that, once examined in isolation, the knowledge needs to be woven back into the complexity into which it exists.

The following table shows a list of statements that focus upon the perceptions of front-line staff and management interference in their work, with an estimated ranking of the impact upon change. 10 would indicate a high level of impact of change and at the other end -10 would indicate a

very low level of impact on change. 10 would also indicate a positive perception of management input/interference and -10 would indicate a negative perception of management input/interference.

The criteria for allocating a number was based on my personal view of being firstly a manager, secondly an insider/outsider (inside the organisation but outside the department - continuum) thirdly analysing what participants said in the interviews. For example the statement 'managers abuse staff to make them do what they want them to do'; this is likely to have some impact upon change -7 (ie negative 7) and the view of management interference would be at the maximum possible -10 (negative 10). Analysing data in this way may provide an opportunity to develop a more balanced approach to change.

Table 28: Statements collated from themes from interviews from case study two.

	Statements collated from what front-line staff said about managers	Impact on change	View of management interference
1	Managers abuse staff to make them do what they want them to do	-7	-10
2	No one should be allowed to cheat to improve the measures	-9	-7
3	Managers shouldn't tell nurses and doctors about moving patients or how to do patient care	7	-7
4	Managers appear only when things are not going well.	2	-6
5	Managers listen to what staff say and then ignore what staff say	-5	-5
6	Managers are highly visible	7	-5
7	Managers want the system changed and now nursing is just numbers and paperwork	5	-4
8	Managers try to force ideas	7	-4
9	Managers allow everyone to make changes which means every shift something has changed which is stressful	8	-3
10	Lots of people need to do lots of things.	9	-3
11	Manager and staff priorities are different	2	-1
12	Managers are good at updating us	1	3
13	Managers have a good rapport with staff	8	4
14	Managers show respect to front-line staff	7	4
15	Managers promote the 'granny test'	5	5
16	Managers do the difficult jobs initially then handed them on when they become less difficult	7	5
17	Translation of what a goal means for managers, staff and patients is advertised and socialised	7.5	5
18	Managers need backstage information to have a reflexive approach	8	5
19	Managers and staff don't see eye to eye but they still talk	8	6
20	Unauthorised feedback to managers bypasses usual hierarchies and is necessary	9	7
21	Managers keep trying	8	8
22	Managers always listen to front-line staff	2	10

Table 28 lists 8 statements that are perceived by front-line staff to be negative management interventions but which are assessed as having a positive impact on change. Table 39 also has 3 statements which are viewed by front-line staff as negative interventions and also identified as having a negative impact upon change. There were 10 items identified

which were viewed as positive management interventions and which had a positive impact upon change. Figure 10 shows better the position of each statement in relation to both manager/leader interference (horizontal axis) and impact of change (vertical axis)

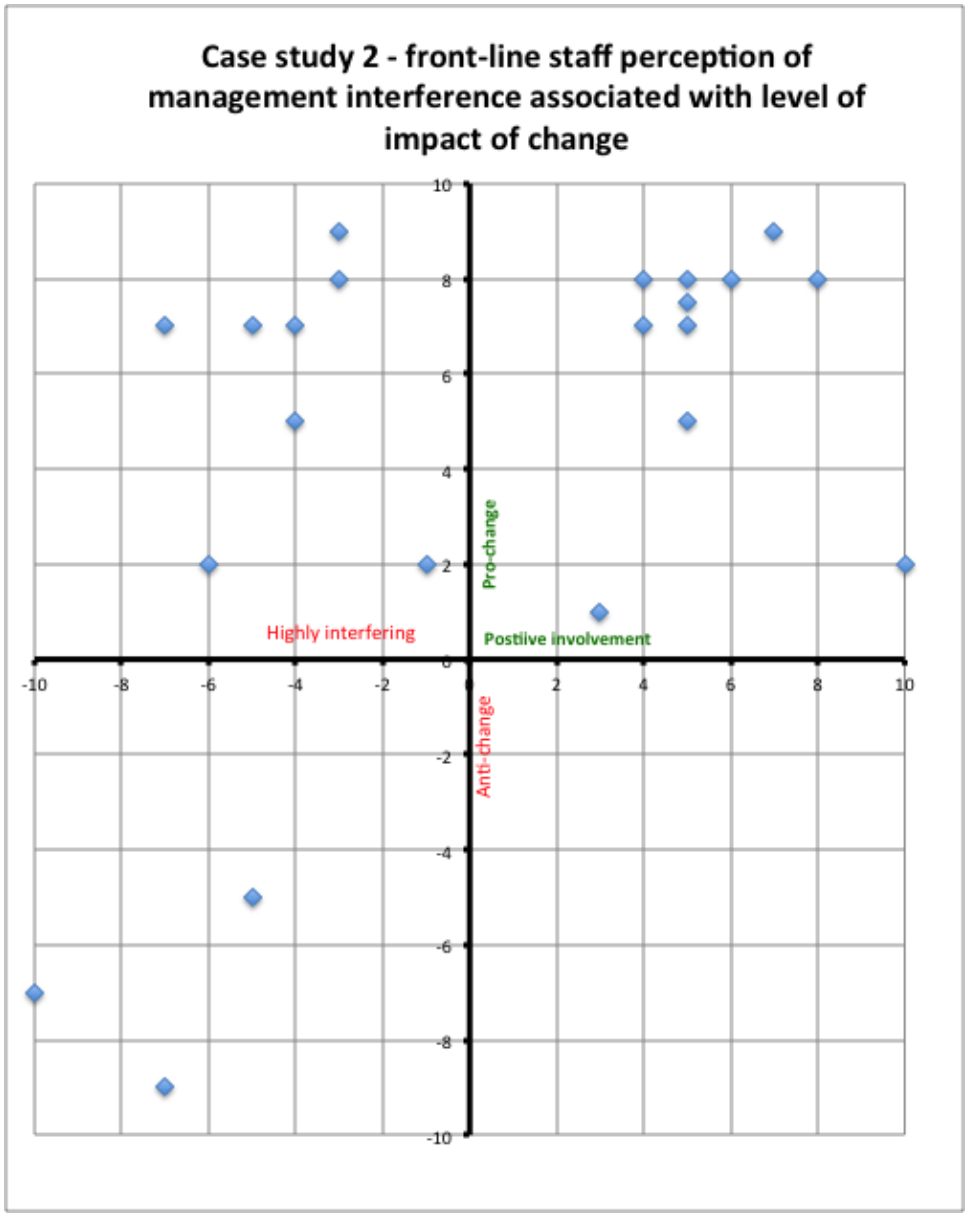


Figure 10: Front-line staff perception of management/leadership interference (case study two)

The upper right quadrant shows areas where front-line staff report positive interference from management and where according to elements of engaging leadership – this is likely to have a positive impact upon change.

The upper left quadrant is where items have been identified by front-line staff as being negative but where they appear to play a positive role in achieving change and form part of engaging staff in change.

The lower left quadrant is where there were items that were identified by front-line staff as negative management/leader interference and where they have been assessed as having a negative impact upon change and should be avoided – for example cheating, bullying and listening but not seen to taking action.

Each statement is reviewed in detail in appendix 33 to examine why it is present in each quadrant and how relevant it is for new learning.

Findings from case study one and to case study two:

A summary of the findings from study one using the same method for presenting data on the two axes of 'perception of management interference' and 'estimate impact on change' was used to review the findings. A list of summary statements from case study one were used and are as follows:

Summary statements from case study one:

1) The newsletter did not engage staff in change (and was estimated to be a weak catalyst for change) although it was perceived to be useful by staff and manager/leaders.
2) The quality meeting was seen as high value by front-line staff and manager/leaders.
3) Front-line staff saw managers 'controlling' the quality group and there was limited front-line staff led initiative.
4) Staff satisfaction surveys were seen as high value strategies for managers but low value for staff due to a perceived lack of response from managers
5) Perceptions as to the effectiveness of the three strategies was higher with managers than front-line staff.

6) Manager/leader intentions regarding engagement were misinterpreted resulting in suspicion that motives and ethics were substandard.

To build on the thematic model developed from case study two, these statements were plotted onto a graph using estimate level of change and perception of management interference (Table 29).

Table 29: Themes from case study one.

	Case study 1 - statements collated from what front-line staff said about managers	Impact on change	View of management interference
1	The newsletter did not engage staff in change although is was percieved to be useful by staff and manager/leaders	1	3
2	The quality meeting was seen as high vlaue by front-line staff and manager/leaders	4	7
3	Front-line staff saw managers 'controlling' the quality group and there was limited front-line staff led initiative.	4	-4
4	Staff satisfaction surveys were seen as high value strategies for managers but low value for staff due to percieved lack of response from managers	4	-8
5	Perceptions of effectiveness of the three strategies were higher with managers than with front-line staff.	2	-4
6	Manager/leader intentions regarding engagement were misinterpreted resulting in suspicion and motives and ethics were substandard.	5	-5

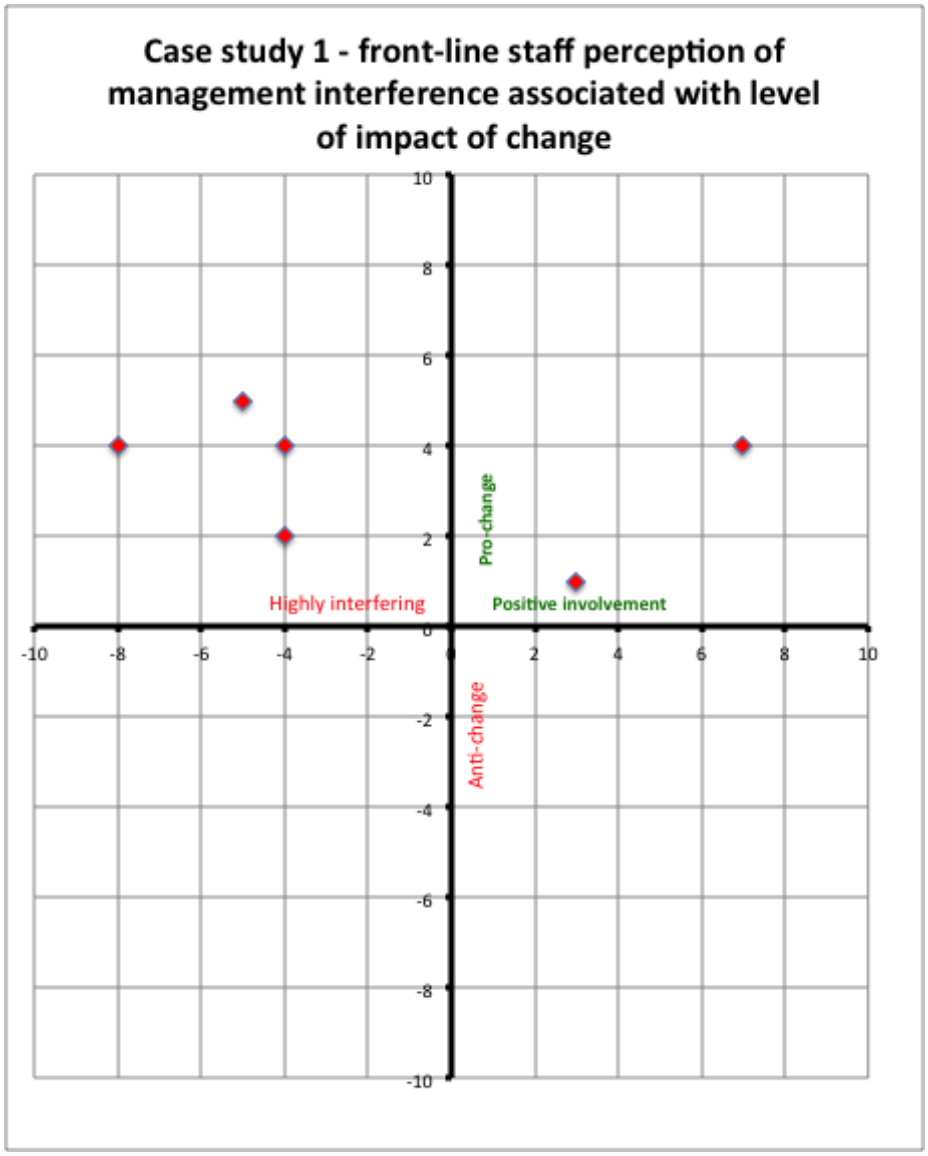


Figure 11: management interference with level of impact (case study one)

Data in the right quadrant (figure 11) indicated that there was a positive view of management interference (from front-line staff) and an estimated positive impact upon change. Data in the upper left quadrant indicated that there was a negative view of management interference (from front-line staff) however there was still some positive estimate as to the impact of change. There were no items in the lower quadrants.

The statements identified that the estimated impact of the strategies were not as high as in case study one. The plots were then overlaid to show how the first case study (red dots) compared with the second case study (figure

12). Whilst it is difficult to make a direct comparison it is interesting to note that the first case study, with its more gentle approach (ie less management interference), still had negative perceptions of management interference.

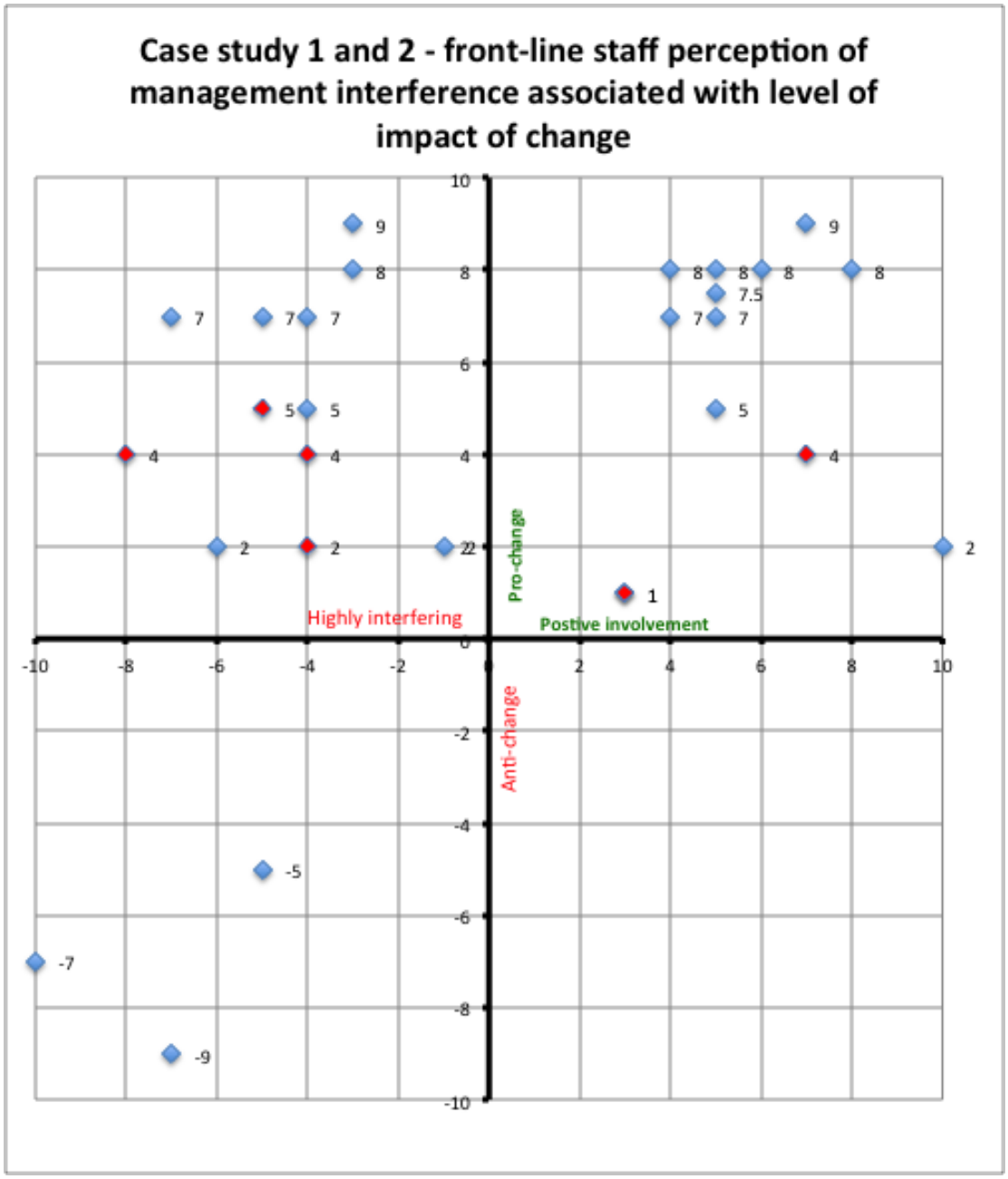


Figure 12: Case study 1 (blue dots) and 2 (red dots) – management interference with level and impact.

A conclusion from this work is that items that are in the upper right quadrant are things that front-line staff value about managers/leaders and which appear to have an impact upon change initiatives (in that they cause a change or are linked to a change). Examples include 'managers always listen to front-line staff, managers keep trying, unauthorised feedback to managers bypasses usual hierarchy, promote the 'granny test' etc. (see figure 13). The further to the right upper corner the item appears the more front-line staff value the strategy and the more effective the strategy. Items in the upper left corner are more complicated in that they appear to be perceived by front-line staff as negative and yet they appear to have a supporting role in change initiatives. Examples of these include; managers allow everyone to make changes - which means every shift something is different, managers shouldn't tell nurses and doctors about moving patients, managers try to force ideas etc. Three items appeared in the lower left quadrant concerning cheating, bullying and ignoring what staff say.

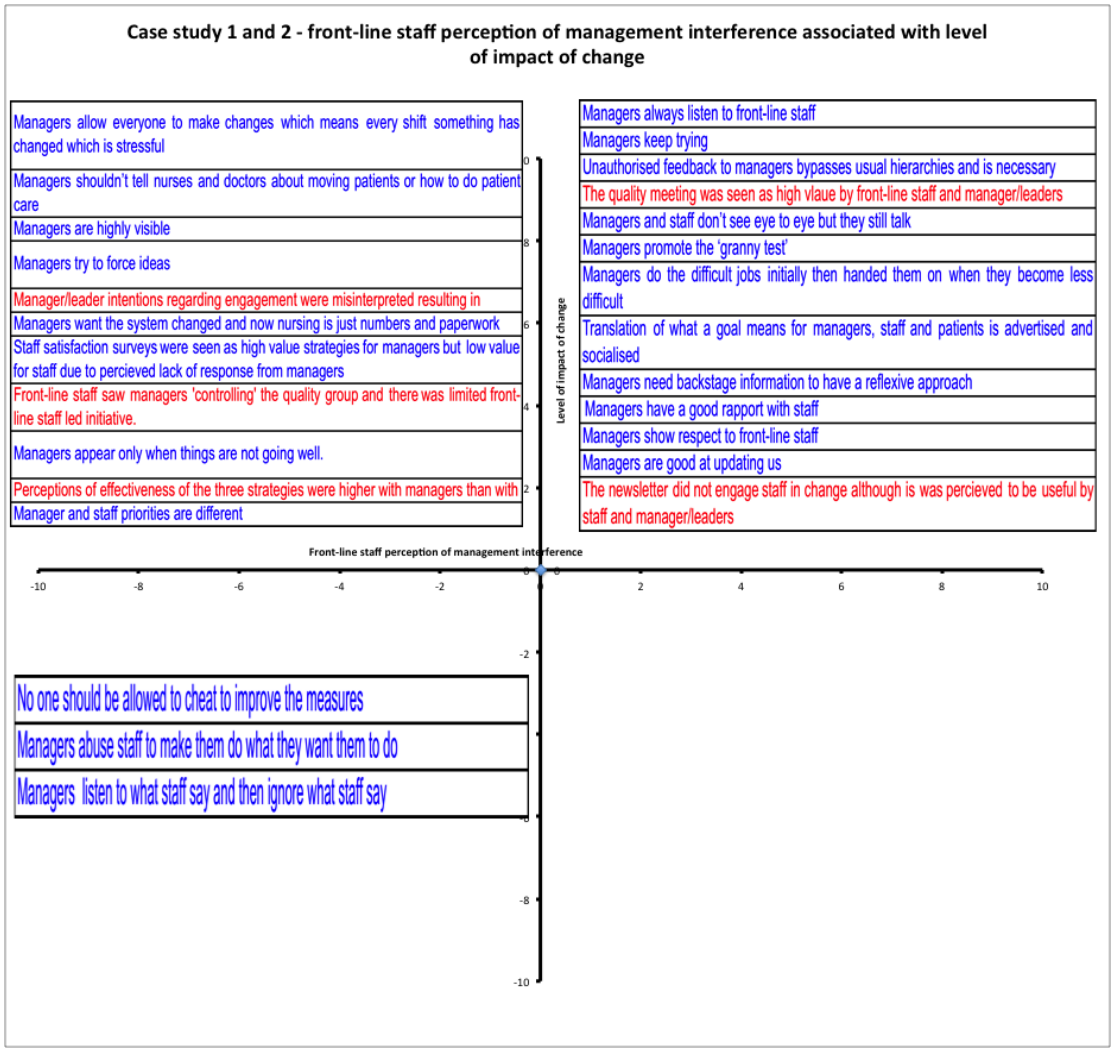


Figure 13: Case study 1 (blue) and 2 (red)– narrative of management interference with level of impact

Both case studies demonstrated that despite the good intentions from middle managers there were negative unintended consequences to strategies to bring about change. Case study one focussed upon three different strategies and examined what front-line and middle managers perceived to have been achieved by the strategies. There was a wide variation between front-line staff and management with front-line staff perceiving that strategies were poorly executed and did not achieve improvements for patients or themselves. The one exception to this was the front-line quality group which involved patients, staff and managers meeting to discuss and implement changes. Case study one did not show

that there was alignment of priorities with front-line staff and middle managers.

Case study two focussed upon a large change in an emergency department. Again there was wide variation between front-line staff and middle management views of how effective the changes were. This case study provided a more in depth analysis of the personal experiences of participants. These were viewed as both positive and negative by individual participants. There appeared to be a number of unconscious and unwitting consequences of middle manager behaviour that had a large impact on how front-line staff viewed middle managers and the changes that had occurred (figure 14).

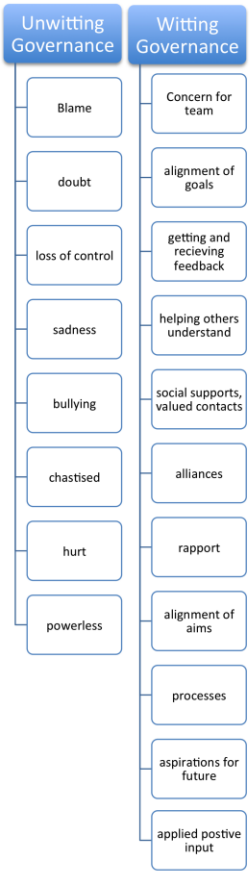


Figure 14: A list of themes attributed to positive and negative aspects of change.

Figure 14 indicates that in case study two there were a number of responses, experiences and beliefs held by front-line staff which were not intended by middle management (as far as can be ascertained) but which occurred as a consequence of conscious actions and more importantly appear to occur due to unconscious actions. This brings into question the idea of managers from the two case studies being in a state of "*unconscious incompetence"* as in *"not knowing that you do not know* (Hannabuss (2000. P402).

This research demonstrates that middle managers are not neutral and as has been proposed from a manageralist viewpoint – there to provide technical advice (Clarke, Gewirtz et al. 2000, p10). Case study one described implementation of three strategies which were designed to share information between managers and front-line staff however front-line staff did not feel positive towards this. Findings from case study one showed that the strategies were perceived to not have been genuinely implemented and questions were raised about the motives of middle managers. Some staff perceived that middle managers wanted to 'tick the box' (clerical staff). In case study two there was no perception that managers were neutral in their involvement of the change process and there was significant blame imposed upon managers for their role in the change that had occurred. Given the political nature of the middle management role and their position between senior management/politicians and the front-line staff, there appears to be a need to work under the scrutiny of both masters as well as work in the zone on the edge of chaos (Stacey 2002 page 28).

This research does not support the idea that more technical skills are required by middle managers. It proposes that middle managers should behave differently and develop different types of relationships with front-line staff.

In thinking about the relationship between the three groups (front-line, middle managers and senior managers), I have devised a Venn diagram

(Assessment Resource Bank 2013). This aims to show both the difference between the two groups (front-line staff and senior management/politicians as well as the commonality (of middle management)). I propose that the more commonalities there are – i.e. the greater the overlap - the more alignment there is in priorities and the more interdependence there is. If there is recognition that there is higher interdependence I propose that there is a higher understanding of how to work with each other in a changing environment. I propose that the area in which middle management works is in this overlap. The ability of middle management to learn the skills and advance their experience in this area would appear to be critical if the aspirations of politicians/senior managers and the front-line staff are to be achieved. Using the Venn diagram as a way to view this however limits the ability of middle management to operate independently to achieve the commonality between front-line staff and senior management/politicians. The relationships between all three parties are interdependent.

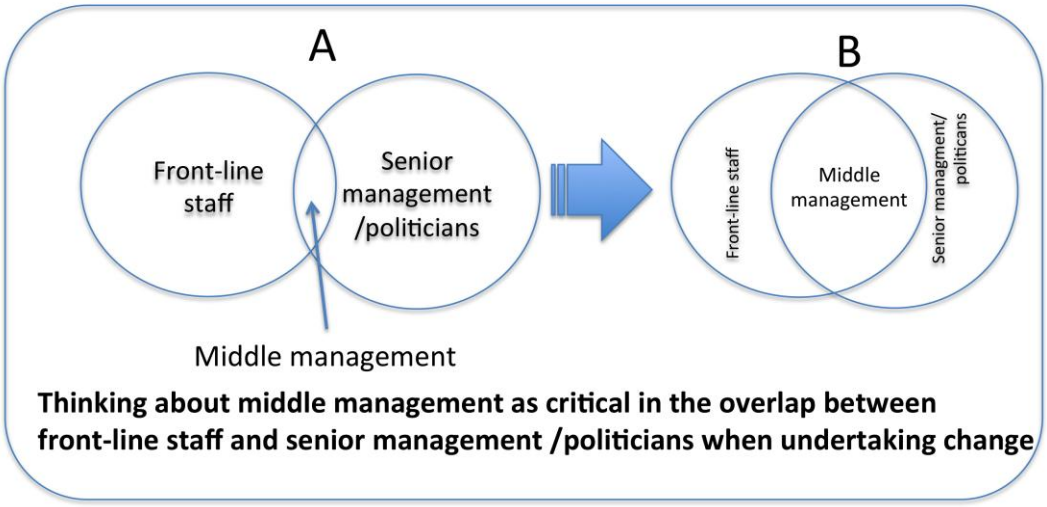


Figure 15: Proposed model for moving middle management to increase engagement

The behaviours of middle managers would appear to be critical to undertaking a change process. Whilst there are a number of examples where manager behaviour strengthened the change process, one conclusion

of this study is that there is significant evidence that managers unwittingly damaged relationships. Whilst it is recognised that there are a number of strategies that counterbalanced the negative perceptions, when and how to apply the strategies remains unclear. Improving how we carry out change is a core feature of this research question. The concept of developing guidance has been considered particularly in light of the ethical issues that have arisen during the process of examination.

Ethical considerations for guidelines

The ethical competence framework proposed by Schrijver and Maesschalk (2013 p37) can be used as a lens in which to view the findings of this research. Which areas were shown to be strengths and which appear to be weaknesses. Thus identifying poor attention by the managers to areas in knowledge, skill or attitude.

Table 30: Schrijver and Masschaick, Ethical Competence Framework as applied to Case study 1 and 2 (CS1, CS2).

CS1 – case study 1, Wales CS2 – case study 2, NZ	Knowledge	Skill	Attitudes
Rule abidance	CS1 – didn't realise implications of not being reliable and consistent? CS2 - Lapses in rules to meet the target	CS1 – no data CS2 – not viewed as addressed by staff	CS1 – acknowledged lapses and tried to mitigate CS2 – managers worked to eliminate lapses
Moral sensitivity	CS1 – not aware of effects of broken 'psychological contracts' CS2 - not always aware of implications of power differences	CS1 – limited ability to pick up on issues raised by staff CS2 –accessible to staff, staff felt they could talk to managers/leaders.	CS1 – interested, unaware of issues, some cynicism re value of staff input into some areas CS2 – willing to listen to front-line staff, element of cynicism to further change work to address staff concerns.
Moral reasoning	CS1 – manager leader priority was to improve care for the patients, secondary consideration for staff CS2 – manager/leaders priority was to improve care for the patients, secondly the staff – clear presentation of moral issues articulate to the staff about patient priorities.	CS1 – limited evidence of reasoning in relation to staff concerns CS2 – evidence of changes in thoughts and practice in relation to feedback concerning how changes were made and impact on patients	CS1 – limited data CS2 – manager/leaders had high contact with staff and an 'open' attitude to staff input.
Moral motivation and character	CS1 – managers unaware that staff did not view attempts of engagement as genuine. CS2 – managers/leaders aware that some staff have concerns. Staff generally felt that the leaders/managers were trying to do the right thing.	CS1 – limited skill due to unawareness CS2 – able to use feedback from staff (and data) to modify priorities reflecting skill in this area	CS1 – some cynicism as to motivation of staff, generally an open attitude. CS2 – priorities noted to be different, viewed as healthy as seen as working in same directly by both front-line staff and manager/leaders.

The data was collected from multiple sources therefore it is artificial in some ways to make conclusions which attempt to define a competency. What was interesting however were the 'knowledge' and 'attitude' components. Without knowledge or awareness of an ethical dilemma it is of course impossible to address this competence in any practical sense.

Attitude is the other component that starts to focus on inherent and personal characteristics – thus moving from a mechanistic approach to a more personal and organic flavour about what is 'good' in someone willing to engage with ethical situations. This exercise reinforces components of a guidance that should provide information on knowledge and attitudes – as well as skill. The guideline should also provide a dynamic and balancing approach which perhaps takes into account trial and error, context and a history of the individuals involved. In looking at the difficulties with assigning evidence to a rather static summary (whilst extremely useful in identifying key features to include) – a guideline should address the need for reflexivity.

Appendix 32 outlines all of the items in the Institute for Health Management code (IHM) (2013). There are a number of themes that have emerged from the data in this research that are not represented in the codes of conduct referred to (table 31).

Returning to the 28 themes that emerged from case study one and two, Table 31 shows how these themes link to items in the IHM code of conduct in the UK (Appendix 32), to an entirely different area which had developed a code of conduct – a school (Appendix 30) and to the New Zealand Nursing Council code of conduct (Appendix 31). The purpose for using a school code of conduct is that this particular code appears to be derived from a different style of leadership. The code of conduct is for teachers at a school in which the pupils have learning and behavioural challenges. The codes demonstrate a move from power and direction (of the teachers) to a learning and understanding code of conduct. I believe this provides a contrast with which to examine the themes that emerged from this study.

It is my intention to demonstrate and justify new themes required in guidance for manager about leadership and change based on the findings from the data.

Table 31 outlines the main themes from the two case studies. Column 3 shows which themes could be mapped to an item in the IHM code of conduct (outline in appendix 32). There are several gaps in the mapping related to

- When managers get involved in the day to day work
- How managers appear to ignore what staff say
- The will of managers over front-line staff
- How managers can help staff with change
- How managers can be reflexive and change the strategy
- Maintaining relationships when there is conflict
- When communication goes wrong
- Problems with trust

Column 4 shows which themes could be mapped to an item in the School code of conduct (if pupil was replaced with front-line staff). When this swap was made it was interesting to see how easily the words front-line staff could be inserted and could be mapped to a theme in the research.

Table 31: Mapping of emerging themes to codes of conduct

Mapping emerging themes to current code of conducts	Emerging themes from case study one and two	Institue of Health Managers code of conduct	School code of conduct	New Zealand Nursing Council Code of Conduct
1	Managers abuse staff to make them do what they want them to do	8, 20, 30	N,B,C	6
2	No one should be allowed to cheat to improve the measures	3, 8, 20	T	
3	Managers shouldn't tell nurses and doctors about moving patients or how to do patient care	5, 13	D	
4	Managers appear only when things are not going well.		M	
5	Managers listen to what staff say and then ignore what staff say		O	6
6	Managers are highly visible			
7	Managers want the system changed and now nursing is just numbers and paperwork		D	1,3
8	Managers try to force ideas		F	6
9	Managers allow everyone to make changes which means every shift something has changed which is stressful			
10	Lots of people need to do lots of things.		I, K	
11	Manager and staff priorities are different	32		
12	Managers are good at updating us	9		
13	Managers have a good rapport with staff	19	L, M, P	
14	Managers show respect to front-line staff	22,28	O,	6
15	Managers promote the 'granny test'	9, 35	H, Q	1,3
16	Managers do the difficult jobs initially then handed them on when they become less difficult			
17	Translation of what a goal means for managers, staff and patients is advertised and socialised	26		
18	Managers need backstage information to have a reflexive approach		E,J, G, V, X	
19	Managers and staff don't see eye to eye but they still talk		H, Q, R, W	
20	Unauthorised feedback to managers bypasses usual hierarchies and is necessary		E	
21	Managers keep trying		R	
22	Managers always listen to front-line staff	19	L, O	
23	The newsletter did not engage staff in change although is was percieved to be useful by staff and manager/leaders			
24	The quality meeting was seen as high vlaue by front-line staff and manager/leaders		R, O, M	6
25	Front-line staff saw managers 'controlling' the quality group and there was limited front-line staff led initiative.		W, D	
26	Staff satisfaction surveys were seen as high value strategies for managers but low value for staff due to percieved lack of response from managers		R, S	
27	Perceptions of effectiveness of the three strategies were higher with managers than with front-line staff.		E	
28	Manager/leader intentions regarding engagement were misinterpreted resulting in suspicion and motives and ethics were substandard.		L	

Whilst there remained gaps (or unmapped themes) it was apparent from the 28 items on the left of table 43 that 21/28 items from the School code of conduct related to the findings of the study compared to only 10/28 in the Institute for Health Management. It is important to review why the themes identified in this research are in conflict with the dominant doctrine of the Institute of Health Management.

This research findings support the idea that a manager's reality is different from that of front line staff. That front-line staff believe that what managers do is done with an agenda and is highly political (and that manager actions are not neutral). Managers and front-line staff are suspicious of each other and that responding reflexively seems important to how this relationship is viewed. The notion of a post modernist approach to management seems academic however the findings from this research would appear to support this and provide a basis for this theory.

This is adapted from the school code of conducts and Greenleaf's (1973) ten characteristics of a servant leader - listening, empathy, healing, awareness, persuasion, conceptualisation, foresight, stewardship, commitment to the growth of people, knowing the unknowable (Speers 2004, p13-16). Mapping of items is provided in Appendix 27.

Proposal for new guidance

This research would support the need for a different style of leadership that is more reflexive in its approach to leading change. The guidance proposed is specific to undertaking change and has arisen from research into quality improvement, leadership and exploration of what happens in the real world. As a result of this, the process of developing guidance is focussed on ethical issues and codes of conduct. My research has involved development of a guideline drawing upon codes of conduct as a way of promoting a different, more pragmatic and pluralistic ethos for undertaking quality improvement. This guidance reviewed ethical concerns raised as part of the analysis of the

data and subsequent literature review. Table 32 outlines a summary of the ethical analysis considered in constructing the guidance.

Table 32: Summary of ethical analysis undertaken for considered inclusion in the proposed guidance.

Summary of ethical analysis for the proposed guidance
Ethical dilemma in care provided in the NHS and the process undertaken by managers and leaders in making change
Findings from the thematic analysis in this research indicated that managers were unaware of some of the consequences of change on the team (on page 183).
Review of findings using typology of power relations (on page 199) – balance/imbalance (Avelino and Rotmans 2009, p557)
Review of findings using staff perception of management interference and impact of change (front-line staff view) (on page 228)
Review of findings using positive and negative aspects of change – witting and unwitting governance (on page 230).
Review of findings using *six moral principles and corresponding duties* (Patankar et al, 2005, p4) (on page 235)
Review of findings mapping three codes of conduct to data from this research (on page 242)

Table 34 is the draft the proposed guidance – in full.

Table 34 Draft guidance for reflexive middle manager behaviour

Guidance for reflexive middle managers		
Core beliefs		**Supportive actions from middle managers**
1a	Front-line staff want to provide excellent care.	We believe that front-line staff do their best when they are part of a team that works together and is supported by each other and middle managers.
1b	Learning new behaviours and ways to undertake change is a task just like learning to read or write.	Front-line staff and middle managers can learn to improve their ability to undertake change together by improving processes on a regular basis.
1c	Mistakes are part of the learning process.	Middle managers understand that some changes are mistakes and these can be rectified. Middle managers don't make a judgement about it – but will support the work of the front line team to get it right. Practice improves performance.
1d	Front-line staff and managers can learn strategies to support teams to improve the change process	Most staff and managers have evolved ways of dealing with change based on their previous experience of being changed or leading change. In many cases these are either a barrier or not sufficiently thought through to be helpful in addressing the sometimes-challenging behaviours of all team members undergoing change. Developing an understanding of why teams behave as they do, a positive attitude to the team and developing effective strategies for the team is a core requirement of a middle manager's job.

The middle manager behaviour		Supportive actions from middle managers
2a	Actively builds trust and rapport with front-line staff	Trust and rapport have to be earned; they're not given. Spending time learning from front-line staff builds rapport and shared understandings
2b	Demonstrates belief in the team	Front-line staff want to see middle management as one of 'us', who does it for us, helps the team work together and makes us matter (adapted from Haslam, Reicher et al. 2001, pxxii).
2c	Treats the front-line staff with dignity and respect	By saying thank you, listening carefully, asking for advice. The middle manager never shouts or threatens front-line staff even if they feel upset, stressed or angry.
2d	Listens respectfully	And makes a judgement about how/when to respond.
2e	Enjoys being with front-line staff	Is courteous, warm and friendly towards front-line staff even when there is disagreement about an issue.
2f	Hears the message behind the word/behaviour	Thinks about why the person is behaving this this way – there will always be a reason; the behaviour is a symptom.
2g	Sees things through	Keeps trying, is tenacious with difficult problems and issues.
2h	Keeps their word	Does whatever they say they will do
2i	Tells the truth	Never lie to front-line staff
2j	Looks for the good	Identifies the good with the team and builds on it
2k	Apologises if they make a	Model humility and apologise

	mistake	
2l	Manages their own emotional reactions to events	Identify and name your own reactions thus monitoring your own emotionally intelligent behaviour at all times.
2m	Let go of your memory/feelings when you feel you have been unfairly treated by front-line staff	Focus on working with front-line staff to get it right in the future.
Conflict		**Supportive actions from middle managers**
3a	Quietly but firmly holds appropriate boundaries for front-line staff	Never let anyone do whatever they want (including yourself) when this would infringe upon the rights or comfort of other staff or services for patients.
3b	Normalise conflict. We believe conflict is normal, expected and healthy.	Middle managers will increase communication with front-line staff when there is conflict, they will keep the dialogue going and won't avoid the team. Acknowledge that everyone is right (to some extent) and recognise that no one person has all the answers. Stay humble and positive.
3c	Unpopular conflict	Sometimes middle managers will be required to hold a stance that is unpopular. Middle managers will seek feedback, allow front line staff to convey their concerns and seek the

		real concerns beyond what is said. In conjunction with the front-line team, middle managers will work to maximise the benefits by proposing alternatives if feasible. Middle managers will work with the front line team to minimise the negative impacts upon patient care and team function. Middle managers will ensure that all front line staff understand the principles/aims of the change and in turn, they understand the full range of issues that have been raised by front-line staff. With the front-line team, the middle manager will clarify how this will positively and negatively impact upon patient care and team working.

This guidance has been developed to provide scaffolding for transformative engagement between managers, front-line staff and ultimately patients. It is based on a manager's desire to 'serve' patients and staff first and lead/manage second. This guidance attempts to recognise what behaviours are important when acting reflexively in a constantly changing and complex environment. It recognises that avoiding illegitimate power can be difficult for middle managers due to roles and context. It also recognises that learning through doing is key to improving how change gets done. In this way this guidance attempts to describe what *phronesis* (practical wisdom) may look and feel like. Figure 16 proposes a schematic view for balancing the need for change with engaging front-line staff. It was derived from the process of analysing the data where themes (from front-line staff point of view) were assigned properties on two linear scales 1) level of management interference – from highly interfering to positive involvement and 2) outcomes of change – anti change (as in no change) and pro –change (as in significant change).

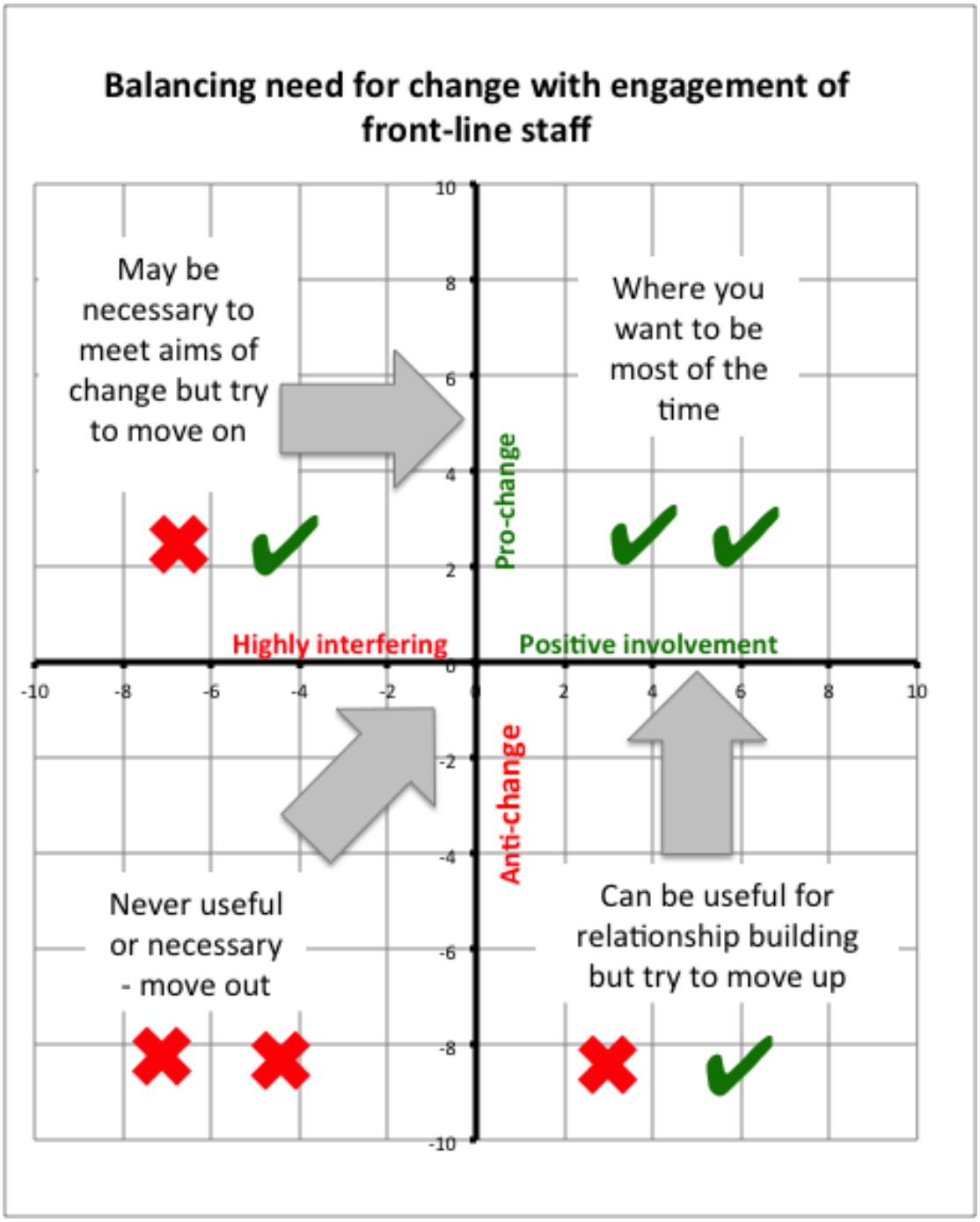


Figure 16: Proposed guide for middle managers undertaking change, balancing the need for change with engagement of front-line staff.

Figure 16 provides a dynamic context for which the guidelines could be used. Appendix 34 is the information presented to a seminar of colleagues (including managers/leaders from medicine, management and nursing).

Feedback on first draft of the guidance (formally described as a Code of Conduct) developed from this research.

An invitation was sent to colleagues to attend an hour-long lunch time seminar where I had an opportunity to present my research and also to introduce the guidance. I requested feedback (via an online feedback survey) in the week following the meeting. Attendees included:

- Medical Director
- Dr Clinical Leader
- Nursing Director
- 3x Charge Nurses
- General Manager medicine
- Quality facilitator
- Information technology Developer

The aim was to present the findings from my research which had lead to the focus of the guidelines, Appendix 34 shows the slides presented. The slide stepped through the research questions, literature, methodology and findings. Immediately following the seminar there was some discussion about the need for change (pro-change versus anti-change) and management interference – (and the presentation of data in figure 16 on the crossed y and x axis). There was some discussion and agreement that this reflected two important but difficult aspects of being a good manager ie balancing the need to facilitate change with the need to engage staff and keep them 'happy'. There was some sharing of experience around trying to keep initiatives going and bemusement as to why good ideas stop or fade out. There was voiced frustration about the difficulties in revisiting 'old' themes and how people appear to be struggling with the same things from 10 years ago.

Subsequent 'business as usual' meetings held with my colleagues over the following week revisited some of this discussion. The discussion moved onto an apparent aversion to taking risks, trusting people to do the right thing

and the impact that 'not taking risks' may have on being able to make change. We discussed the idea that people may be too apprehensive to make change not because of fear that it will go wrong but that it might not go 'perfectly'. This was very useful exploration of resistance as the idea of admitting failure or having to revert to the old way because it didn't go as planned was not seen as something that professionals appear to be comfortable with.

Subsequent to the seminar, I sent out a survey requesting feedback on the items selected for the guidance (Appendix 35). This was implemented using Survey Monkey® (2014). The on-line survey link was sent to 18 people (including the above list of people that attended (10) and a smaller group who were unable to attend (8)). All had been invited to attend the seminar. For each conduct item, participants were asked if they agreed with the item being included in the guidance (based on a code of conduct) with options of 'yes/no/don't know/irrelevant'. Each item also contained an option to explain why they had answered as they had.

Feedback from the survey:

12 out of 18 participants responded in the on-line survey. None chose to provide feedback in person or via another means as offered in the invitation. Appendix 36 provides a verbatim narrative of how the participants answered. Each participant was allocated a number and their full feedback has been captured in this document. This was extracted using the reporting tool in Survey Monkey® (2014) and transferring to a Word Document so that it could be presented and modified with clear justification as to the changes made. Appendix 37 shows how this feedback modified the draft document. The guidance was then split into a short version (2 pages) and a long version (4 pages) – Appendix 38. The proposed short guidelines is below.

Appendix 37 gives a summary of consensus expressed by the seminar participants and it demonstrated how modifications were made to the draft.

Examination of the feedback was separated into three themes – clarity and use of language to depict what was intended, the level of consensus shared by the participants with the sentiment of the elements proposed and also most importantly an assessment of uniqueness (compared to other guidance around codes of conducts that had been viewed).

Proposed guidelines for managers to engage front-line staff in change
(short version – page 1)

Core Beliefs:

- Front-line staff want to provide excellent care.
- Learning new behaviours and ways to undertake change is an essential task.
- Mistakes are part of the learning process
- Front-line staff and managers can learn strategies to support teams to improve the process involved in change

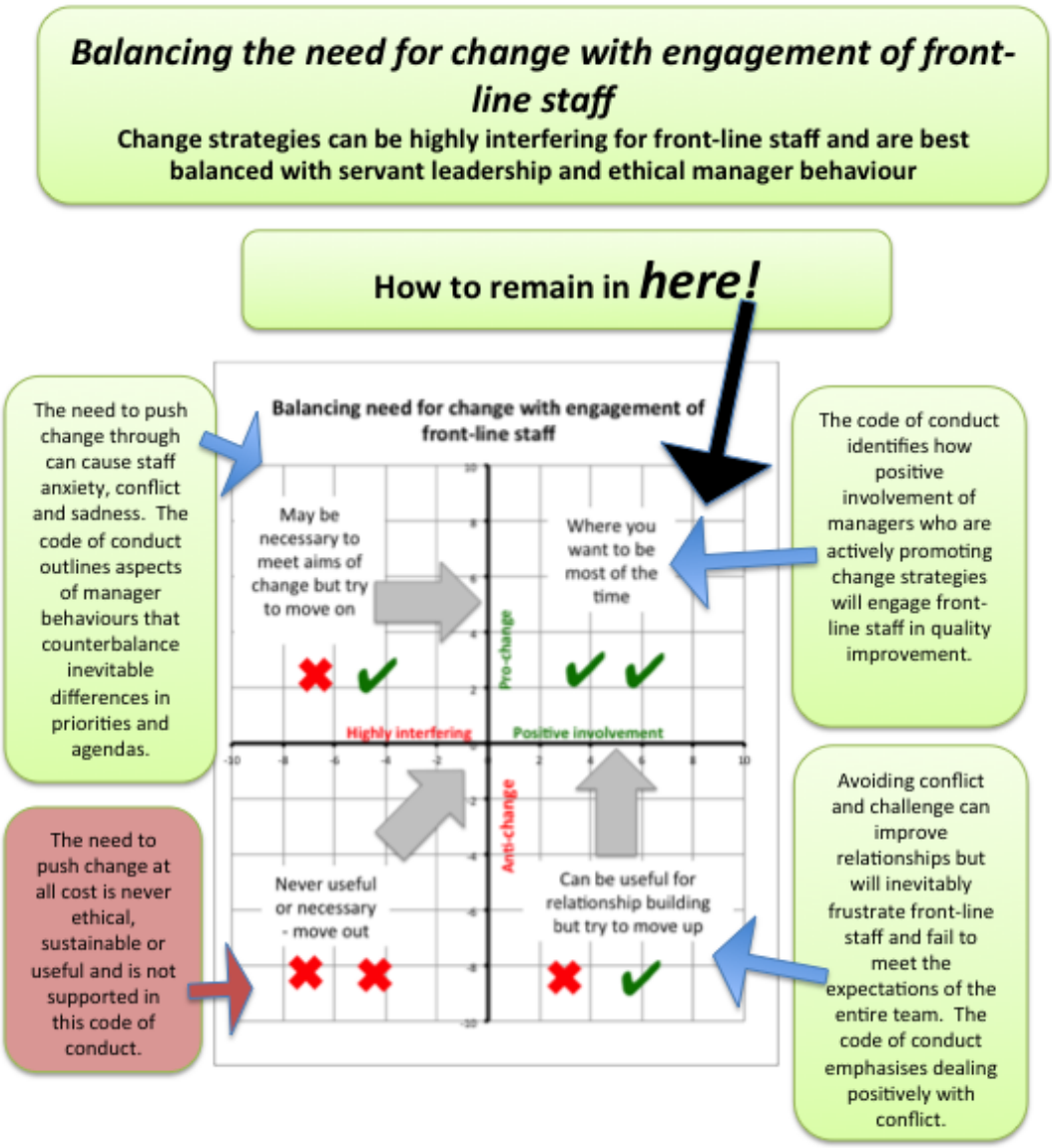
Core Behaviours of managers:

- Actively seeks to gain the trust of and build rapport with front-line staff and senior management
- Demonstrates belief in the team
- Treats the front-line staff with dignity and respect
- Appreciates and understands the importance of, and benefits gained from, spending time with front-line staff
- Listens for the message behind the word/behaviour
- Sees things through
- Keeps their word
- Is always honest
- Looks for the good
- Apologises when they make a mistake
- Manages their own emotional reactions to events
- Lets go of memory/feelings when they feel they have been unfairly treated by front-line staff or senior management
- Quietly but firmly maintains appropriate boundaries with front-line staff
- Normalises conflict
- Makes unpopular decisions and choices with knowledge and transparency

Balancing the need for change with engagement of front-line staff

Tools, techniques and strategies for change can be highly interfering to front-line staff and need to be balanced and supported by ethical manager behaviour. Ethical manager behaviours alone may not achieve the change necessary and need to be supplemented with tools, techniques and strategies.

Guidelines for managers to engage front-line staff in change
(short version – page 2)



See Appendix 39 for full version of the guidance

END of Short version

Figure 17: Proposed final guidelines

The way information was presented in the guidance were examined for ambiguity and understanding of the intention of the element. There were

modifications made according to suggestions by the participants – for example 'truth' was substituted for 'honest'. Other minor modifications were made to increase clarity.

There was also a need to gauge how much of the guidance was endorsed wholeheartedly by the participants. Proponents of naturalistic generalisation assert that evaluation should be carried out in a way which – *"provide(s) maximum of vicarious experience to the readers who may then intuitively combine this with their previous experiences"* (Stake and Trumbull 1980, p1). Whilst the participants who had attended the seminar had an opportunity to hear the justification (and identify with this personally), almost half of the group had not. Most participants however were able to understand and agree with the sentiments. They were able to explain why they felt the elements were important. This reinforced that the elements were appropriate. A concept developed that was not part of the draft guidance. This was the 'balanced approach to change' diagram. Because this appeared to provide an 'aha' moment for attendees during the seminar and subsequent discussion – I included this as an integral part of the guidance. I think that it provides a more dynamic framework and gives an emphasis to the idea of reflexively managing change. This also helps, I think, to move away from the idea of guidance being a list of rules – to more a way of being.

The third component requiring feedback was regarding the uniqueness of the guidance. Did it provide a fresh approach to managing change? There is evidence in the feedback and during the discussion that there were three areas which were fresh and new in the proposed guidance which appeared to be novel. The first were in the core beliefs i.e. staff want to provide excellent care, learning new behaviours, mistakes are part of the process and teams can learn strategies. Whilst there was general agreement, there was also consideration that this view was not shared by all managers. Whilst this did not mean that managers were out and out unethical, by not acknowledging core beliefs, there was agreement in the group that this led

to mistrust and poor outcomes. My assessment is that it does lead to unethical management behaviour through imbalances in power. The second area was regarding relationships with front-line staff. Again there was general agreement that this was important for good outcomes but was generally viewed (in their experience) as an 'optional extra'. The third element which appeared novel, were the features related to conflict, including holding boundaries, normalising conflicting and dealing with unpopular decisions. These elements appeared important because they described behaviours that were felt to be hidden from everyday discussion and that participants worried about.

These three areas – core beliefs, ethics about relationships and dealing with conflict appear to present a unique approach to guidance for managers navigating ethically and successfully manage change.

Reflections on findings:

During the process of analysis I became aware of wanting to simplify and jump to conclusions. I realised that by trusting the research process I could suspend my impatience and enjoy the mechanics of reviewing data and themes. Because of the heavy emphasis in the findings regarding the ethics of change, one of the ideas that I progressed was to create a code of conduct. Without a professional body to support this (in New Zealand where I currently reside), this proposal was abandoned. Instead I have produced a set of guidelines which I believe encapsulate my findings well and have been shown to be accessible to many staff that I work with. In retrospect, a code of conduct was unlikely to have been supported, even if there was a body in NZ to work with, as my findings are far removed from the usual health manager codes that still are largely managerialist (both in the UK and NZ). By developing guidelines for middle managers undertaking change, the guidelines are perhaps more universal and I hope will provide a common benefit.

Chapter 6 Discussion

This study was able to examine in detail the impact of manager led strategies on groups of staff in Wales and New Zealand. It did this from multiple perspectives through analysis of documentation and interviews with front line staff, patients and managers.

The two case studies utilised middle manager approaches which on the face of it were successful – in that they were reported to have achieved what they set out to achieve; reduced waiting times, feedback loops, forums for staff. In case study two, 95% of patients were moved out of the emergency department in 6 hours. Examination below the surface however demonstrated themes of perceived poor integrity of managers and discontent with how managers carried out their duties by front-line staff. Managers spoke of poor support from more senior management.

The findings of this research do not offer a further adaptation of the managerialist approach to middle management. An alternative guideline for middle managers has been proposed based on a requirement of a more reflexive approach to change and an adoption of a servant leadership model (Greenleaf 1973). Greenleaf proposed servant leadership *"begins with the natural feeling that one wants to serve, to serve first"* (ibid loc. 347). The servant leader makes sure that '*other people's highest priority needs are being served'* (ibid loc. 350). The context for development of the guidance relates to a key component of servant leadership

> "*do those served grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, more likely themselves to become servants?*" (Greenleaf 1973 loc. 351)

The findings of this research would suggest that managers working as servants in a more equal relationship with their usually professional

colleagues will achieve more. To understand what this might look like and describe some features of this, I have proposed guidance for managers and front-line staff undertaking change which incorporates elements of servant leadership, organisation learning, *phronesis* (practical wisdom) and a more egalitarian distributed leadership that is more appropriate when working with professional groups of staff in the public health service.

The following four areas provide a basis on which I believe the doctrine of managerialism is inadequate.

1. Distributing leadership to followers,
2. A pragmatic approach to wicked problems,
3. Upsetting traditions of power – necessary and sufficient and
4. Creating environments to allow people to develop *phronesis*.

Distributing leadership to followers

Disturbing the normal hierarchies for communication, solving problems and decision-making may be important to engage front-line staff with improving work. The first aspect of Tate's metaphor of an organisation as a fish tank (2013, p5) does the manager see themselves as being in the fish tank at all? or do they see themselves looking in? This might suggest that the manager needs to be in the fish tank to be able to assist in keeping the fish tank healthy and adaptable. There are two ways to gain information about what is really going on – from favourite people (risky) or from going out and speaking with a lot of different people. A conclusion from this study is the need for managers to recognise what is really going on. They need to understand what staff really think, to be able to modify their own approach and behaviour, to be more reflexive (and show more compassion). Kindness and concern was highly valued by front-line staff even when there was some conflict or disagreement with how some of the work was to be done. Wheatley refers to compassion as an essential ingredient in collaboration -

> *"We need to expect that we will wander off course and not make straight progress to our destination. To stay the course, we need*

> *patience, compassion, and forgiveness. We should require this of one another."* (Wheatley, 2006, Loc 2806)

Other data that positively supported manager interest and engagement was – 'gaining feedback from all echelons of staff not just through the usual hierarchies'. This appeared to relate to how frequently front-line staff came into contact with managers and the types of conversations that arose from this interaction. The idea that front-line staff should only raise issues with their immediate supervisors or superiors inhibits managers further up the hierarchy from receiving information and feedback.

A pragmatic approach to wicked problems

Case study two could be defined as multiple "wicked" problems ("wicked" problems are referred to in Chapter 2 p61). The department was one of the first departments in New Zealand to have achieved the 6 hour emergency . The areas in this study which would appear to relate to supporting the domain of solving wicked problems is the positive impact that managers always listening to staff may have on assessing information. Assuming that when undertaking large-scale change, all problems are 'wicked', could slow down a team from making decisions about 'tame' problems.

"Managers allow everyone to make changes which means every shift something has changed which is stressful" (Sarah, ED Nurse). Perhaps this is a symptom of wicked problems. Wicked problems generally needed a lot of consultation and consensus before trying something to see if it will work. The multitude of wicked problems envisaged in the second case study could serve to stultify a team. Their approach to frequently trying different changes to resolve different issues (with the knowledge that they could return to the old way and that is ok) was a way to keep everyone involved, reduce fear of wicked problems and perhaps gain experience of solving wicked problems (and turn them into tame ones).

"Managers keep trying" (Steve, Registered Nurse) provides an element of doggedness and persistence that perhaps is required by the team to battle the wicked problems and not become fatalistic (Grint refers to the fatalist as "*there is nothing that can be done, people are selfish AKA we are all doomed*' (Grint 2008, p15). Managers/leaders in case study two spoke of how they worked with their colleagues to keep a focus on achieving the target. It appeared that it was the manager's role to keep a focus on the what was needed to be improved.

Upsetting traditions of power and people in general – necessary and sufficient?

Front-line staff approached the subject of change in relation to interference from management. "*Managers shouldn't tell nurses and doctors about moving patients or how to do patient care*" (Sarah ED Nurse) is a statement that gets to the nub of change for front-line staff. Prior to the changes in case study two, the decision (and power) for when to move a patient was within the control of the front-line nursing staff and Clinical charge nurses. A significant part of the angst of the change for front-line staff was losing this power and presumably increasing the pressure of time. The opportunity to look holistically at the patient and their needs was eroded when someone else decided what was happening to a patient because from their point of view, the patient is "*a line on the computer" (*Lucy ED Nurse*)* and they need to be moved elsewhere. The contrary position of this of course is that the delivery of service to a patient, who is lying on a trolley, is not appropriate either. The delays in receiving x-ray, findings from blood tests, reviewed by a doctor, charting of pain medication, consult from the urologist, all cause delays which are outside of the nurses control – but are part of the system. The work done on improving the system (or to use the metaphor 'the health of the fish tank') may not be sufficient to work at all times resulting in other staff (or managers) 'taking over'. The impact of managers interfering with front-line staff roles may not be desirable or sustainable however it may seem necessary at times to achieve the desired outcome of the target. It is also interesting to note – that 'management' – refers to clinical charge

nurses (involved with clinical care) as well as managers. Clinical charge nurses in other areas would provide a high level of coordination and decision-making regarding location of patients – which perhaps was not part of the culture in the department.

*"Managers want the system changed and now nursing is just numbers and paperwork" (*Lucy, ED Nurse*).* Similar to above – this interference from management to change the system may result in changes from bedside care to coordination and oversight. Promotion of all professions working to the 'top of their scope' seems to mean that positions such as nursing (and medical staff) provide less holistic bedside care and more oversight and traditional 'management' type input. This is based on what both Vicky (manager/leader) and the front-line nurses reported about the changes to their roles.

Creating environments for phronesis:

When managers are highly visible this upsets the balance of power through the hierarchies as all staff have an opportunity to speak with management. Whilst this may undermine the traditional positions of power this may need to be viewed as highly desirable because it promotes an opportunity for exchange of ideas and sharing experiences. It would appear that the more managers/leaders interact and interfere with front-line work, the higher the chance they may damage fragile relationships and not meet expectations of those they are leading or those they are accountable to.

The context in which the guidance has been developed presumes that undertaking change takes practice and may be key to improving how it is done. Most people's experience in undertaking change involves dealing with some degree of conflict or loss and involves changes in roles. It is however unlikely to be a popular part of a role. From my own point of view stability and relationships that are not fraught with tension are far more preferable than negotiating in the edges of chaos. There is a fear from this researcher

that managers may 'tinker around the edges', disguising the focus of targets but not addressing a 'whole sale change in culture'.

With different intensities to change in the two case studies, front line staff found management wanting (with regard to holding high ethical perspectives, not following through on actions, not listening to front-line staff, interfering with work, controlling forums etc.). Some of the findings would suggest that despite front-line staff being unhappy with different strategies, change still occurred and made positive changes for patients e.g. reduced waiting times in ED and waiting for chemotherapy. A balance appeared to be required to weigh up the need for change and the need for doing the right thing by the staff. Practice in negotiating this balance would appear to be useful and create experience in both the front-line staff and the middle manager.

Managers interfering with front-line processes may be necessary in order to learn about the system. It may also be necessary for understanding how problems occur and, as a result, experience different conversations with front-line staff. Challenging staff and being challenged by staff as an equal, involves building rapport and developing different types of relationships. Managers fully engaged in a system of change may encourage *phronesis* or practical wisdom that is learned not in a classroom or a coaching session but by the bedside, in an emergency department, in the orderly hub. The value in seminal moments and reviewing change strategies would appear to be important in learning and reflecting on relationships and change in an organisation.

The Granny test may be a metaphor which provides a mandate to allow *phronesis* to flourish in the boardroom as well as the ward in a hospital. It encourages empathy (in asking the question 'how would you like your granny to be treated') and thus providing a complex context which all levels of staff can reflect on. Whilst rules govern many systems of care and are required for good decision making, there may be a need to move from '*what*

can be done' to '*what we should and, indeed, must be done' (Davis 1997, pg 185)* with the aim to ensure that the 'right' thing always gets done.

Front-line staff and manager/leaders experienced high levels of stress when engaged with rapid change. This meant that some conversations did not go well, some arguments and discussions were had that perhaps could have been better handled. The opportunity to reflect and learn from charged environments may provide an environment for rapid learning and collaboration.

Reflections on the analytical framework:

The analytical framework (table 5, page 96) was proposed to ensure that the type of data gathered and the type of analysis carried out did not presume a particular stance but would provide multiple views through which findings could be assessed. Case study one showed that there was a dis-connect between the total quality management approach and the other two approaches (change management and leadership theories). In that there appeared to be important improvement work being undertaken but that staff and managers did not have a shared view of what had occurred. A number of the activities associated with quality improvement (including a structured approach and focussing on important themes) were determined as intact and operating. What was not so apparent were perceptions of honour, trust, legitimacy and credibility.

The literature review emphasised limitations in the technical / scientific approach to change and improvement (which total quality improvement could be classified as). This in many ways has been borne out by this study. Leadership theories offer different characteristics of how leaders, followers and fellow travellers are viewed. What would appear to be a key link between the analytical framework, the literature and this study, is the control that middle managers can have over their own behaviour. Moreover how changes in manager behaviour can alter the perceptions of front-line staff and followers. The guidelines propose that it is the managers themselves who can change how they are viewed by followers and fellow travellers.

Reflections of actions undertaken during the study.

My idea at the beginning of this research was to develop a toolkit for middle managers to demonstrate how they could undertake quality improvement and change, in an ethical, valid and useful way. What I found however was that managers (that both worked for me and myself as manager) were perceived to be unreliable and in some cases untrustworthy. Managers were perceived by front-line staff as having agendas that were viewed as

unwholesome and misguided. Managers (including myself) believed that, with front-line staff, we had achieved real findings – reducing waiting times for patients, improving systems with and for staff. My experience in facilitating change projects (in developing clinical care pathways) had been viewed as very successful (and sustainable) both from within the organisation and outside – so much so that I had been invited to co-author a chapter in a book about systematising health care (Cumming and Cochrane, 2008) - Appendix 28. Clearly there was a dis-connect with what I, managers and front-line staff believed to be true. My first instinct was to take sides. Firstly I sided with the managers and thought that front-line staff didn't know the background to decisions and how things had been carried out behind the scenes. Clearly they needed more information than had been provided and that this was poor marketing on the part of the managers – they (and I) hadn't sold the ideas sufficiently. Given that the strategies in case study one were about sharing information with front-line staff, this didn't really seem to fit with this conclusion. Then I sided with the front-line staff and decided that they must be correct and the managers were clearly misguided. This however, would mean that staff and myself had bad intentions or were completely incompetent, which I also did not conclude to be true. Exploring further explanations became an important mission and I recognised may provide the potential new knowledge required for this doctoral research. It is for this reason that the second case study was added with a focus upon what managers and front-line staff believed to be happening (and their views about this). I undertook the interviews myself as I felt I could get closer to the data. Whilst I was not part of the department that I interviewed, I had inside knowledge as to the hospital wide initiative that had been undertaken and I had followed the initiatives in the department. I also knew that the middle managers and clinicians had 'good' intentions and were very focussed upon getting the staff working together to achieve the goals.

The negativity held by some front-line staff (in case study two) was quite alarming at times and difficult to reconcile with their views that it had also

been a successful programme of work because the waiting times in the emergency department were shorter for patients. Analysing this data provided a complex interweave of ideas about the fallibility of humans trying to do the 'right' thing. The data also described the idea that there may be levels of views held by staff (who hold many contradictory ideas in themselves) and that there is no one truth to be found but components of good things and components of bad which appear to balance up somehow – to be either generally good or generally bad. In order to explain how managers with good intentions turn out to be viewed as bad, I categorised and re-categorised the data coming up with three ideas about how the themes might be viewed - 1) challenging versus liberating, 2) witting versus unwitting intentions and 3) level of impact of change versus front-line staff perception of management interference. Slicing the data in multiple ways provided a rich way to examine firstly the nature of the action - for front-line staff (challenging versus liberating), the unconscious behaviours of the managers (witting versus unwitting) and combining the impact of the change with the perceived interference by managers (from a front-line staff perspective). This examination of the data from both case studies provided me with the platform to focus upon the behaviours and intentions of middle managers if a more engaging style of leadership were to be developed. This research provides cautionary tales for middle managers functioning in the dominant doctrine of the hegemony of managerialism. The starting point with cautionary advice is in some ways back to the basics principles. I believe that a guideline based on code of conduct principles provides the foundations on which a different type of leadership and middle-management can and should be signalled and practical advice can be delivered. It breaks with the dominant traditions, thus adapting a code of conduct from a unique educational institution where a more servant leadership model appears to be ascribed to.

Chapter 7: Conclusions and Recommendations

This final chapter revisits the aims, objectives and research questions as well as targets the recommendations, derived from the findings for middle and senior managers working in the NHS and the New Zealand Health Service.

This research has addressed the objectives set out in chapter two. I have reviewed and critically appraised the literature in relation to approaches to change in the NHS and the NZ health system through studying two areas of change. I have developed an alternative view of the role of middle managers resulting in the formulation of new guidance based on a servant leadership model which is presented in appendix 39.

The following objectives and research question were set out and I shall respond to each of these in turn:

To search for evidence of important quality improvement work carried out when three manager led strategies were implemented.

1. To study staff, patient and manager perceived effectiveness of the strategies implemented.

Both case studies had manager led strategies. In both case studies, the middle managers (and patients/carers) held that the strategies were more effective (and positive) than front-line staff.

2. To develop theoretical concepts and models for operational managers leading change and quality improvement in the NHS and the New Zealand Health Service.

The contradiction in objective one, led to the idea that new models were required to firstly explain how the numerous contradictions might exist and search for different ways for managers to behave in order to achieve different outcomes. The response to the research questions below includes discussion based upon the project findings from this study.

Research question:

1. What knowledge do health sector middle managers require to undertake transformative engagement with staff and patients?

The dominant doctrine in the NHS and public health sector in New Zealand could be described as managerialist. This research would suggest that a largely managerialist approach, despite the most noble intentions, leads to unwitting behaviours of coercion and unreliability thus generating mistrust. As each context (group of staff, set of circumstances and group of patients is different), the generalist principles and tools in managerialism appear to be of limited use and do not explicitly recognise the views of front-line staff as an important evaluation factor in achieving the principles.

The health sector middle managers may benefit from knowledge that is related to servant leadership and developing reflexivity as a manager thus leading to a more balanced approach. The proposed guidance in appendix 39 offers principles that are more akin to working alongside staff with the view of improving change through collaboration, repetition and practice.

i Are there changes to the team as a result of the implementation of change strategies?

This study proposes that the changes to the team may not be what managers and leaders intended. The variation between what managers thought were the values of strategies and the outcomes of events were not supported by the front-line staff who tended to have a more negative view (seen in both case studies). Whilst in case study one there was consensus

between managers and front-line staff regarding what the strategies could deliver, there remained wide variation between what was implemented. The strategies in case study one would appear to generate more opportunities for staff to mistrust managers.

Case study two demonstrated that there were significant changes to the team as a result of the implementation of change however staff generally viewed the changes as both negative and positive. Front-line staff whilst acknowledging the improvements the strategies had made, on a personal level, they found the change difficult and in some circumstances abusive.

ii What features of the strategies were important for managers and front line staff?

The features of the strategies which were reported to be most positively viewed by the front- line staff were the opportunities to discuss matters with middle managers. This was noted in case study one (with the quality group) and case study two (with reports that managers always listened, were around). A number of areas were identified as being useful to change processes however they may not have been seen as positive from the front-line staff point of view.

iii Were the strategies perceived as useful and sustainable?

The strategies were not perceived as useful or sustainable from the front-line staff point of view. Whilst most front-line staff in case study one identified that the strategies were theoretically useful, their experience in implementation was variable and in some cases destructive. The research methodology exposed short comings in implementation as it triangulated data from interviews with managers, front-line staff and patients as well as collected data from documents. A top down approach of the strategies implemented in case study one and two provided some insight into how on

one level there were positive changes with regard to changes for patients. On the other hand the change experience for staff was not always positive.

In view of the long list of negative themes that emerged, it is clear that the strategies were not perceived as effective in engaging all staff nor sustainable. This research proposes that the middle manager has two masters – front line staff and senior management (and politicians). Figure 15 titled 'moving middle management from A to B' proposes the idea that the larger the overlap between front-line staff and senior management/politicians in beliefs, the easier it is for middle management to operate. All three groups when looking outside appear to need to view the outside as working with and for 'us'.

iv What 'governance' themes emerge following implementation of the strategies?

Data revealed that managers were unwitting of transgressions in their behaviour. The behaviours observed by front-line staff were perceived to be in conflict with what managers thought they were doing. Part of the analysis in this research focussed on the knowing and unknowing behaviours (or witting and unwitting) – these are outlined in figure 14. The reflexivity of a middle manager would appear to be critical if unwitting behaviours are to be counteracted at an appropriate time with a balancing or nullifying behaviour. Recognising and balancing the need to firstly - get engagement with front line staff and secondly to nurture improvements, appears to be a critical concept to transformational change.

The main governance themes that emerged using the largely managerialist strategies were not as extreme as what might be described in the 'allegory of good and bad governance' (Lorenzetti, 1339: [online]). The characters of cruelty, deceit, fraud, fury, division, war, avarice, pride and vainglory whilst extreme, displayed elements in the data particularly from case study two.

As with most guidance, this guidance reinforces a close alignment with the other characters in the 'allegory of good and bad governance' Lorenzetti, A (1339) [online] i.e. faith, hope, charity, peace, fortitude, prudence, magnanimity, temperance and justice. What is different is that this guidance proposes the idea that serving front-line staff in the context of uncertainty is of key concern. It proposes that the underpinning of servant leadership may be useful to observe. The guidance stresses that understanding when matters do not go well it is important to involve front-line staff and managers in learning from mistakes. It stresses that this is a key component of the role of a manager.

Limitations in design:

At the completion of this research I can see limitations in the design regarding decisions that were taken during the study period.

1. **Decisions regarding the exploration of emerging themes in case study one**

The qualitative nature of the data collection meant that documents and interview summaries (from case study one) were able to be reviewed and analysed several times during the study and particularly once analysis had occurred in case study two. It was recognised that interview data collected in case study one could have benefited from full transcription instead of summary points – (with quotes taken from the audio recording when the interviewer collated the data onto the preformatted summary sheets). This meant that there was some limitation in how this data could be examined. Initially the data was gathered for the purposes of verifying evidence of effective quality improvement processes, however once it was recognised that there were a number of themes that did not support verification, the raw data from audio transcriptions was not available both because it had not been presented to me by the interviewer and secondly because consent had been given based upon a summary of the interviews not transcriptions (the summaries had been verified by the participants). This therefore limited the exploration of themes which arose from the interviews and thus

limited the generation of theory. The reason for developing a summary template for the interviewer in case study one was because I did not recognise the importance that this data may have on the study. Whilst I recognised that interviewing front-line staff, patients/carers and managers would enrich the knowledge about the impact of the strategies from a multiple perspective, I did not realise how much this information might alter the direction my research would take.

A further element regarding the interviews in case study one was that I did not undertake these myself so that there was an element of anonymity in what was said in the interviews - because I was the line manager for all of the staff interviewed. I believe that getting an outside interviewer and undertaking summary data collection was valid because of this reason. To avoid summarising the interviews I could have researched another area of quality improvement led by someone else. This however would not have been a core part of my work and at the time I started my doctorate there were few other areas where quality improvement was being undertaken that I was not specifically involved.

Overall I believe that preserving the confidence and integrity of the data from case study one (so that I was not able to influence or identify which participants said what) was the correct decision (given I was their line manager). In adding the second case study I was able to undertake thematic analysis on the interviews and I believe that this balanced this decision from case study one. Case study one was critical in my personal learning as I was able to reflect on a decision I had personally made which I believe has enhanced my line of questioning and research.

2. Decisions regarding the development of a set of guidelines

The conclusion of my research findings in an idea which offers an alternative to the dominant doctrine of managerialism. If I had started with the premise that managers were unwittingly unethical and required a new code of conduct, I believe my research would have included some validation

of a code of conduct. As this research was exploratory and certainly did not start with developing this type of product, this has not been included in my research.

Conclusions and recommendations

This project has focussed upon a gap in understanding about what happens when NHS middle managers instigate change. The identified gap has been an important one to me as it represents a dis-connect in the dominant doctrine of managerialism with the potential for achieving true transformational engagement. The overall aim of this work-based research was the development of new knowledge to assist middle managers to work more effectively with front line staff. In delivering this aim, I have engaged with many staff across the NHS and the public health sector in New Zealand to facilitate discussion and debate. In the discussion sections I have identified key factors which have contributed to the guidelines. I have also critically reflected on the basis of the guidelines in terms of ethical behaviour of middle-managers.

Middle managers operate in a challenging environment where the strategies identified by politicians and more senior colleagues fall upon them to implement. The need for managers and senior leadership to 'push' through changes has resulted in a high number of public disasters and reduced confidence in the public health services.

This research recognises that the most valuable asset in healthcare is the knowledge and dedication of those involved in delivering the services and the role that managers may play to ensure front-line staff deliver the best health care they can.

In this project I identified that the ability of middle managers to act reflexively as a key competency to engaging with staff. In doing so, this research recognises that change takes practice, it does not always go smoothly and that the factors affecting success and failure are often hard to define or perceive. Acknowledging human fallibility in guidelines I believe

is a new and important feature to guide managers to work collaboratively with staff to improve services to patients (i.e. to serve). The guidelines cover the areas that the middle manager has most influence over – themselves (what they do and what they say). It covers some fundamental beliefs about clinical teams, learning and their role in the supporting front-line teams. It also covers core responsibilities in behaviour, laying out what might be expected from the people they serve – the front-line staff. Lastly the guideline covers how middle managers might be expected to behave when dealing with conflict. The guideline aims to provide guidance for the most relevant but most difficult aspects of being a manager. The areas that front line staff have said that they need the most assistance with. The areas that managers have previously not provided the most support in.

It is anticipated that, because the proposed guidance challenges the status quo (and the dominant doctrine of managerialism), there will be considerable criticism of it. I believe however that this is an important debate to have and an important proposal to make. I perceive that it will take another 5-10 years (possibly less with reduced finance going into the NHS and the NZ Public health service) before large scale research provides more insight into the deteriorating relationships between managers and front-line staff through the process of pushing through more and more change without addressing underlying issues such as trust, respect and emerging relationship problems.

Contribution to practice

In this research I have demonstrated the importance of reflexive management and how this sits more with a servant leadership role for middle managers than a managerialist The guidelines proposed, link themes that emerged from the data in this research, literature and it highlights the importance of *phronesis*. This research proposes that achieving practical wisdom (i.e. *phronesis*, balancing instrumental rationality with value rationality (Flyvberg 2001, p3)) is through four areas of personal and group exploration; a view of self as a servant first, leader second; a view of self as a practitioner of change (i.e. someone who

frequently practices change), a view of self as a person who will unwittingly make mistakes and develops counter-measures for these and view of self as the 'Granny'; helping to achieve systems that I would want members of my family to receive.

Recommendations for participatory management

- There is a need to embark on additional research, to test the elements of the guidelines against rapid improvement initiatives and gain further case study examples. Thus potentially using the guidelines as part of an evaluation programme.
- To spread and evaluate how the guidelines can be used in organisations to create positive collaborative relationships and a higher level of engagement for front line staff.
- To develop a programme of support for middle managers using the guidelines as a source for understanding and exploring common situations for managers.
- Further qualitative research into ethical issues and dilemmas for managers in health as perceived by front-line staff.

Some of the recommendations that have been made are being explored within the current organisation I work in and there is an opportunity to formalise some of these expectations over the next few years. The potential to use elements from the guidelines for evaluating the success or failure of a team in implementing change will also be tested both within the organisation and external to the organisation through national groups and local academic institutions where I work.

The most significant contribution of this research will be through publication to a wider audience. It is intended that a publication to appropriate journals in the UK will be undertaken with advisors in the next year.

References

Adair, J. (1989). Great Leaders. Guildford, Talbot Adair Press.

Alban-Metcalfe, J. and B. Alimo-Metcalf (2013). "Reliability and validity of the "leadership competencies and engaging leadership scale"." International Journal of Public Sector Management **26**(1): 56-73.

Alimo-Metcalf, B. and J. Alban- Metcalfe (2002). Leadership. Pscyhology at Work. P. Warr. Bury St Edmunds, Penguin**:** 300-325.

Alimo-Metcalf, B. and J. Alban- Metcalfe (2008). Engaging leadership. Creating organisations that maximise the potential of their people. London, Chartered Institute of Personnel and Development.

Argyris, C. (1960). Understanding Organisational Behaviour. Homewood, Il, Dorsey Press.

Argyris, C. (1974). Behind the front page; [organizational self-renewal in a metropolitan newspaper. San Francisco,, Jossey-Bass Publishers.

Argyris, C., Putnam, R., Smith, D. (1985). Action science. San Francisco, Jossey-Bass.

Argyris, C. and D. Schön (1974). Theory in practice : increasing professional effectiveness. San Francisco, Jossey-Bass Publishers.

Aristotle, Brown, L. (2009). The Nicomachean Ethics (Oxford World's Classics). Oxford University Press. Oxford.

Assessment Resourc Bank (2013). "Venn Diagrams." English, mathetics and science. Retrieved 23/11/2013, 2013, from http://arb.nzcer.org.nz/strategies/venn.php.

Australian College of Health Services Management (2013). "Code of Conduct." Retrieved 23/11/2013, 2013, from http://www.achsm.org.au/about-us/code-of-ethics/.

Avelino , F and J. Rotmans (2009) 'Power in Transition: An Interdisciplinary Framework to Study Power in Relation to Structural Change' European Journal of Social Theory **12**(4) p 543–569

Bate, P. and G. Robert (2006). "Experience-based design: from redesigning the system around the patient to co-designing services with the patient." Qual Saf Health Care **15**(5): 307-310.

Bate, P., Robert, G., Bevan, H. (2004). "The next phase of healthcare improvement: what can we learn from social movements?" Quality and Safety in Health Care **13**(1): 62-66.

BBC News, 2001. "Organ scandal background" http://news.bbc.co.uk/2/hi/1136723.stm BBC News, 29.1.2001. Accessed June 2015.

Belbin, R. (1996). Management teams : why they succeed or fail. Oxford, Butterworth-Heinemann.

Berwick, D (1996). "A primer on leading the improvement of systems" BMJ **312**:619-622

Berwick, D (2013). "A promise to learn - a commitment to act: Improving the Safety of Patients in England". Crown copyright 2013. www.gov.uk/government/publications/berwick-review-into-patient-safety. Accessed June 2015.

Bevan, H. (2007). The Sustainability and Spread of Organizational Change. Oxon., Routledge.

Birken, S., Lee, S., Weiner, B. (2012). "Uncovering middle maagers' role in healthcare innovation implementation." Implementation Science **7**(28): 1-12.

Bittle, M. J., Charache, P., Wassilchalk, D. (2007). "Registration-associated patient misidentification in an academic medical center: causes and corrections." Jt Comm J Qual Patient Saf **33**(1): 25-33.

Bolman, L. and T. Deal (2003). Reframing organizations : artistry, choice, and leadership. San Francisco, Jossey-Bass.

Bowman, J., West, J., Berman, E. and M. Van Wart. 2004. *The Professional Edge: Competencies in Public Service*. Armonk, NY: M.E. Sharpe.

Bradley, E., Holmboe, E., Mattera, J., Roumainis S., Radford, M., Krumholz, H. (2004). "Data feedback efforts in quality improvement: lessons learned from US hospitals." Quality and safety in health care **13**(1): 26-31.

Braun, V. and Clarke, V. (2006) Using thematic anlaysis in pyschology. Qualitative research in Pyschology 3(2):77-101

Buchanan, D. (2010). NHS Managers: The other frontline? The Cranfield Knowledge Interchange, Cranfield University, School of Management.

Buchanan, D., Fitzgerald, L., Ketley, D. (2007). The Sustainability and Spread of Organizational Change. Oxon., Routledge.

Buhr, G. and H. White (2006). "Quality improvement initiative for chronic pain assessment and management in the nursing home: a pilot study." J Am Med Dir Assoc **7**(4): 246-253.

Butcher, T. (1995). Delivering welfare : the governance of the social services in the 1990s. Buckingham, Open University Press.

Chatterjee, D. (1998). Leading Consciously: A pilgrimage oward self-mastery. Woburn, Butterworth-Heinemann.

Clarke, J., Gewirtz, S., Mclaughlin, E. (2000). New managerialism, new welfare? London, SAGE.

Cmnd 9085 (1983). Financial management in government departments. London: HMSO

Collins English Dictionary (2013). "Code-of-conduct." Retrieved 23/11/2013, 2013, from http://www.collinsdictionary.com/dictionary/english/code-of-conduct.

Costley, C., Elliott, G., Gibbs, P. (2010). Doing work based research : approaches to enquiry for insider-researchers. London, SAGE.

Crawford, M., Rutter, D., Manley, C., Weaver, T., Bhui, K., Fulop, N., Tyrer, P. (2002). "Systematic review of involving patients in the planning and development of health care." Bmj **325**(7375): 1263.

Crotty, M. (1998). The foundations of social research : meaning and perspective in the research process. London, SAGE.

Crotty, M. (2003). The foundations of social research : meaning and perspective in the research process. London, SAGE.

Cumming, A. (2005). A Guide to Good Practice: Elective Services. Cardiff, National Leadership and Innovation Agency.

Cumming, A. and J. Cochrane (2008). Organisational lessons from systematisation: the experience of Healthcare Otago. Changing Clinical Care - experience and lessons of systematisation. Gray. Oxford, Radcliffe Publishing**:** 176-190.

Cunliffe, A. L. (2009). A very short, fairly interesting and reasonably cheap book about management. London, SAGE.

Cutler, T. and B. Wain (1998). Managing the Welfaire State. Oxford, Berg Publishers.

Dans, P. (1994). "Credibility, cookbook medicine, and common sense: guidelines and the college." Annals of Internal Medicine **120**(11): 966-968.

Darzi, A. (2008). High quality care for all : NHS next stage review review final report. Norwich, TSO.

Davis, F. D. (1997). "Phronesis, clinical reasoning, and Pellegrino's philosophy of medicine." Theor Med **18**(1-2): 173-195.

Davis, K., Schoen, C., Schoenbaum, S. Collins, K., Tenney, K., Hughes, D., Audet, A (2007). "Mirror, mirror on the wall: An international update on the comparative performance of American health care." The Commonwealth Fund **59**.

Degeling, P., Maxwell, S., Kennedy, J., Coyle, B. (2003). "Medicine, management, and modernisation: a "danse macabre"?" Bmj **326**(7390): 649-652.

Degeling, P., Maxwell, S., Iedema, R., Hunter, D. (2004). "Making clinical governance work." Bmj **329**(7467): 679-681.

Denscombe, M. (2003). The good research guide for small-scale social research projects. Maidenhead, Open University Press.

Department of Health (2000). NHS Plan: a plan for investment, a plan for reform. D. o. Health. London, Stationery Office.

Department of Health (2002). "Code of conduct for NHS Managers." Retrieved 16/9/2012, 2012, from http://www.nhsemployers.org/SiteCollectionDocuments/Code_of_conduct_for_NHS_managers_2002.pdf.

Department of Health (2008). High quality care for all : NHS next stage review review final report. Norwich, TSO.

Department of Health (2009). The NHS constitution : government response to consultation. London, Department of Health.

Department of Health (2010) Equity and excellence: liberating the NHS. London: The Stationary Office Ltd.

Department of Health (2010) *Front Line Care: Report by the Prime Ministers Commission on the Future of Nursing and Midwifery in England*. London: The Stationary Office Ltd.

Department of Health (2012) *Compassion in Practice: Nursing, Midewifery and Care Staff, Our vision and strategy*. London: The Stationary Office Ltd.

Department of Health (2012). Partnership Agreement: an agreement between DH, NHS Employers and NHS Trade Unions. London: The Stationary Office Ltd.

Department of Health (2013) Report of the Mid Staffordshire NHS Foundation

Trust, Public Inquiry: Chaired by Robert Francis QC. Volume 2: Analysis of evidence and lessons learned (part 2). T London: The Stationary Office Ltd.

Department of Health (2014). The NHS Constitution: the NHS belongs to us all. D. o. Health, Crown. London: The Stationary Office Ltd.

Dettmer, H. (1997). Goldratt's theory of constraints : a systems approach to continuous improvement. Milwaukee, Wis., ASQC Quality Press.

Dewey, J. (1998). How we think : a restatement of the relation of reflective thinking to the educative process. Boston, Houghton Mifflin.

Dickinson, H. and C. Ham (2008). The governance of health services in small countries: what are the lessons for Wales? N. L. I. A. f. H. (NLIAH). Cardiff, University of Birmingham**:** 15.

Dopson, S., FitzGerald, L., Ferlie, E., Gabbay, J., Locock, L. (2002). "No magic targets! Changing clinical practice to become more evidence based." Health Care Manage Rev **27**(3): 35-47.

Dreyfus, H. and S. Dreyfus (1986). Mind over machine : the power of human intuition and expertise in the era of the computer. Oxford, Basil Blackwell.

Durie, M. (1998) Whaiora: Māori health development. Oxford University Press 2nd Ed.

Edwards, N. and M. Marshall (2003). "Doctors and managers." Bmj **326**(7381): 116-117.

Egan, G. (1994). Working the Shadow Side: a guide to positive behind-the-scenes management. San Fransico, Jossey-Bass.

Eisenberg, P. and J. Painter (2002). "Intravascular therapy process improvement in a multihospital system: don't get stuck with substandard care." Clin Nurse Spec **16**(4): 182-186.

El Baz, N., Middel, B., van Dijk, J., Ooosterhof, A., Boonstra, P., Reijneveld, S. (2007). "Are the outcomes of clinical pathways evidence-based? A critical appraisal of clinical pathway evaluation research." J Eval Clin Pract **13**(6): 920-929

Eraut, M. (2000). "Non-formal learning and tacit knowledge in professional work." The British journal of educational psychology **70 (Pt 1)**: 113-136.

Executive, S. (2007). Employee engagemnt in the public sector: a review of the literature. S. G. Publications. Edinburgh, Scottish Governmet Publications.

Farbstein, K. and J. Clough (2001). "Improving medication safety across a multihospital system." Jt Comm J Qual Improv **27**(3): 123-137.

Feast, L. and G. Melles (2010). Epistomological Positions in Design Research: A Brief Review of the Literature. 2nd International conference on design education. Sydney, Australia**:** 1-5.

Flynn, M. and D. Mercer (2013. 'Is compassion possible in a market-led NHS?' Nursing Times **V**ol 109 No 7:p12-14

Flyvbjerg, B (2001) Making Social Science Matter: why social inquiry fails and how it can succeed again. Cambridge: Cambridge University Press.

Fransella, F. and D. Bannister (2004). A manual for repertory grid technique. London, Academic Press.

Follett, M., Metcalf, H., Urwick, L. (2003). Dynamic administration : the collected papers of Mary Parker Follett, [S.l.] : Pitman, 1941 (1965).

Ford (1922) My life and my work: a timeless wisdom collection book. Business Leasership Plublishing, Business and Leadership Publishing, Los Angeles, California, USA.

Fox, A. (1974). Beyond contract: work, power and trust relations. London,, Faber.

Fox, M., P. Martin, et al. (2007). Do Practitioner Research. London, Sage.

Francis, R. (2010). Independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust, January 2005 - March 2009, House of Commons.

Francis, R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Volume 3: Present and future Annexes. The Statonery Office, London.

Freeman, T. and K. Walshe (2004). "Achieving progress through clinical governance? A national study of health care managers' perceptions in the NHS in England." Qual Saf Health Care **13**(5): 335-343.

Fudge, N., Wolfe, C., McKevitt, C. (2008). "Assessing the promise of user involvement in health service development: ethnographic study." Bmj **336**(7639): 313-317.

Gerada, C. (2006). "What is clinical governance and how does it affect us?" Doctor(00460451).

Glaser, B. and A. Strauss (2011). The discovery of grounded theory; strategies for qualitative research. Chicago,, Aldine Pub. Co.

Gleeson, D. and F. Shain (1999). "Managing ambiguity: between markets ad managerialism - a case study of 'midde' managers in further education." The Socialogical Review **47**(3): 461-490.

Goldratt, E (1984). "The Goal: a process of ongoing improvement". First Ed, North River Presss. Great Barrington.

Gollop, R., Whitby, E., Buchanan, D., Ketley, D. (2004). "Influencing sceptical staff to become supporters of service improvement: a qualitative study of doctors' and managers' views." Qual Saf Health Care **13**(2): 108-114.

Gould, M. (2006). "Number of C difficile cases rises." Bmj **333**(7561): 215.

Gray, J., Eden, G., Williams, M. (2007). "Developing the public health role of a front line clinical service: integrating stop smoking advice into routine podiatry services." J Public Health (Oxf) **29**(2): 118-122.

Greenhalgh, T. (2001). How to read a paper : the basics of evidence based medicine. London, BMJ.

Greenleaf, R. (1973). The Servant as Leader. Mass., Greenlead Centre.

Grint, k. (2005). Leadership Possibilities. Basingstoke, Palgrave MacMillan.

Grint, k. (2008). "Wicked problems and clusmy solutions: the role of leadership." Clinical Leader **1**(2): 11-26.

Gryna, F., Chua, R., De Feo, J., Juran, J. (2007). Juran's quality planning and analysis : for enterprise quality. Boston, McGraw-Hill.

Hannabuss, S. (2000). "Narrative knowledge: eliciting organisational knowledge from storytelling." ASLIB Proceedings **52**(10): 402 - 413.

Harrington, J. and E. Newman (2007). "Redesigning the care of rheumatic diseases at the practice and system levels. Part 1: practice level process improvement (Redesign 101)." Clin Exp Rheumatol **25**(6 Suppl 47): 55-63.

Hartley, J. (2006). Case Study Research. Essential Guide to Qualitative Methods in Organiszational Reearch. C. Cassell and G. Symon. London, Sage: 384.

Haslam, S., Reicher, S., Platow, M. (2011). The new psychology of leadership : identity, influence, and power. Hove, Psychology Press.

Health and Disability Commissioner (2014) History [online] http://www.hdc.org.nz/about-us/history. Accessed 4/8/2014

Hefford, M. Crampton, P. Foley, J (2005). "Reducing health disparities through primary care reform: the New Zealand experiment" Health Policy **72** p 9-23.

Hewison, A (2004). "Evidence-based management in the NHS: is it possible?." JHOM 18(5): 336-348

Hogan, H., Basnett, I., McKee, M. (2007). "Consultants' attitudes to clinical governance: barriers and incentives to engagement." Public Health **121**(8): 614-622.

Hofstede Centre (2014) Cultural Tools [online] http://geert-hofstede.com/united-kingdom.html accessed 7/8/2014.

Horbar, J., Plsek, P., Leahy, K. (2003). "NIC/Q 2000: establishing habits for improvement in neonatal intensive care units." Pediatrics **111**(4 Pt 2): e397-410.

House, W (2009). "Vested interests and the greater good. Journal of Holistic Healthcare" 6 (1):23

HSE (2007). "HSE publishes investigation report into outbreaks of Clostridium Difficile at Stoke Mandeville Hospital." Retrieved 6/2/2013, 2013, from http://www.hse.gov.uk/press/2007/e07043.htm.

Humphreys, K. (1999) What every engineer should know about ethics. New York: Marcel Dekker Inc.

Iedema, R. and P. Degeling (2001). "Quality of care: clinical governance and pathways" Australian Health Review **24(**3) p12-15.

Improvement, I. f. I. a. "Quality and Service Improvement Tools." Project Management Guide. Retrieved 25/10/2013, 2013, from http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/project_management_guide.html.

Insititute of Healthcare Management (2013). "The full IHM Code of Conduct." Retrieved 23/11/2013, 2013, from http://www.ihm.org.uk/en/about-us/code-of-conduct/ihm-code-of-conduct.cfm.

Institute of Medicine (U.S.) (2005). Keeping patients safe : transforming the work environment of nurses. Washington, D.C., National Academies Press.

Institute of Medicine (U.S.). Committee on Quality of Health Care in America. (2001). Crossing the quality chasm : a new health system for the 21st century. Washington, D.C., National Academy Press.

Ivers, N., Jamtvedt, G., Flottorp, S., Young, J., Odgaard-Jensen, J., French, S., O'Brien, M., Johansen, M., Grimshaw, J., Oxman, A. (2012). "Audit and feedback: effects on professional practice and healthcare outcomes." The Cochrane database of systematic reviews **6**: CD000259.

Jamtvedt, G. Young, J. Kristoffersen, D. O'Brien, M. Oxman, A. 'Does telling people what they have been doing change what they do? A systematic review of the effects of audit and feedback. Quality and Safety in Health Care 2006 **15** 433-436.

Jankowicz, D. (2004). The easy guide to repertory grids. Chichester, Wiley.

Jimmerson, C (2007). A3 Problem solving for Healthcare: A practical method for eliminating waste New York, Healthcare performance Press.

Joiner, B., Reynard, S., Ando, Y. (1994). Fourth generation management : the new business consciousness. New York, McGraw-Hill.

Keogh, B. (2013). Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. NHS, NHS: 61.

Kernick, D. (2002). "The demise of linearity in managing health services: a call for post normal health care." J Health Serv Res Policy **7**(2): 121-124.

Kernick, D. (2004). Complexity and Healthcare Organization, a view from the street. San Francisco, Radcliffe Medical Press.

Kernick, D. (2004). Complexity and the development of organizational theory. Complexity and Healthcare Organization, a view from the street. D. Kernick. San Francisco, Radcliffe Medical Press: 370.

King's Fund (2012). Leadership and engagement for improvement in the NHS. London, The King's Fund.

Kings Fund (2013) http://www.kingsfund.org.uk/audio-video/don-berwick-improving-safety-patients-england-full-presentation. Accessed Aug 2013

Kirkpatrick, I (2006). Taking stock of the new managerialism in English Social Services Social Work and Society International Online Journal Vol 4(1): Retrieved from http://www.socwork.net/sws/article/view/173/564 (accessed 3/8/2014)

Kohn, L., Corrigan, J., Donaldson, M. (2000). To err is human : building a safer health system. Washington, D.C., National Academy Press.

Komives, S. Lucas, N. McMahon, T. (2013). Exploring leadership for college students who want to make a difference. San Francisco, Jossey-Bass. Third Ed.

Koshy, E. and V. Koshy (2011) Action research in Healthcare. Sage Publications Ltd, London. First Ed.

Leape, L., Rogers, G., Hanna, D., Federico, F., Fenn, C., Bates, D., Kirle, L., Clarridge, B. (2006). "Developing and implementing new safe practices:

voluntary adoption through statewide collaboratives." Qual Saf Health Care **15**(4): 289-295.

LeCompte, M and J Goetz (1982) "Problems of Reliabiliyt and Validity in Ethnographic Research' Review of Education Research, **52** (1) p 31-60.

Levinson, H., Price, C., Munden, K., Mandl, H., Solley, C. (1962). Men, management and mental health. Cambridget, MA, Harvard University Press.

Lewin, K. (1946). "Action research and minority problems." J Soc. Issues **2**(4): 34-46.

Lincoln, Y. S. and E. G. Guba (1985). Naturalistic inquiry. Beverly Hills, Calif., Sage Publications.

Linstone, H. and M. Turoff (2002). "The Delphi Method Techniques and Applications. Retrieved from http://is.njit.edu/pubs/delphibook/ch1.html (accessed 21/3/2014)

Locock, L. (2003). "Healthcare redesign: meaning, origins and application." Qual Saf Health Care **12**(1): 53-57.

Lorenzetti, A (1339). Allegory and effect of good and bad government. Retrieved 09/03/2014, from http://smarthistory.khanacademy.org/the-allegories-and-effects-of-good-and-bad-government.html
Lundy, S (2013) "Professional ethics in occupational health and safety practice" A project submitted to the School of Health and Social Science, Middlesex University in partial fulfilment of the requiremnet for the degree of Doctor of Professional Stuides in Risk.. London.

Marang-van de Mheen, P., Stadlander, M., Kievit, J. (2006). "Adverse outcomes in surgical patients: implementation of a nationwide reporting system." Qual Saf Health Care **15**(5): 320-324.

Marriott, S., Palmer, C., Lelliott, P. (2000). "Disseminating healthcare information: getting the message across." Qual Health Care **9**(1): 58-62.

Martin, S., Greenhouse, P., Merryman, T., Shovel, J., Liberi, C., Konzier, J. (2007). "Transforming care at the bedside: implementation and spread model for single-hospital and multihospial system." The Journal of Nursing Adminstration **37**(10): 444-451.

McConville, T. and L. Holden (1999). "The filling in the sandwich: HRM and middle managers in the health sector." Personnel Review **28**(5/6): 406-424.

McWatt, J. (2013). "Nearly one in five NHS staff have suffered bullying, harassment or abuse from workmates." Retrieved 5/5/2013, 2013.

Medina, M. (2011). "Leadership and the process of becoming: An artist never paints the same picture twice." Existential analysis **22**(1): 71-82.

Menzies Lyth, I (1960) "Social Systems as a Defense Against anxiety: an empiriical study of the nursing service of a general hospital. Human Relations 13:95-121

Merry, A. and M. Seddon (2006) "Quality improvement in healthcare in New Zealand. Part 2: are our patients safe - and what are we doing about it? The New Zealand medical Journal **119**(1238), 21 July 2006.

Meyer, J (2000) "Using qualitative methods in health related action research. British Medical Journal **320**(7228) p178-181.

Millburn, A. (2001). Bristol Royal Infirmary Inquiry. S. o. S. f. Health. Westminster, HANSARD. **372:** 289-304.

Ministry of Health, New Zealand (2011). Targeting Emergencies: Shorter Stays in Emergency Departments, Wellington NZ. Accessed 15/3/2014: http://www.health.govt.nz/system/files/documents/publications/targeting-emergencies-health-target.pdf

Ministry of Health, New Zealand 9(2014) Emergency Departments [online] http://www.health.govt.nz/our-work/hospitals-and-specialist-care/emergency-departments accessed 6/8/2014.

Mintzberg, H. (1989). Mintzberg on management, Free Press.

Morgan, G (2006). Images of Organisation, Thousand Oaks, London.

Neath, A. (2007). Tracking sustainability: lessons from the patient booking timeline. The sustainability and spread of organisational change. D. Buchanan, L. Fizgerald and D. Ketley. London, Routledge**:** 303.

Nelson, E., Batalden, P., Godfrey, M. (2007). Quality by design : a clinical microsystems approach. San Francisco, Jossey-Bass.

Newman, E. D. and J. T. Harrington (2007). "Redesigning the care of rheumatic diseases at the practice and system levels. Part 2: system level process improvement (Redesign 201)." Clin Exp Rheumatol **25**(6 Suppl 47): 64-68.

Newman, J. (1998). Managerialism and social welfare. London, Routledge/Open University.

NHS England, (2014). Managing conflicts of interest: Statutory Guidance for CCGs. Co-commissioning of primary care, London 2014.

NHS Institute for Innovation and Improvement (2005). Improvement Leaders Guides - Involving patients and carers. Coventry, NHS Institute for Innovation and Improvement

NHS Institute for Innovation and Improvement (2005)a. Improvement Leaders' Guide - Improving flow, process and systems thinking. Nottingham, NHS Institute for Innovation and Improvement 2005.

NHS Modernisation Agency (2004). 10 High Impact Changes for Service Improvement and Delivery. London, Department of Health.

Nolan, E., VanRiper, S., Talsma, A., Mageno, L., Richter, A., Kearly, G., Kendrick, C. Leggett, S., Crissey, J., Tsai, T., Blackford, G., Shlafer, J., Montoye, C., Mehta, R., Koelling, T., Cody, R., Eagle, K. (2005). "Rapid-cycle improvement in quality of care for patients hospitalized with acute myocardial infarction or heart failure: moving from a culture of missed opportunity to a system of accountability." J Cardiovasc Manag **16**(1): 14-19.

Nuance (2012). "http://www.nuance.com/dictate ". Retrieved 16/9/2012, 2012.

Olenginski, T., Newman, E., Hummel, J., Hummer, M. (2006). "Development and evaluation of a vertebral fracture assessment program using IVA and its integration with mobile DXA." J Clin Densitom **9**(1): 72-77.

Oxford Dictionaries (2013). "Oxford Dictionaires." Retrieved 23/11/2013, 2013, from http://www.oxforddictionaries.com/definition/american_english/.

Oxman, A., Thomson, M., Davis, D., Haynes, R. (1995). "No magic bullets: a systematic review of 102 trials of interventions to improve professional practice." Canadian Medical Association Journal **153**(10): 1423-1431.

Panella, M., Marchisio, S., Di Stanislao, D. (2003). "Reducing clnical variations with clinical pathways: do pathways work?" Internation Journal for Quality in Health Care **15** (6): 509-5210

Patankar M., Brown J. Treadwell M. (2005 Saftey Ethics: Cases from Aviation, Health Care and Occupational and Environmental Health. Aldershot: Ashgate.

Patterson, R. (2008) "Inquiries into health care: learning or lynching?: Nordmeyer Lecture. The New Zealand Medical Journal (2008) **121** (1286) p 100-115

Papadopoulos, I. (2003) "The Papadopoulos, Tikki and Taylor Model for the development of curltural competence in Nursing." Journal of Health, Social and Environment issues. Vol 4, pages 5-7.

Papadopoulos, I. (2006) Promoting culturally competent research. Transcultural Health and Social Care Development of Culturally Competent Practitioners. Papadopoulos. London. Churchhill Livingston.

Papadopoulos, I. (2006) Transcultural health and social care: development of culturally competent practitioners. Ed Papadopoulos. London, Elsevier

Papadopoulos, I. (2008). "The Papadopoulos, Tilki and Taylor model for developing cultural competence." Retrieved 6/5/2013, 2013, from http://www.ieneproject.eu/download/Outputs/intercultural model.pdf

Papadopoulos, I (2014) "*The Papadopoulos Tilki and Taylor model of cultural competence by Professor Irena Papadopoulos*" www.youtube.com/watch?v=ePkAqEv9OuI, 53secs.

Pettigrew, A., Ferlie, E., McKee, L. (1992). Shaping Strategic Change: Making change in large organisations, the case of the National Health Service. London, Sage Publications.

Plsek, P. E. and T. Greenhalgh (2001). "Complexity science: The challenge of complexity in health care." BMJ **323**(7313): 625-628.

Plsek, P. E. and T. Wilson (2001). "Complexity, leadership, and management in healthcare organisations." BMJ **323**(7315): 746-749.

Pronovost, P., Morlock, L. Davis, R., Cunningham, T., Paine, L., Scheulen, J. (2000). "Using online and offline change models to improve ICU access and revenues." Jt Comm J Qual Improv **26**(1): 5-17.

Raffo, D (2013) "Teaching followership in Leadership Education". Journal of Leadership Education. Vol 12, Issues 1 - Winter 2013. http://www.leadershipeducators.org/Resources/Documents/jole/2013%20Winter/JOLE%2012%201%20(Winter%202013).pdf. Accessed: 23/3/2014

Reid, W. (2002). "Clinical governance: implementing a change in workplace practice." Professional nurse **17**(12): 734-737.

Robson, C. (2002). Real world research : a resource for social scientists and practitioner-researchers. Madden, Mass. ; Oxford, Blackwell Publishers.

Rogers, E. M. (1995). Diffusion of innovations. New York, Free Press ; London : Collier Macmillan.

Russell, D. (2013) "Introduction: Virtue ethics in modern moral philosphy" The Cambridget companion to virtue ethics, First Ed, Cambridge, Cambridget University Press.

Samual, P. (2011). How Scotland uses NHS staff to cure poor management. Guardian. London, Guardian.

Scally, G. and L. Donaldson (1998). "The NHS's 50 anniversary. Clinical governance and the drive for quality improvement in the new NHS in England." Bmj **317**(7150): 61-65.

Scottish Executive (2007). Employee Engagemet in the Public Sector: a review of literature. O. o. t. C. Researcher. Edinburgh, Scottish Executive Social Research: 69.

Schrijver AD, Maesschalck J (2013) Chapter 2: A new definition and concept of ethical competence. Cooper TL and Menzel DC (Eds). ME Sharp Inc New York.

Shared Services Partnership (2013). "Minister tells NHS managers: 'listen to your staff and take action'." Retrieved 25/10/2013, 2013.

Simmons, J. (2005). "Transforming Care at the Bedside: Using a Team Approach to Give Nurses - and their patients - new voices in providing high-qualtiy care." The Quality Letter for Healthcare Leaders **800**(787-8981): 2-8.

Sinclair, A. (1998). Doing leadership differently : gender, power, and sexuality in a changing business culture. Victoria, Australia, Melbourne University Press.

Smajdor, A. (2013). *Compassion is not the answer to failings in the NHS.* The Guardian online. 19.09.2013. http://www.theguardian.com/healthcare-network/2013/sep/19/compassion-failings-nhs. Accessed March 2015.

Smith, C. (2013). Stop bullying and heed whistleblowers, doctors warn NHS. The Times. London, The Times.

Smith, R. (2001). "One Bristol, but there could have been many." Bmj **323**(7306): 179-180.

Smith, R. and J. Bingham (2009). Failing hospital: NHS rating system should be scrapped says inspection cheif. The Telegraph. London, The Telegraph.

Smith, R. and J. Bingham (2009). Patients died due to 'appalling care' at Staffordshire hospitals - Healthcare Commission. The Telegraph. London, The Telegraph.

Sorokin, R. and J. Gottlieb (2006). "Enhancing patient safety during feeding-tube insertion: a review of more than 2,000 insertions." JPEN J Parenter Enteral Nutr **30**(5): 440-445.

Spears, L. (1984) "*the understanding and practice of servant-leadership?*" in Spears, L and M Lawrence. Practicing servant leadership: succeeding through trust, bravery and forgiveness. Indianapolis:The Greenleaf Centre for Servant Leadership p9-24

Stacey, R. (2002). Strategic management and organisational dynamics: the challenge of complexity. Harlow, Prentice Hall.

Stacey, R. (2012). Tools and Techniques of Leadership and Managemet: Meeting the challenge of complexity. Oxon, Routledge.

Straughair,C. (2012). "Exploring compassion: implications for contemporary Nursing, Part 2." British Journal of Nursing, **21**(4):239-244

Stake, R. and D. Trumbull (1980). Naturalistic Generalizations**:** 1-7.

Strang, S. and K. Kuhnert (2009). "Personality and leadership developmental levels of leaders performance." The Leadership Quarterly **20**(2009): 421-433.

Survey Monkey® (2014) https://www.surveymonkey.com (accessed August 2014).

Tanne, J. (2006). "US campaign to save 100,000 lives exceeds its target." Bmj **332**(7556): 1468.

Tate, W. (2013). White paper: Managing leadership from a systemic perspective. London Metropolitan University, Centre for Progressive Leadership.

Taylor, F. (1911). The priniciples of Scientific Management. New York, Harper Bros.

Taylor, M. McNicholas, C. Noclay, C. Darzi, A. Bell, D. Reed, J (2013) "Systematic review of the application of the plan-do-study-act method to improve quality in healthcare". BMJ Quality and Safety Online **0**1-9 http://qualitysafety.bmj.com/content/early/2013/09/11/bmjqs-2013-001862.full.pdf+html.

The NHS Confederation (2007). Management in the NHS: the facts. London, NHS Confederation distributors.

The Robert Wood Johnson Foundation and Institute for Healthcare Improvement (2007). "Transforming Care at the Bedside - a new era in nursing." from http://www.aone.org/aone/pdf/TCABBrochure.pdf.

Tosey, P, Visser, M and Saunders, M (2012) *The origins and conceptualisations of `triple-loop' learning: a critical review* Management Learning, 43 (3). 289 - 305. ISSN 1350-5076

Traynor, M (1999). Managerialsm and Nursing: Beyond oppression and profession. Routledge, London

Trochim, M. (2013). "Idea of Construct Validity." Measurement. Retrieved 6/5/2013, 2013, from http://www.socialresearchmethods.net/kb/considea.php.

University of Nottingham (2013). "Surveys: Guidance on question wording." Retrieved 26/10/2013, 2013, from http://www.nottingham.ac.uk/survey-unit/questioncompiler.htm.

van Tiel, F., Elenbaas, T., Voskeuilen, B., Herczeg, J., Verheggen, F., Mochtar, B.,Stobberingh, E. (2006). "Plan-do-study-act cycles as an instrument for improvement of compliance with infection control measures in care of patients after cardiothoracic surgery." J Hosp Infect **62**(1): 64-70.

Viney, M., Houston, S., Belcik, K. (2006). "Transforming care at the bedside - designing new care systems in an age of complexity." J Nurs Care Qual **21**(2): 143-150.

Vinten, G. (1994). "Participant observation: A model for organisational investigation." journal of managerial psychology **9**(2): 30-38.

Wachter, R. and P. Pronovost (2006). "The 100,000 Lives Campaign: A scientific and policy review." Jt Comm J Qual Patient Saf **32**(11): 621-627.

Walshe, K. (2007). "Understanding what works--and why--in quality improvement: the need for theory-driven evaluation." Int J Qual Health Care **19**(2): 57-59.

Walshe, K. and T. Freeman (2002). "Effectiveness of quality improvement: learning from evaluations." Qual Saf Health Care **11**(1): 85-87.

Weller, G., Volante, M., and Garelick, H. "Power, particiaption and partnership: methodological reflection on researching professional doctorate candidates' experiences of researching in the workplace". Work Based Learning e-Journal, Vol. 2, No. 1 (2011).

Wenger, E. (1998). Communities of practice: Learning, meaning, and identity. Cambridge, UK, Cambridge Unviersity Press.

Wenger, E., McDermott, R., Snyder, W. (2002). Cultivating communites of practice: a guide to managing knowledge. Boston, Harvard Business School Press.

Wheatley M. (2006). Leadership and the New Science: Discorvering order in a chaotic world. Berret-Koehler Publisher, Inc Sn Francisco. 3rd Ed.

Wilson, S. (2011). "The middle manager's role in quality improvement." British Journal of Helathcare Management **17**(10): 458-461.

Wroth, T. and J. Boals (2005). "Application of quality-improvement methods in a community practice: the Sandhills Pediatrics Asthma Initiative." N C Med J **66**(3): 218-220.

Yin, R. (2004). Complementary Methods for Research in Education. Washington DC.

Appendices

Appendix 1: Ethics sign-off Case Study 1

Canolfan Gwasanaethau Busnes
Business Services Centre

South East Wales Research Ethics Committee
Direct Line: 02920 376822/376823
Fax: 02920 376835

Ms J Cochrane
Service Improvement Manager
Velindre Hospital
Whitchurch, Cardiff
CF14 2TL

26 February 2007

Dear Ms Cochrane

RE: Develop a toolkit to integrate quality improvement with operational management in the NHS

Thank you for your letter of the 16 February 2007, which was received in this office on the 20 February 2007, enquiring whether the above project would require an application for ethical approval.

The Chairman of the South East Wales Research Ethics Committee, Dr D E B Powell, has considered the documentation that you enclosed with your letter and has confirmed that in his view your project should be regarded as a service evaluation and management survey.

Dr Powell has also confirmed that an application for ethical approval is not required.

The appropriate Trust R&D Department must be informed of the project, and any necessary management approval obtained before the project commences.

With kind regards

Yours sincerely

Mr Carl Phillips
Executive Officer
South East Wales Research Ethics Committees
E-mail: Carl.Phillips@bsc.wales.nhs.uk

Copy:- R&D Office, Velindre NHS Trust

JOANNE DIRECTORY: 26 FEBRUARY 2007

Canolfan Gwasanaethau Busnes
Ty Churchill
17 Ffordd Churchill
Caerdydd, CF10 2TW
Ffôn: 029 20376820 WHTN: 6855
Ffacs: 029 20376926

Business Services Centre
Churchill House
17 Churchill Way
Cardiff, CF10 2TW
Telephone: 029 20376820 WHTN: 6855
Fax: 029 20376826

NHS WALES GIG CYMRU

Appendix 2: Ethics sign-off case study two

Health and Disability Ethics Committees

Northern X Regional Ethics Committee
Private Bag 92522
Wellesley Street
Auckland 1141
Phone: (09) 580 9105
Fax (09) 580 9001
Email: northernx_ethicscommittee@moh.govt.nz

18 October 2011

Janine Cochrane
999 Clevedon-Kawakawa Rd
RD 5
Papakura
Auckland

Dear Janine

Re: Ethics ref: **NTX/11/EXP/236** (please quote in all correspondence)
Study title: Integrating quality improvement with operational management. Protocol V#1, 9/11; PIS/Cons V#1, 9/11
Investigator: Janine Cochrane
Supervisor: Dr Gordon Weller, Middlesex University

Thank you for your application received 5 October 2011. The above study has been given ethical approval by the Deputy Chairperson of the **Northern X Regional** Ethics Committee under delegated authority.

Approved Documents

- Protocol number [version 1, dated September 2011]
- Information Sheet(Interview Schedule)/Consent Form [version 1, dated 9/11]

This approval is valid until 30 December 2012, provided that Annual Progress Reports are submitted (see below).

Amendments and Protocol Deviations

All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:

- the researcher responsible for the conduct of the study at a study site
- the addition of an extra study site
- the design or duration of the study
- the method of recruitment

Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

Annual Progress Reports and Final Reports

The first Annual Progress Report for this study is due to the Committee by **18 October 2012**. The Annual Report Form that should be used is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz.

We wish you all the best with your study.

Yours sincerely

Cheh Chua(Ms)
Assistant Administrator
Northern X Regional Ethics Committee

cc: CMDHB Research Office 1148

Appendix 3: Ethics sign-off Middlesex University

School of Health and Education
The Burroughs
London NW4 4BT

www.mdx.ac.uk
Main switchboard:
020 8411 5000

To: Janine Cochrane

Date: 10/12/12

Dear Janine

Re: Application 927 "Integrating quality improvement with operational management: Hemda Garelick Category: A1

Thank you for the information which you submitted to the ethics sub-committee (health studies) regarding the above project.

I can confirm that since your project was categorised as A1 and does not formally require ethical approval, your application will be logged on our database for information only.

Yours sincerely

Prof. Gordon Weller
Chair of Ethics Sub-committee (Health Studies)

Appendix 4: Participant information, case study one

STAFF INFORMATION

Developing a manager's toolkit to integrate quality improvement with operational management in the NHS

You are being invited to take part in the above research study. Before you decide, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with colleagues or your manager. Ask me if there is anything that is not clear or if you would like more information. If you do decide to take part in this study you will be given a copy of the information sheet and a signed consent form to keep.

What is the purpose of the study?

To develop a toolkit for NHS managers to use which makes improving services easier and part of everyday work for staff. There are three parts to the toolkit. The first part involves developing a QUALITY GROUP - inviting patients and carers to meeting with staff to talk about quality issues. The second is to develop a STAFF MONTHLY NEWSLETTER on important issues affecting the service. The third part is to develop and carry out a STAFF SATISFACTION SURVEY for the staff in your area.

Why have I been chosen?

You have unique knowledge and experience of working at Velindre. It is essential that we involve staff in the improvement of services and your manager has said that you would be a valuable staff member to assist with this.

Do I have to take part?

No, taking part in the study is voluntary. You may refuse to take part in the study without explanation. If you should decide not to take part, that decision will not affect your work or relationship with your manager or colleagues. If you do decide to take part, but then change your mind, you may withdraw from the study at any time, without explanation, and without that decision affecting current or future employment.

What will happen to me if I take part?

You will be invited to attend an interview with the researcher or research assistant. The interview will be audio taped. The tape will be destroyed after you have seen notes from the interview and you agree with the content. You will be asked to sign a consent form prior to the interview. The purpose of the interview is to:

Find out about your opinion on how you view your work, your relationships with peers and managers and the services the hospital provide.

You will be asked your opinion on some/all of the three tools mentioned above (staff satisfaction survey, quality group and staff newsletter).

You will receive a copy of the notes made at the meeting for you to check (after which the audio tape will be destroyed).
No aspect of the research study will be attributable to you unless the researcher asks you specifically (for example for a quote).

What are the benefits of taking part?
You will have an opportunity to inform the researcher as to what is feasible and what is not with regard to introducing the 3 tools. You will have informed a wider audience of your views about the NHS and it's work through publication opportunities undertaken by the researcher.

Will my taking part in this study be kept confidential?
All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which leaves the hospital will have your name and address removed so that you cannot be recognised from it. Please note that NO INFORMATION ABOUT YOUR PERSONAL LIFE IS REQUIRED BY THE RESEARCHER.

What will happen to the results of the research study?
The results of this study will be presented to meetings at Velindre and at a National Level. There may be publications in professional journals. **You will not be identified in any reports or publications about the study.**

Who is organising and funding the research?
Funding for this research is from the Velindre Cancer Centre.

Who has reviewed the study?
This study has been reviewed and approved by the Research Risk Review Committee at Velindre Cancer Centre (September 2005). The South East Wales Local Ethics Committee has reviewed the proposal and deemed that it does not need to be scrutinised by the Ethics Committee (February 2007). It has also been reviewed and approved by the Middlesex University Doctorate Board (October 2005).

Contact for Further Information
If you have any questions or would like to discuss any aspect of the study please contact:
Janine Cochrane, Service Improvement Manager, Velindre Cancer Centre, Phone 02920 19 6182, Mobile 07776 138 704

SELECTED STAFF CONSENT FORM
Developing a toolkit to integrate quality improvement with operational management in the NHS

The staff member should complete the whole of this sheet himself/herself	**(Please circle one)**
Have you read **and understood** the staff information sheet?	YES/NO
(Please take a copy to keep)	
Have you had an opportunity to discuss this study and ask any questions?	YES/NO
Have you had satisfactory answers to all of your questions?	YES/NO
Have you received enough information about the study?	YES/NO
Who has given you an explanation about the study?	
Dr/Mr/Ms ……..	
Do you understand that you are free to withdraw from the study: At any time? Without having to give a reason? Without affecting your future employment conditions? That details of your participation up to the time of withdrawal will be stored anonymously on file and may be used in the final analysis of data	YES/NO
Have you had sufficient time to come to your decision?	YES/NO
Do you agree to participate in this study?	YES/NO

SELECTED STAFF CONSENT FORM

Developing a toolkit to integrate quality improvement with operational management in the NHS

STAFF MEMBER

Signed …… ……

Date ……..

Name (BLOCK LETTERS) ……
WITNESS

Signed ……..

Date ……..

Name (BLOCK LETTERS) ……

I have explained the study to the above patient and he/she has indicated his/her willingness to take part.
INVESTIGATOR

Signed ……..

Date …….

Name (BLOCK LETTERS) ……..……

PATIENT and CARER INFORMATION
Developing a toolkit to integrate quality improvement with operational management in the NHS

You are being invited to take part in the above research study. Before you decide, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends or relatives. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. If you do decide to take part in this study you will be given a copy of the information sheet and a signed consent form to keep.

What is the purpose of the study?
To develop a toolkit for NHS managers to use which makes improving services easier and part of everyday work for staff. Part of the toolkit involves inviting patients and carers to meetings with staff (such as the Outpatient Quality Group). The aim is for patients/carers and staff to share ideas and improve how and what services are delivered.

Why have I been chosen?
You have unique knowledge and experience of receiving services from Velindre and from being a member of the Outpatient Quality Group. It is essential that we involve patients and carers in the improvement of services and increase the centre's 'patient, family, carer focus' further.

Do I have to take part?
No, taking part in the study is voluntary. You may refuse to take part in the study without explanation. If you should decide not to take part, that decision will not affect the standard of care that you (or your family members) receive now or in the future. If you do decide to take part, but then change your mind, you may withdraw from the study at any time, without explanation, and without that decision affecting current or future care.

What will happen to me if I take part?
You will be invited to attend an interview with the researcher or research assistant. The interview will be audio taped. The tape will be destroyed after you have seen notes from the interview and you agree with the content. You will be asked to sign a consent form prior to the interview. The purpose of the interview is to:
Find out about your opinion on how you view your work with the Cancer Centre, your relationships with staff and managers your perception about the services the hospital provide.
You will be asked your opinion on the Quality Improvement Group you have attended in Outpatients.
You will receive a copy of the notes made at the meeting for you to check (after which the audio tape will be destroyed).
No aspect of the research study will be attributable to you unless the researcher asks you specifically (for example for a quote).

What are the possible benefits of taking part?

You will have an opportunity to contribute to improving services and the Quality Improvement Group. You will have an opportunity to give feedback regarding the group.

What if something goes wrong?
If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms may be available to you. There are no formal arrangements to cover you if you are harmed and it is not due to someone's negligence but should this occur each case will be looked at individually and an ex-gratia payment may be made.

Will my taking part in this study be kept confidential?
All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which leaves the hospital will have your name and address removed so that you cannot be recognised from it. Please not that NO INFORMATION ABOUT YOUR MEDICAL TREATMENT IN THE PAST OR FUTURE IS REQUIRED BY THE RESEARCHER.

What will happen to the results of the research study?
The results of this study will be presented to meetings at Velindre and at a National Level. There may be publications in professional journals. **You will not be identified in any reports or publications about the study.**

Who is organising and funding the research?
Funding for this research is from the Velindre Cancer Centre.

Who has reviewed the study?
This study has been reviewed and approved by the Research Risk Review Committee at Velindre Cancer Centre (September 2005). The South East Wales Local Ethics Committee has reviewed the proposal and deemed that it does not need to be scrutinised by the Ethics Committee (February 2007). It has also been reviewed and approved by the Middlesex University Doctorate Board (October 2005).

Contact for Further Information
If you have any questions or would like to discuss any aspect of the study please contact:
Janine Cochrane, Service Improvement Manager, Velindre Cancer Centre, Phone 02920 19 6182, Mobile 07776 138 704

PATIENT and CARER CONSENT FORM

Developing a toolkit to integrate quality improvement with operational management in the NHS

The patient and/or Carer should complete the whole of this sheet himself/herself	(Please circle one)
Have you read and understood the patient/carer information sheet?	YES/NO
(Please take a copy home with you to keep)	
Have you had an opportunity to discuss this study and ask any questions?	YES/NO
Have you had satisfactory answers to all of your questions?	YES/NO
Have you received enough information about the study?	YES/NO
Who has given you an explanation about the study?	
Dr/Mr/Ms ……..	
Do you understand that you are free to withdraw from the study: At any time? Without having to give a reason? Without affecting your future medical care? That details of your participation up to the time of withdrawal will be stored anonymously on file and may be used in the final analysis of data	YES/NO
Has the researcher/interviewer discussed circumstances when compensation may be due?	YES/NO
Have you had sufficient time to come to your decision?	YES/NO
Do you agree to participate in this study?	YES/NO

PATIENT and CARER CONSENT FORM

Developing a toolkit to integrate quality improvement with operational management in the NHS

PATIENT/CARER

Signed …… ……

Date ……..

Name (BLOCK LETTERS) ……
WITNESS

Signed ……..

Date ……..

Name (BLOCK LETTERS) ……

I have explained the study to the above patient and he/she has indicated his/her willingness to take part.
INVESTIGATOR

Signed ……..

Date …….

Name (BLOCK LETTERS) ……..……

Appendix 5: Participant information, case study two

Participant information sheets for Emergency Department
Participant Information Sheet
(Clinical staff and Managers)

Project title: Integrating quality improvement with operational management

Name of Researcher: Janine Cochrane – Doctoral Researcher, MHA (UNSW), Dip OT (NZ)

Project description and invitation
You are invited to take part in this qualitative research which aims to investigate the process of change and quality improvement upon front-line staff and managers. This research explores how change is viewed by different staff roles in an organization and explores the underpinning by values and beliefs. Knowledge of the perceived impact of the process of change is critical to understanding and develop transformational leadership. This interview-based stream of work is part of a larger study examining the impact of a change programme in the Welsh NHS. Taking part in this research will contribute to the understanding managers have in leading change.

Researcher introduction:
My name is Janine Cochrane; I am undertaking a part-time Professional Doctorate through the University of Middlesex. I currently am also a Service Manager in Medicine at Counties Manukau District Health Board. For the last 15 years I have worked as a manager in health in New Zealand and the UK. Prior to this I worked as an Occupational Therapist (10 years). This doctorate work has been supported by my employers in NZ and the UK and by myself. I receive no research grants.

Research Project Procedures
Voluntary participation in this research project is sought from both clinical staff and managers across different levels of the health care organization who have relevant experience of a significant change process.

Approximately 5 participants will be asked to participate in face-to-face interviews with the researcher. The interviews will be conducted in a place and at a time of convenience deemed appropriate by the individual participant. If this is outside of your work place and time, you will be reimbursed for the reasonable cost of travel to and from that outside that venue.

Informed consent will be obtained from participants prior to the conduct of the interviews (see the informed consent document). Interviews of approximately 45-60 minutes duration will follow a semi-structured format (see the interview schedule) and will be digitally voice recorded and later transcribed.

All information pertaining to the interviews will be kept confidential. Participants will be invited to check their interview transcripts prior to analysis.

Anonymity/Confidentiality/Right to withdraw.

The name of your hospital will be anonymised for reports. No material that could personally identify individual participants will be used in any reports on this study. You have the right to participate voluntarily, to give informed consent, and to withdraw from the study at any time without explanation. Participants also have the right to withdraw their interview or document data at any time up to two weeks following invitation to review their interview transcripts.

Data storage/retention/destruction/future use
Digital voice recordings and interview documents will be securely stored in a locked cabinet at CCREP premises throughout the conduct of the study. Electronic data will be stored on a password protected data stick on CCREP premises. Consent forms will also be securely stored separate to other research data. Access to the data on any form will be limited to the researcher, transcriptionist and research supervisors for the purposes of the study. At the completion of the study, research data will be securely stored for 3 years after which they will be destroyed.

DHB and participant report back
At the completion of the study a summary of research findings will be provided to each participant. Other forms of research finding dissemination and feedback in the health sector are anticipated including publication.

Contact details and approval
Please contact Janine Cochrane by email if you wish to take part in this study.

Janine Cochrane, Doctoral Researcher, Staff Centre, Level 2 – AMC, Middlemore Hospital. Janine.cochrane@middlemore.co.nz 021 824 908.

Academic Advisor, Gordon Weller etc.

Consent form
(Clinical staff and Manager)

Project title: Integrating quality improvement with operational management

Researcher: Janine Cochrane – Doctoral Researcher, MHA (UNSW), Dip OT (NZ)

I have read the Participant Information Sheet, have understood the nature of the research and why I have been selected. I have had the opportunity to ask questions and have them answered to my satisfaction

I agree to take part in this research
I understand that I am free to withdraw participation at any time, and to withdraw any data traceable to me up to two weeks after receiving an invitation to review my interview transcript

I agree/do not agree to be digitally recorded
I wish/do not wish to receive a copy of my transcript
I wish/do not wish to receive the summary of findings
I acknowledge that I have had the opportunity to discuss my participation with a whaanau member or friend.
I understand that a third party who has signed a confidentiality agreement will transcribe the digital recordings
I understand that data will be kept for 3 years, after which they will be destroyed.

Participant Name_____
Signature_____
Date_____
Project explained by _____
Project Role_____
Signature_____ Date _____

Appendix 6: Case study one - anonymised example of newsletter

Medical Records newsletter
May 2005

Cancer Centre

Compiled by: xxx and Janine Cochrane

News:
We said goodbye to two members of staff this month Nicola and Katie we wish them well in their new post as medical secretaries at PLT.Also congratulations to Alison who has been seconded as the lead for training and welcome to Charmaine who is covering for Alison
Good luck to Caroline who sits her coding ACC exam this month.

Risk:
Paperless results are still being trialed by Drs C, A and B.

Routine typing will continue to increase with the loss of two secretarial assistants clinics on the boards 8 working days (longest)

Incidents with regards to the failure of staff to track case notes are still occurring All staff need to be vigilant.

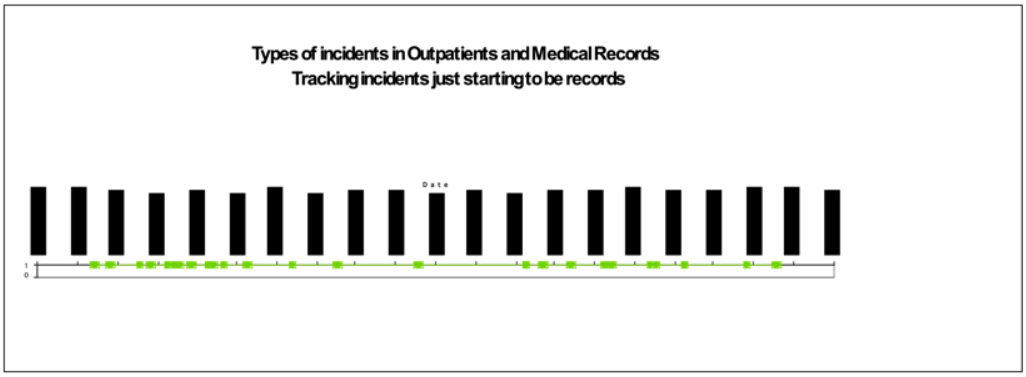
Staff also need to ensure that all result are filed securely in the correct place in the case note folder

Highlights and low lights:
Routine typing is within acceptable levels only overtime being paid to deal with ward discharges approx 6hrs per week.

Projects on the go:
Preparation of clinics –4 members of staff have started training for 14 weeks. We hope that all staff involved will be trained by May/June 2005.
Concerns about where the job will be banded and at what grade continue. Staff will decide if they wish to continue training. The final job description and personal spec has been agreed with staff, union and management.

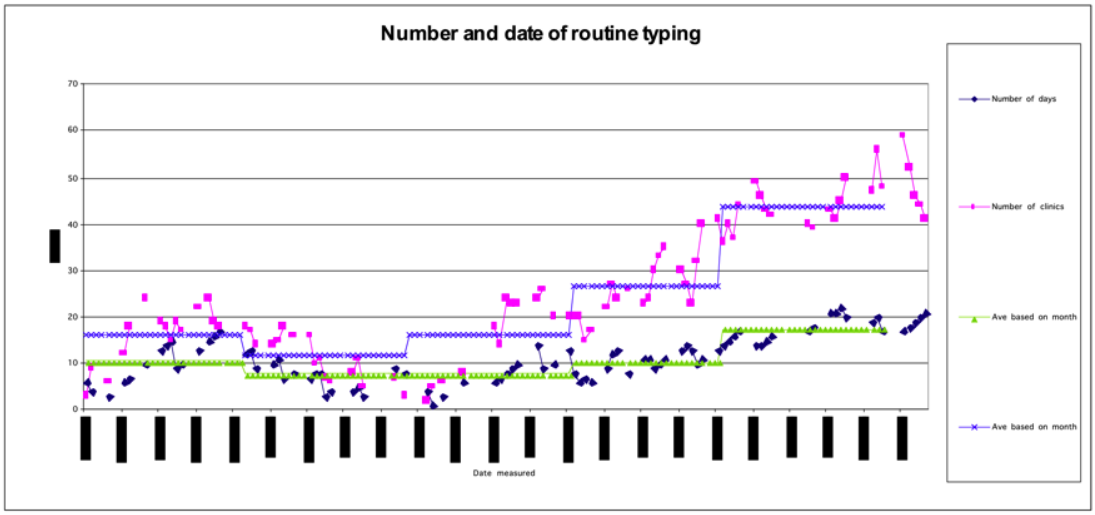
Waiting list module is being piloted by some secretaries this will continue to be rolled out to all secretarial staff.
Staff survey will be sent out this month please complete and return.

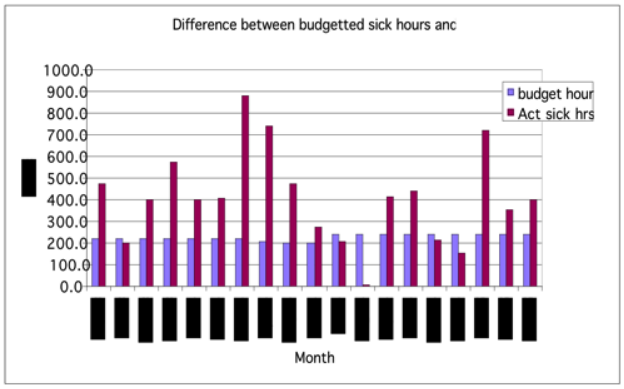
Here we go again!
Health Records Accreditation and Development of Health Records Programme survey to take place 7 & 8 of March 2006.



Discharge letter audit starting Friday 4th March 2005 (for 2 weeks)

Date of discharge	Date dictated	Date typed	Days between discharge and dictation	Days between dictation and typing	Total days between discharge and typing	
16 February 2005	Date not given	07 March 2005	#VALUE!	#VALUE!	19	
17 February 2005	Date not given	07 March 2005	#VALUE!	#VALUE!	18	
18 February 2005	Date not given	09 March 2005	#VALUE!	#VALUE!	19	
03 February 2005	Date not given	09 March 2005	#VALUE!	#VALUE!	34	
15 February 2005	Date not given	09 March 2005	#VALUE!	#VALUE!	22	
05 March 2005	07 March 2005	09 March 2005	2	2	4	D
04 March 2005	07 March 2005	09 March 2005	3	2	5	D
02 March 2005	07 March 2005	09 March 2005	5	2	7	D
28 February 2005	07 March 2005	09 March 2005	7	2	9	
07 March 2005	07 March 2005	09 March 2005	0	2	2	
04 March 2005	07 March 2005	09 March 2005	3	2	5	
24 February 2005	07 March 2005	10 March 2005	11	3	14	
04 March 2005	07 March 2005	10 March 2005	3	3	6	
01 March 2005	07 March 2005	14 March 2005	6	7	13	
07 March 2005	08 March 2005	14 March 2005	1	6	7	D
07 March 2005	08 March 2005	14 March 2005	1	6	7	D

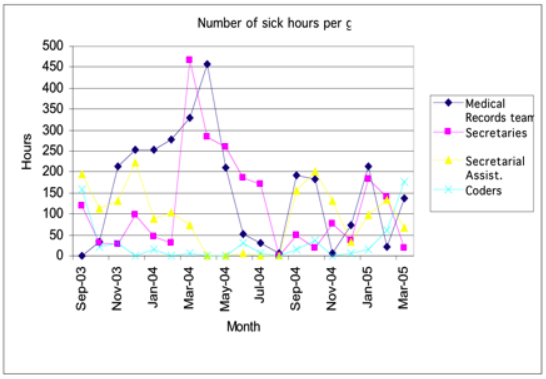


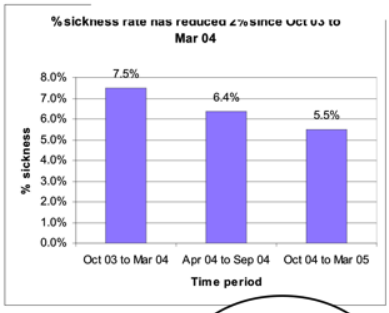


Comings and goings:

The sickness rate for March & April still over budget.

Sec and SA forum to be held June/July.
Interviews to take place for Secretarial assistants posts 26th May 2005.





Jan-January 05	WTE	Hrs/mth*	Budg rate	Budg days	Act sick hrs*	Actual %
Medical Records team	12.16	18447	4%	737.9	1584	9%
Secretaries	13.67	28966.5	4%	1158.7	1421	5%
Secretarial Assist.	6.43	12838.5	4%	513.5	824	6%
Coders	4	8550	4%	342.0	347	4%
	36.26	68802		2752.1	4390	6%

Target for trust was 4.75% which was achieved.

Money, money, money!

Medical Records	February 05 budget	February 05 expend	Month Variance	YTD Expend	YTD Budget	Variance
Senior/supervisor staff	4,424.00	4,354.57	-69.43	48,253.61	48,664.00	-410.39
A&C4	32,019.56	31,677.78	-341.78	346,494.60	341,673.76	4,820.84
A&C3	6,651.13	3,358.73	-3,292.40	57,338.37	77,859.81	-20,521.44
A&C2	14,032.16	13,059.37	-972.79	146,158.38	153,709.84	-7,551.46
Agency typing	0.00	0.00	0.00	4,172.08	0.00	4,172.08
Vacancy	0.00	0	0.00	0	-8,363	8,363.00
Total	57,126.86	52,450.45	-4,676.41	602,417.04	613,544.41	-11,127.37

Overspend for maternity cover.

Overtime being paid for discharge summaries only and maternity cover.
It has been agreed that we keep our vacancy factor money as we will require some bank staff to work during the summer and we have a number of vacancies.

	ANNUAL BUDGET	PERIOD BUDGET	PERIOD ACTUALS	PERIOD VARIANCE	YTD BUDGET	YTD ACTUALS	YTD VARIANCE
TOTAL NON STAFF EXP.	54634	6968	5346	-1622	50300	50774	474

Performance matters:

Balanced Scorecard	Apr - June 04	July - Sept 04	Oct - Dec 04	Jan - Mar 04
No of patients waiting over 2 months	0	0	0	
% cancelled outpatient clinic appointments by organisation	7.30%	7%	9.10%	
% cancelled outpatient clinic appointments by patient	6.50%	6.5%	5.90%	
No. patients booked as % of total new outpatient attendances	1:1.22	1:1.19	1:1.37	
No DNAs as % of patients booked for new and follow-up	7.16%	6.7%	6.40%	

performance is meeting or exceeding expectations within pre -set tolerance levels.

performance is not meeting expectations but is within tolerance levels that indicate that the organisat ion can get performance back on track with day -today actions.

performance is not meeting expectations and is outside of the tolerance levels that indicate that the organisation can manage sufficient improvmenet with day -to-day action. In such circums tances there needs to be an escalation procedure in place to ensure recovery -plans are developed and that closer monitoring and management takes place.

Ongoing Issues:

a. Paperless results to be presented to Consultant Group
   Dr B has started to pilot this project
b. Clinic co-ordinator role job description and spec has been agreed staff to decide date to be signed off
c. Risk register not developed – S to work on this hope to complete in June
d. Vacancy and long term sick has had an impact on the coding levels.

Report for discussion at XX Management Board
23rd February 2005

Tracking notes
Finding notes for clinics and admissions is primarily the responsibility of medical records and other clerical staff in the hospital. It is however the responsibility of all staff to electronically track patient notes.

Medical records have **started recording all incidents related to** tracking with the results as follows:

- **For the first 18 days of February there were 20 tracking incidents.**
- **The areas sited in the incidents included Radiology, Radiotherapy, Medical Staff, all Medical Records areas, all Ward areas.**
- **Over a 2 day period, incidents forms record a total of 8 hours spent searching for notes due to poor tracking.**

Incidents recorded over a 2 day period:

Date	Incident	Hrs searching
16/02/2005	tracked to library, found in PMW discharge	00:30
16/02/2005	Tracked to DPM, found in coding	00:15
16/02/2005	Tracked to peripheral clinic, found with Reg	00:20
17/02/2005	Tracked to clinic, taken by Dr, found on Sec desk	02:00
17/02/2005	Tracked to clinic, taken by Dr, found on Sec desk	02:00
17/02/2005	Tracked to library, found outside Sec office	02:00
17/02/2005	Tracked to clinic, found in Day Unit	01:00
18/02/2005	Tracked to LA2, found in Dr office	00:30
		08:35

Action is needed:
- There are procedures around how notes flow around medical records pre and post clinic – we need to make sure these make sense and happen.
- We need to understand why clinical areas do not track the notes in a timely fashion

Suggestions proposed:
1. More wands in clinical areas
2. A tracking bench in medical records
3. Change in procedures in the clinical areas
4. Awareness of responsibilities – new and present staff

Appendix 7: Case Study 1 - Development of staff survey

The following section outlines the process for development of staff satisfaction surveys in case study one.

The development process was duplicated in both departments in case study one ie they each developed a different survey (examples are shown in appendices). The main differences were related to specific specialty topics – one group were interested in how well the computer system worked another did not include this item.

In each case three rounds were planned and followed:

Round 1: brain storm by representative experts as to relevant themes and issues for staff satisfaction

Round 2: all staff invited to rate each issues for level of perceived importance from items identified in round 1.

Round 3: all staff invited to rate their level of satisfaction based on highest priority items from round 2.

Staff were informed via several staff meetings of the intention by the myself as the manager to undertake a survey. Volunteers from each area were asked for ie 1 secretary, 1 coder, 1 receptionist/filing clerk. The initiative involved the following steps:

Round 1

1. A single meeting was held with the volunteers, led by the researcher. A comprehensive list of issues were identified at the meeting by the volunteers.
2. Any duplicate issues were removed.
3. Issues were entered onto the "importance survey spread sheet". This was developed by the researcher to explain to staff the process for getting the items to be included in the survey. In other words, to demonstrate that the items included were not developed by managers, but by the staff themselves.

4. The group identified 5 volunteers to pilot this pre-survey to make sure the instructions were clear.

Round 2

5. Once the group had confirmed that the questions were appropriate (from feedback), a survey was handed to each person in the department with a verbal explanation that we wanted to hear about the most important issues in terms of their work satisfaction.
6. The surveys were anonymous and were sent via internal mail to a clerical person outside the departments being surveyed – but internal to the hospital (appendix 8).
7. The volunteers measured each survey using the method below.

   How to measure:

   - *Please can you measure in centremetres (cm) where the mark crosses the line from the "not important" end.*
   - *Measure to the edge of the mark (closest to the "not very important" end ie the left side of the mark (some are thick marks)*
   - *If there are two marks on the line, but one is the most obvious intended answer – measure to the left side of this.*
   - *Please write the number cms and millimetres (mm) to the right of the box. Eg. 8.2 cm*
   - *Any queries – put a question mark to the right of the box*

   For invalid responses, please put a cross to the right of the box

   Invalid responses include:

   - *No mark on the line*
   - *More than 1 mark on the line where the intention is not clear*
   - *A cross on the line where there are 2 marks crossing the line (ok if exactly in the middle)*

(an example is show in appendix 7)

8. The survey questions were reviewed by the group and all the responses were put onto a spread sheet and summed. The questions that scored the highest scores were selected to be included in the survey.
9. The questions were rewritten by the group (in a meeting) to ask a further question about the level of satisfaction perceived.
10. A further pilot was completed and questions rephrased again further.

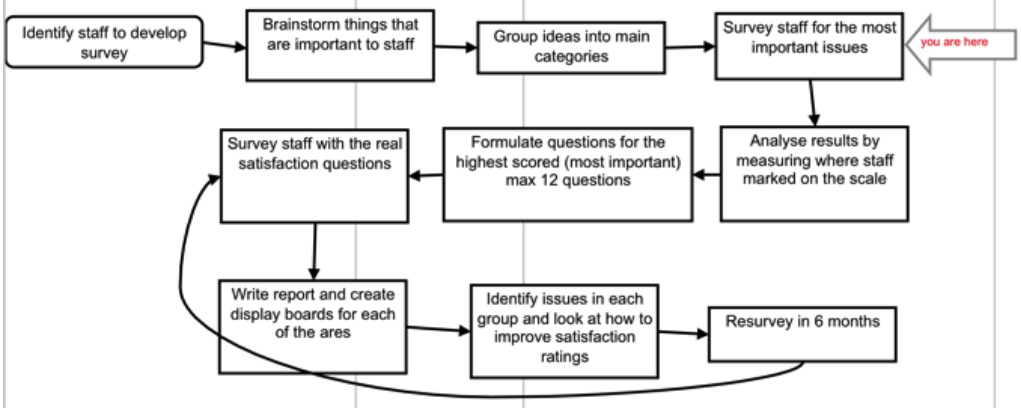
Round 3

11. The survey was then sent out to all staff with an accompanying letter (appendix 18)
12. Surveys were entered onto a spread sheet (by a staff member external to the department). All scores were logged and comments entered into a spread sheet.
13. A survey report was written by the Manager (insider researcher). Results were initially shared with the team leaders, then sent out to all staff via notice boards and email. Appendix 13 and 14 shows an example of the four year results
14. A meeting should have been held after each survey to discuss results (although this was not always done).

What is important to you?

Coding

We want to develop a staff survey to ensure that issues which are important to staff satisfaction are raised. Staff from your work group are assisting in developing a local/customised survey.



As you will see from above, this is not the satisfaction survey, but a survey to determine what questions should be included in the final survey. We expect the real survey to be carried out in July 2004. The survey will be completed every 6 months. Thi

Thank you for taking time to complete this survey. Your views are appreciated. Janine Cochrane, Outpatient Improvement Manager

Please answer the following questions by placing a **vertical mark on the lines below** to indicate how important you feel the issue is today.

EXAMPLE ONLY

How important is it that...

You get to work on time?

Not important — Extremely important

How important is it that...

Equipment and supplies are adequate?

Not important — Extremely important

How important is it that...

You have a suitable environment to work in?

Not important — Extremely important

How important is it that...

You have opportunities for upskilling and training?

Not important — Extremely important

PTO

Appendix 8: Case Study 1: Staff satisfaction Survey

Staff Satisfaction Survey,
Medical Records September 2004

* The results of this survey will be available for all staff who work in Medical Records
* Individuals responding to this questionnaire will not be identifiable in any reports.
* Information will be collated by a person external to the department to minimise handwriting recognition.
* Surveys to be returned by February 14th 2007

Please tick which are you work in:

- ☐ Secreatrial Area
- ☐ Filing library & Reception
- ☐ Coding

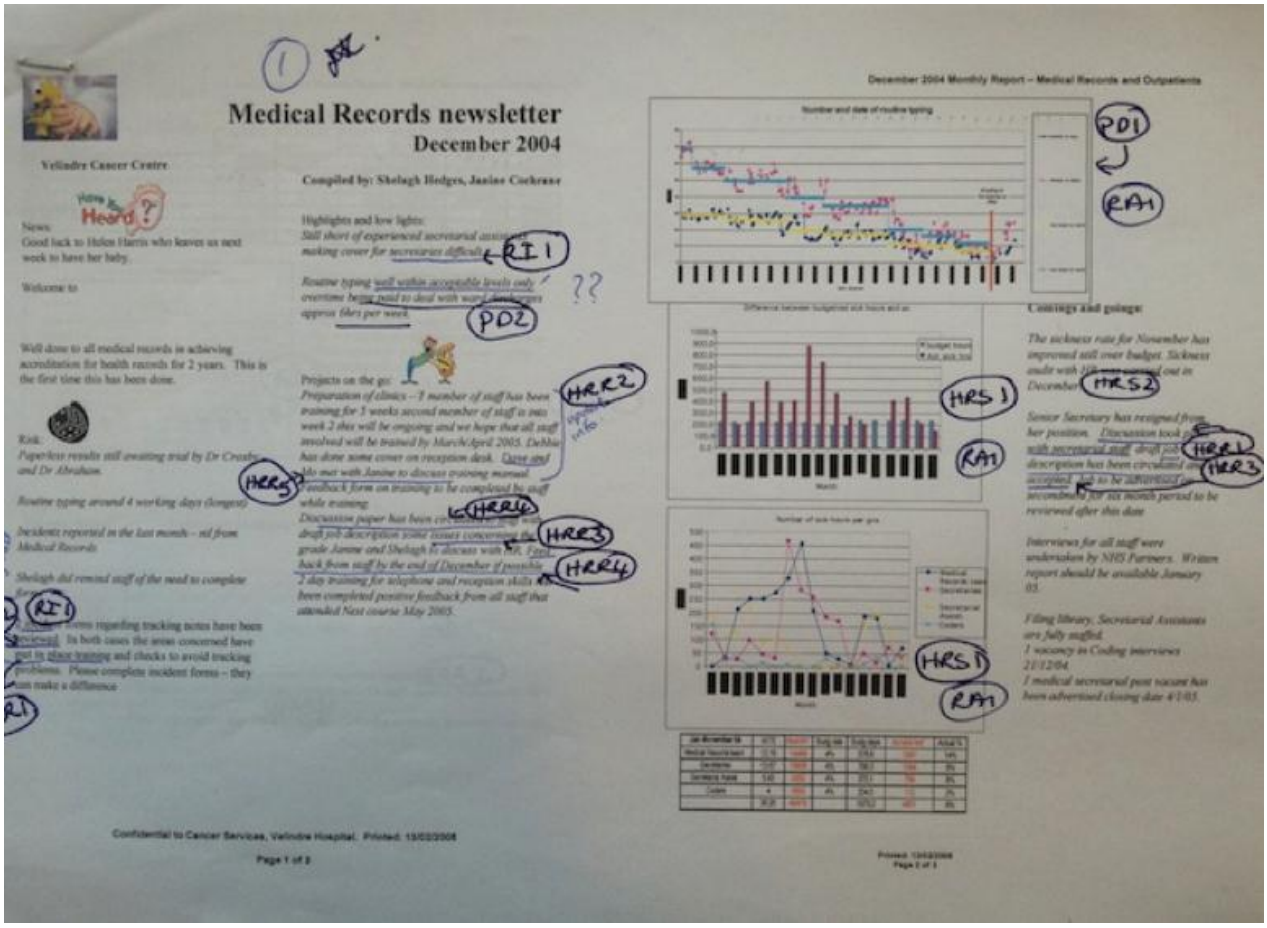
Please circle how satisfied or dissatisfied you are with each of the following statements.
Only circle the numbers shown. Entries between these numbers will be declared invalid.

1	**Very unsatisfactory**
2	**Unsatisfactory**
3	**Satisfactory**
4	**Very satisfactory**

The tracking of notes is…	**1**	**2**	**3**	**4**
Comments:				
Support from my colleagues is …	**1**	**2**	**3**	**4**
Comments:				
I find opportunities for up-skilling and education in our service are …	**1**	**2**	**3**	**4**
Comments:				
My ability to keep up to date with my work is…	**1**	**2**	**3**	**4**
Comments:				
The amount of enjoyment/fun I have at work is …	**1**	**2**	**3**	**4**
Comments:				
I find ISCO…	**1**	**2**	**3**	**4**
Comments:				

The communication within my department is generally…	**1**	**2**	**3**	**4**
Comments:				
The communication between my department and others is generally…	**1**	**2**	**3**	**4**
Comments:				
With my level of responsibilitiy, my salary is…	**1**	**2**	**3**	**4**
Comments:				
My work environment is…	**1**	**2**	**3**	**4**
Comments:				
Consultation when developing new ideas is…	**1**	**2**	**3**	**4**
Comments:				
Equipment and supplies are…	**1**	**2**	**3**	**4**
Comments:				
The way department and management decisions are made is…	**1**	**2**	**3**	**4**
Comments:				
The way we book patients for appointments is…	**1**	**2**	**3**	**4**
Comments:				
My workload is usually…	**1**	**2**	**3**	**4**
Comments:				
The organisation of the department is…	**1**	**2**	**3**	**4**
Comments:				
The appreciation shown to me at work is…	**1**	**2**	**3**	**4**
Comments:				
My satisfaction with work over the last week has been…	**1**	**2**	**3**	**4**
Comments:				
Any other comments:				
This is an annonymous survey - please return in the envelope provided.				

Appendix 9: Case study one - example of a coded newsletter



Protocol 1
Randomising staff

There were 4 categories of staff to be interviewed from case study one. The staff to be interviewed will be randomly selected within their staff grouping. The following procedure was used to identify the staff:

Researcher	
1)	Put staff into correct grouping on an Excel spread sheet ie:
	a. Medical records supervisor
	b. Medical records staff (non supervisor)
	c. Outpatient Qualified Nurses
	d. Outpatient unqualified and Phlebotomy
2)	Delete staff who are not eligible ie:
	a. Working under 24 hours or less
	b. Employed in department for less than 6 months
Interviewer	
3)	Ensure no gaps between lines of staff
4)	Generate a random number between 1 and 50 - formulae is =RANDBETWEEN(1,50 and drag down Excel column.
5)	Use the lowest number to identify staff to be interviewed ie number 1 and 2 if two staff to be interviewed from the group.
Manager/ Insider Researcher	
6)	Approach the staff member to see if they are interested in being interviewed
7)	Send prospective interviewee the information sheet
8)	Contact interviewee after 5 days and confirm that person prepared to be interviewed.
9)	If staff member not interested in being interviewed – thank them for considering it.
10)	Inform interviewer of the name of the person that agreed.
Interviewer	
11)	Contact staff member to arrange interview
12)	Refer to interview protocol

Protocol 1
Semi-structured interview format

Interviewer – you will need

1. **Cards with statements**
2. **Sheet of paper with 'never, sometime, mostly, always' written on it**
3. **Digital audio recorder**
4. **Quiet room with no interruptions**
5. **1 hour**

Say to the interviewee…

Thank you for participating in this research. Have you had a chance to read the information regarding the research project?

Our discussion today is to get your opinion on how you view the relationship between staff and managers/nurses/supervisors. If you agree, I would like to tape the interview so that I can make notes afterwards instead of during our discussion. When I have written up the notes, I will get you to take a look at them and see if they are correct.

Our discussion is confidential in that your immediate supervisors/colleagues will not know who has said what. The notes that I make I will keep as general comments. And will be available to the researcher, once you have agreed that my notes are accurate I will destroy the audio recording.

Are you happy for me to audio record our conversation? Your name will not be attributed to any specific comments.

Do you have any questions? Are you happy to sign the consent form?

Turn the digital audio recorder on and say

Firstly, I am going to give you a set of cards, each of the cards has a statement which I would like you to think about. I would like to you place each card on this scale at the point which you think mostly describes how you feel about the statement.

Scale

Never	Sometimes	Mostly	Always

Once the interviewee has placed all the cards on the preferred descriptors, say…

'now I would like you to go through each card and explain why you have put this card there',

once they have explained, ask them…
'where would you like to see this issue?',

once they have explained, ask them…
'what barriers stop this aspect being better?',

once they have explained that, as them…
'what would it look like if this was achieved?'

The second part of the interview is to identify from the subject cards given to the interviewee, which tools if any, would be useful in addressing any gaps that they had identified. Say to the interviewee….
'which of the tools do you think may be helpful to improve each of these gaps' (if they have identified gaps).

Background information on the tools if needed by the interviewer.

Description of the staff survey
The staff survey is for a specific small group – not an organisation wide survey. It is devised using brainstormed staff issues that they rank from important to not important. The questions therefore are identified by the staff not the managers. It's given to all staff to complete every 6 months and the aim is to find out what managers and staff can do to improve work and processes and raise ideas and issues that staff want to raise with managers.

Description of the Staff Newsletter
The staff newsletter is for a department and it includes performance indicators, gossip, progress on targets. It's usually monthly and put together by the manager. It focuses on giving information that managers think is important like progress on projects, incidents, health and safety issues etc.

Description of the Quality Group
This is a group where front line staff and interested patients and carers get to meet to talk about quality issues. The agenda is loose in that depending on the area depends on what aspects of care and service the group want to focus on. The actual agenda is usually led by the manager, but agreed by staff. Notes of the meeting are available afterwards. The idea is that the group identify and make plans to change the service liaising with relevant other staff as appropriate.

Interviewee Summary Template

Statement	Ranking	Reason why ranked at that	Barrier to Improving	What would it look like at higher

		level		performance

Quality Group

What is good about the Quality Group?

What is bad about the Quality Group?

If you were to form a Quality Group would there be anything you must do to ensure its success?

Staff Newsletter

What is good about the Staff Newsletter?

What is bad about the Staff Newsletter?

If you were to produce a Staff Newsletter would there be anything you must do to ensure its success?

Staff Survey

What is good about the Staff Survey?

What is bad about the Staff Survey?

Given these negatives why do a staff survey?

What are the difficulties associated with a staff survey?

If you were to start a Staff Survey would there be anything you must do to ensure its success?

Which Quality Improvement Tool could help to improve performance against each statement?

Statement	Quality Group	Staff Newsletter	Staff Survey

Appendix 12: Case Study 1 - Letter to staff re staff survey

J Cochrane
Outpatient Improvement Manager

31 August 2004

«First» «Second»
Medical Records
Velindre Hospital
Whitchurch
CF14 2TL

Dear «First»
Re: Staff Satisfaction Survey

The views of staff are extremely important in deciding the direction of service initiatives. This is your opportunity to tell us how we as managers and supervisors meet your needs. It also gives you a chance to give us ideas for changing the service and improving your time at work.

This survey is to be carried out 6 monthly. The results will be available for all staff. The results will be split into three groups - Secretaries, Filing library and reception, Coders (although we may combine the coders). The survey is anonymous and your responses will not be attributed to individuals. To reduce recognising handwriting we will get someone from outside the department to analyse the surveys.

Please find enclosed the first staff satisfaction survey and return envelope. Thank you for taking the time to contribute.

Yours sincerely

Janine Cochrane
Outpatient Improvement Manager

Appendix 13: Case study 1 – Analysis of Staff Newsletter (Case Study 1)

Coded themes present in the newsletter (case study one)

	Codes recorded in each Newsletter	CODE
RISK ASSURANCE	1. Are there quantitative measurements over time?	RA1
	2. Are measures regularly reported?	RA2
	3. Are the measures key to the performance or quality of the service?	RA3
RISK IDENTIFCATION	1. Are new risks identified	RI1
	2. Is there investigation of the source of the risk	RI2
RISK REDUCTION	1. Is there a plan to reduce the risk or manage it when it is present	RR1
	2. Is there a communication strategy to advertise the risk?	RR2
PERFORMANCE DELAYS	1. Quantitative measures are display and regularly updated.	PD1
	2. Plans to address delays are described	PD2
PERFORMANCE PRODUCTIVITY	1. Quantitative measures are display and regularly updated.	PP1
	2. Problems of key activities are described.	PP2
	3. Progress on any project work is described	PP3
	4. Staff involvement is described.	PP4

	Codes recorded in each Newsletter cont...	CODE
HR SICKNESS	1. Quantitative results are documented.	HRS1
	2. Results are put into context	HRS2
HR WORKFORCE STABILITY	1. Quantitative results are documented.	HRWF1
	2. Issues raised by staff are documented and	HRWF2
HR RELATIONSHIP	1. Feedback from meetings are documented	HRR1
	2. Actions are documented	HRR2
	3. Views from staff are available	HRR3
	4. Opportunities for how to be involved are described	HRR4
	5. Opportunities to meet senior staff are described	HRR5

Where data in the newsletter could be coded under several items – this was done so. For example a graph showing sickness rates over the last two years could be coded under HR Sickness, Risk and Performance Productivity.

A total of 180 elements were identified and coded. Figure 7 (page 147) shows the profile of where the most common elements were classified.

Human Relation relationships was the most frequently occurring and had subsections of sickness, workforce stability and relationships. So for example in appendix ten there is a coding for nine HR categories including

- "*D and M met with J (myself) to discuss training manual".* Is categorised under two areas HRR2 - Human Relations/Relationships/actions are documented and HRR5 – Human Relations/Relationships/opportunities to meet senior staff are described
- "*Discussion paper has been circulated to staff with draft job description, some issue concerning the grade, J (myself) and S (manager) to discuss with HR"*– HRR3 – Human Relations/relationships/views from staff from meetings are documented and HRR4 HR/relationship/opportunities to be involved are described.
- *"Feedback from staff by the end of December if possible"* HRR4 – Human Relations/Relationships/opportunities to be involved are described.
- *"The sickness rate for November has improved, still over budget. Sickness audit with HR was carried out in December."*– HRS2 - Human Relations/Sickness/findings are put into context –
- *Graph showing difference between budgeted sick hours and actual* HRS1 – Human Relations/Sickness/quantitative findings are documented.
- *Graph showing difference between actual sick hours by staff group* HRS1 – Human Relations/Sickness/quantitative findings are documented.
- *"discussion took place with secretarial staff, draft job description has been circulated and accepted"* HRR1 – Human Relations/relationships/feedback from meetings are documented and HRR3 – Human Relations/relationships/views from staff are available.

Risk identification was high scoring however the risk identified and investigated tended to be the same ones reviewed and discussed. Conversely risk reduction (or actions to minimise) also scored lowly. Investigation of this revealed that whilst there was high-risk identification

(usually of the same things), there was little or no description of measures that had been put in place to minimise risk. Remembering that the newsletter was a management driven and structured initiative – this would appear to be a significant flaw in this area of work.

Examples of coding of Risk areas in appendix 9 as follows:

- *"Two incident forms regarding tracking notes have been reviewed."* RI1 – Risk/Identification/are new risks identified and RI2 – Risk/ Identification/is there identification of the source of the risk?
- *"In both cases the areas concerned have put in place training and checks to avoid tracking problems.* RRI – Risk/Reduction/plan to reduce or manage
- *"Still short of experienced secretarial assistants making cover for secretaries difficult"* RI1 – Risk/Identification/are new risks identified
- *Graph of number and date of routine typing* – RA1 – Risk/ Assurance/are there quantitative measures over time?
- *2x Graph of sickness* - RA1 – Risk/ Assurance/are there quantitative measures over time?

Performance delays scored 3rd lowest. This was because there was only 1 item consistently measured – delays in routine typing. It is unlikely that this is the only delay and therefore this area is likely to be under developed.

Examples of coding of performance delays in appendix 6:

- "*Routine typing well within acceptable levels only overtime being paid to deal with ward discharges approximately 6 hours per week."* PD2 – Performance/delays/plans to address delays are described.
- *Graph of number and date of routine typing* – PD1 Performance/delays/quantitative measures are displayed and regularly updated.

Case Study one: Newsletter – interview analysis

Three participants were interviewed who received the newsletter. One of the staff reported to the interviewer that she had never seen a newsletter therefore and was unable to talk about it[3]. The interview analysis from staff was therefore from one member of medical records (front-line) and one member of management.

The responses to the interview questions were not thematically analysed. The data was collated by the interviewer as a summary of the response from the participant.

Summary of interview from staff (1) about the staff newsletter (case study one)

What was good about the staff newsletter?
Good way of informing us of any changes that have happened or news within the department
Emailed to us so it is a good form of communication as opposed to a meeting which we may not be able to attend.
Nice mix of work and non-work information e.g. staff who have passed exams, had children
Interesting and enjoyable to read.

What was bad about the staff newsletter
Not frequent enough
Could be more attractive from a visual sense – catch peoples attention and stand out from other e-mails that people receive

A manager who was involved in producing the newsletter was also interviewed.

[3] The newsletter was sent out to all members of the medical records group – the interviewee was one of the members of this group.

Summary of interviews from manager (1) about the newsletter (case study one)

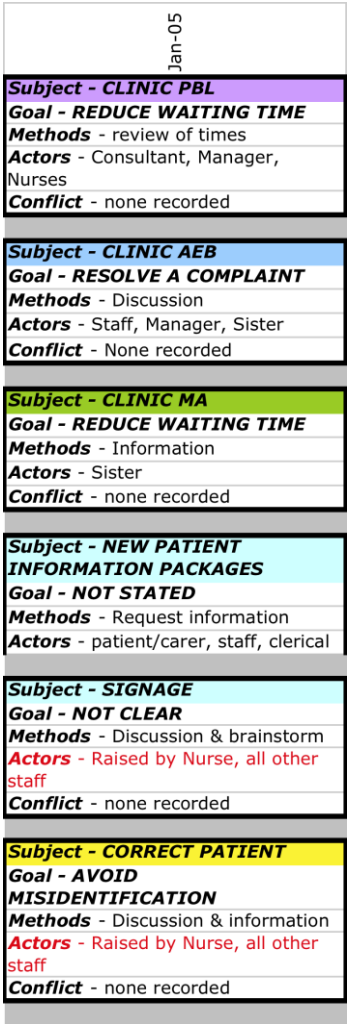
What was good about the staff newsletter
One of the best ways of communicating throughout the department.
Tied into that you need to have a light hearted aspect.
To give staff a voice and a way to communication information, new initiatives, key dates.
People enjoy getting a newsletter, opportunity to communicate work information but in a non work format.
Gives staff a way to contribute to the newsletter
Benefits far out way the limitations

What was bad about the staff newsletter
Time consuming
Someone needs to take ownership and have commitment.

Appendix 14: Case study 1 – Analysis of Quality Group

The constructs selected were subject, method, goals, actors and conflict. An example of how the data was categorised is seen in appendix . The data is sorted under subject and identifies associations with the other constructs.

Example of subject analysis under headings "goal, methods, actors, conflict"



Subject - 44 discrete subject topics were identified from the minutes and there were 82 instances where different subjects were documented. Figure 24 shows the subject topic and the number of meeting notes entries related to each subject topic. The minutes were taken by myself or an administrative assistant.

Subjects identified from Quality meeting minutes

Subject	Number of times topic recorded in minutes
NEW PATIENT INFORMATION PACKAGES	4
HARPIST	2
WEBSITE	1
WAITING AREA	1
CONFERENCE	1
SPIRITUAL AWARENESS	1
CLINIC PBL	6
APPOINTMENT CARDS	4
OPINION METER	4
CHEMO UNIT	3
ELECTRONIC RESULTS	3
CLINIC TSM	2
CLINIC JPB	2
CLINIC MA	2
TIMETABLE	2
EQUIPMENT	2
CLINIC PROTOCOLS	2
CHEMO CLINIC	1
MEDICAL RECORD CHANGES	1
PATIENT FOCUSSED BOOKING	1
PATIENT QUESTIONNAIRE	1
NEW ROLE	1
STAFF TEACHING	1
ENHANCED ROLES	1
PATIENT SATISFACTION SURVEY	1
BLOOD ANALYSIS	1
DEVELOPMENT OF NEW BOOKING CENTRE	1
INFORMATION TO PATIENTS IN CLINIC	4
CLINIC SIGNAGE	4
PRE ASSESSMENT	4
SLUICE	3
AUDIT	2
ENVIRONMENT	2
CLINIC AEB	1
CLINIC JPB	1
FEEDBACK RE COMPLAINTS	1
CORRECT PATIENT	1
BLOOD TRANSFUSION	1
THERMOMETER	1
FOLLOW UP APPOINTMENTS	1
INSPECTION	1
STAFFING LEVELS	1
QUALITY STRATEGY DOCUMENT	1
STAFF SATISFACTION SURVEY	1

The above table shows the range of topics discussed and how often. Many of the items appear only once in the data. Some items when grouped together for example “clinics” appear frequently. Each of the topics were further group together. Subject headings were written onto post-it notes and clustered to like types of activity. From this process four high level themes were identified as subjects relating to; performance of the care system, risk to patients and staff, adding features (things that are additional) and sustainability – doing things differently going forward.

Where a subject could be identified under both risk and performance – unless there was a clear risk stated in the minutes a decision was made to categorise it as a performance issue. The highest amount of data was related to reducing waiting times which was categorised under performance.

Frequency of subjects discussed and topic cluster

Subject	Number of times topic recorded in minutes	Type of Managerial Governance Theme
NEW PATIENT INFORMATION PACKAGES	4	Added features
HARPIST	2	Added features
WEBSITE	1	Added features
WAITING AREA	1	Added features
CONFERENCE	1	Added features
SPIRITUAL AWARENESS	1	Added features
CLINIC PBL	6	Performance
APPOINTMENT CARDS	4	Performance
OPINION METER	4	Performance
CHEMO UNIT	3	Performance
ELECTRONIC RESULTS	3	Performance
CLINIC TSM	2	Performance
CLINIC JPB	2	Performance
CLINIC MA	2	Performance
TIMETABLE	2	Performance
EQUIPMENT	2	Performance
CLINIC PROTOCOLS	2	Performance
CHEMO CLINIC	1	Performance
MEDICAL RECORD CHANGES	1	Performance
PATIENT FOCUSSED BOOKING	1	Performance
PATIENT QUESTIONNAIRE	1	Performance
NEW ROLE	1	Performance
STAFF TEACHING	1	Performance
ENHANCED ROLES	1	Performance
PATIENT SATISFACTION SURVEY	1	Performance
BLOOD ANALYSIS	1	Performance
DEVELOPMENT OF NEW BOOKING CENTRE	1	Performance
INFORMATION TO PATIENTS IN CLINIC	4	Risk
CLINIC SIGNAGE	4	Risk
PRE ASSESSMENT	4	Risk
SLUICE	3	Risk
AUDIT	2	Risk
ENVIRONMENT	2	Risk
CLINIC AEB	1	Risk
CLINIC JPB	1	Risk
FEEDBACK RE COMPLAINTS	1	Risk
CORRECT PATIENT	1	Risk
BLOOD TRANSFUSION	1	Risk
THERMOMETER	1	Risk
FOLLOW UP APPOINTMENTS	1	Risk
INSPECTION	1	Risk
STAFFING LEVELS	1	Risk
QUALITY STRATEGY DOCUMENT	1	Sustainability
STAFF SATISFACTION SURVEY	1	Sustainability

The table above shows that most topics related to performance (and process). The next largest group was risk, then adding features (new things to the department) and then sustainability.

Topics clustered under themes from thematic analysis

Type of Managerial Governance Theme	Total	Percentage
Performance	42	51%
Risk	28	34%
Added features	10	12%
Sustainability	2	2%
Grand Total	**82**	**100%**

Method

There was very little data that was attributed to goal analysis. Goal as a construct heading was abandoned as I deemed that too much interpretation

was required by me to gain insight into the goal, I felt that this biased the data too much. A further reason was that the construct did not appear discrete enough – ie an item could be classified under several topics.

There were 7 common types of approaches (intellectual process or practical tasks) identified through review of each entry in the notes. The final categories with a brief description were:

- *Review of complaints/incidents* (a one off event that required investigation or discussion),
- *Information sharing* (including updates, new procedures internally or externally developed),
- *Suggestions* (from any member of the group),
- *Discussion/opinion* (idea generation, sounding out ideas)
- *Plan to change work processes* ("plan" cycle in PDSA (plan/do/study/act)
- *Review of data/information* ("study" cycle in PDSA)
- *Plan for data collection* ("study" cycle in PDSA).

Topics recorded as discussed only once were categorised mainly as "sharing information" and "discussion/opinion" type activities. Topics recorded as discussed more than once had a number of - "plan to change work processes" and "review of data/information". The below table shows how each topic was classified.

Type of activity documented in quality meeting minutes

Type of method	Subject topics only recorded as discussed once	Subject topics recorded as discussed more than once
Complaint/incident	3	0
Information sharing	10	18
Suggestion	3	1

Discussion/opinion	9	16
Plan to change work processes	0	10
Review of data/information	0	10
Plan for data collection	0	2

The four methods commonly used in the quality group were

- *information sharing,*
- *discussion/opinion,*
- *plan to change work processes and*
- *review of data/information.*

Data items related to information sharing and review of data/information were identified as high. There was also a high frequency of discussing/giving opinion and planning. These constructs would appear to be more interactive than just information sharing.

Actors:

Actors were identified if they raised an issue in the meeting. The frequency with which each group of actors raised issues is as follows – Manager 11, Patient/Carer 6, Nurse Manager 4, Phlebotomist 3, Staff Nurse 2, Clerical 1, HCA 0. There were a number of regular items on the agenda. Unless a specific person was mentioned these were classified under general discussion items in which it is assumed everyone is involved.

The high number of items documented as raised by myself and the Patient/Carer's may indicate a high level of power perceived to have been held by both the manager and patient/carers. Whilst there was evidence documented of participation (and taking responsibility for actions) by front-line staff in activities sited by the quality group, the topics raised were largely done by the manager and patient and carer. The newsletter is an artefact to gain an understanding about the relationships and "what

happened" between front-line staff and managers when undertaking change. It is documented largely by managers and may not necessarily provide insight into the role that followers and leaders undertook in each situation. Raffo in her teaching of followership to students provides a summary of the importance of followers (Raffo 2013, page 265)

- "…
- *Followers are active rather than passive. They can and should initiate change and engage in problem-solving and ethical behaviour.*
- *Leaders and followers share a common purpose. They may have different functions or roles, but they are both equally committed to the organization, share responsibility for meeting organizational goals, and should both strive for organizational excellence.* (Raffo 2013, page 265)
- *There is an interconnection between follower and leader. They are interdependent, a two-way influence process, in a partnership, and reciprocal. Much of a leader's success depends on effective followers and both roles deserve equal weight. "* (Raffo, 2013 p 265)

With regard to actions (and theoretically related to issues that had arisen) most of the actions were for myself as the overall manager of the area and the Charge Nurse manager. It would appear that the problem solving and actions from the meetings largely fell to the responsibility of managers of the area and not individual staff members.

Conflict

There were 11 recordings where there was assessed to be disagreement or concern in the minutes. It appeared that a number (regarding speed of clinics) were around what were the expectations regarding clinic flow, what patients expected and what was possible to deliver. There was evidence that these issues were discussed in some detail by the group however the documentation was limited in showing how the conflict was resolved.

Conflict documented in the quality group

Conflict
Conflict - Nurse opposition to cycle, all agreed not to proceed.
Conflict - cycle action did not work
Conflict - Staff raised if waiting was really an issue
Conflict - Staff raised if waiting was really an issue
Conflict - taking longer (new appt cards)
Conflict - staff raised that clinic now too quick?
Conflict - staff raised that patients on new system elitist?
Conflict - Process for new patients still a problem
Conflict - Nurse opposition to cycle, all agreed not to proceed.
Conflict - delay - not happy
Conflict - staff raised that clinic now too quick?

It was difficult from the minutes to understand how conflict was resolved other than describing practical solutions to problems ie

> *"analysis showed that there was huge variation in consultation times - next cycle Nursing stream to be set up at 15 min intervals and non nursing (doctor) to be changed from 15 mins to 30 mins"*. Extracted from minutes from 19 May 2004.

In changing the doctor times above to twice as long as previously this proved to be too long. The final solution was to have a mixture of 15 min (short) and 30 mins (long). This was shown to be able to be predicted by the practitioner accurately. This was the final solution to this particular area of concern.

Document analysis of staff satisfaction survey

The first part of the thematic analysis involved clustering items/questions into themes and sub themes. Each question was examined and assessed as to whether it could be categorised under one of the three themes identified in the quality group data analysis. The three high level themes identified in the analysis of the quality group included – 1) risk (for patients, staff and organisation), 2) performance and 3) human relations (HR). Where items did not fit into these three themes, they were set aside and new themes were identified following a review in the literature regarding staff satisfaction.

Sub themes were identified within each of the high level themes of risk, performance and HR. For example risk was broken down to a) assurance, b) identification of risk and c) reduction of risk. See Table 26 for the list of sub headings. A checklist with codes was developed for each subheading (table 26) and this was used to record items in the newsletters. The overarching headings and subheadings identified elements of the guideline in terms of what might be expected. The checklist coded each descriptor of the three over arching themes.

Items were ranked as a significant link to the theme (in green), or a weak link to the theme (in red). Using Moss Kanter's (cited in Buchanan et al 2007, p58) characteristics for an integrated culture, gaps and weaknesses were identified in the item list. The surveys were assessed as to the combined areas of weakness and strength in the inclusion of relevant themes (table 28)

Three thematic areas of development

Risk – Assurance, Identification, Reduction	**Performance** – Delays, Productivity	**HR** – Sickness, Stability of staff, Relationships

Green items – a strong association with the theme i.e. if this item was ranked highly positive in the department it would have a strong impact on that area.

Red items – a weak association with the governance theme i.e. if this item was ranked highly positive in the department it may or may not have a strong impact on that area as other factors would also have to be strong.

Further reading around staff satisfaction and the vitality of staff provided additional focus for the data analysis. The context for quality improvement to thrive is important (Buchanan et al 2007, p58). Research undertaken over the last 40 years has searched for the features of innovative organisation cultures. The features described by Kanter in an innovative organisation which is integrative not segmentalist are not naturally occurring in the NHS which is historically hierarchical, and risk averse (Buchanan et al 2007, p58). Kanter provides eight characteristics of integrative organisations.

1. *"Holistic problems solving*
2. *Team orientation and co-operation*
3. *Mechanisms for ideas generation and exchange*
4. *Sense of purpose and direction*
5. *Ability to overthrow history and precedent*
6. *Use of internal and external networks*
7. *Person and creation centred*
8. *Results oriented."* (Kanter 1983, p27-36)

For this reason two new areas were added to the analysis – innovation and sustainability. These are described in table 29 the document analyses for the quality group and the newsletter were reviewed to see if these two new themes were present also.

Two new themes were added to analysis of written information; they emerged from the literature

Sustainability – frequent involvement in improvement activities by front line staff	**Innovation** – front line staff in meetings and involved with projects

An indicator of strength in link to the item was also used – green for high link, red for weak link. The original key themes of risk, performance and HR were used and sustainability, innovation were added.

The staff survey items were developed by both front-line staff and managers through a consensus approach what I have since recognised as described by Linstone and Turoff (2002) as the Delphi method. This is described as "a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem' (Linstone and Turoff 1975, pg 3)

Because the front-line staff only selected the final items, there was a supposition that the survey items could identify common problems which managers would be interested in helping improve. The aim of this analysis was to identify how well the item selection by front-line staff for two surveys addressed issues relevant to management.

Appendix 21 and 22 show how each item was identified under each category for the two departments. The results are summarised under risk, performance, HR, sustainability and innovation.

Medical records – content analysis of the staff satisfaction survey:

Risk – Assurance, Identification, Reduction

Eleven out of seventeen items were identified with strong links to risk (as indicated by green writing). The questions covered resource allocation issues, the organisation of work, general safety practice and specific process issues for patients. Item 11 and 13 specifically address how staff can contribute to reducing or eliminating risk. There were no items to specifically address the speed of resolution of issues raised or whether the solution was a good one (characteristics 4, and 8 from Kanter's list).

Performance – Delays, Productivity

Ten out of seventeen items were identified strongly under performance (as indicated by green writing). They covered how the work was organised and the communication associated with doing the work. There were no items to address feedback on performance either of the individual or the department (characteristic 8 from Kanter's list)

HR – Sickness, Stability of staff, Relationships

Twelve out of nineteen items were categorised under HR. Attitudes to work as well as satisfaction for how the work was organised was covered in this topic. A number of the issues have been included in HR because of their contribution to the stability of the workforce (retention of staff) e.g. workload, organisation, communication, appreciation.

Sustainability – frequent involvement in improvement activities by front line staff

Eight out of seventeen items were covered under this topic, however only 4 were included as having a strong link. Strongly linked items included support from colleagues (due to support for ideas and cover for staff involved in projects), up-skilling (due to the bringing in of new ideas to the group), consultation on new ideas and the way decisions were made. The last two specifically looked at the role and relationship of the manager with

the staff (which was deemed important for long term sustainability). Four items were identified as weakly contributing to sustainability. These included items referring to communication and how work was organised. These items were not enough in themselves to assure sustainability but had a contributory factor. There were no items that addressed issues around releasing time for staff to be involved in quality improvement work or frequency of involvement (characteristics 2,3 and 7).

Innovation – front line staff in meetings and projects

Eight out of seventeen items were covered under innovation. They were the same items as under sustainability and were categorised in the same way strong and weak. There were however no questions specifically to address how staff can make suggestions and follow through any changes (characteristics 2,3 and 7).

Case Study one: Outpatients – analysis of the staff satisfaction survey:

Risk – Assurance, Identification, Reduction

Eleven out of nineteen items were identified under risk. The questions covered resource allocation issues, the organisation of work, general safety practice and specific treatment issues for patients. No items identified how staff could raise issues or ideas for improvement (characteristic 3). Also absent were items about the satisfaction with the speed of change (characteristics 4 and 8)

Performance – Delays, Productivity

Nine out of nineteen items were identified under performance. They covered how the work was organised and the communication associated with doing the work. As with the Medical Records Survey there were no items to address feedback on performance either of the individual or the department (characteristic 8 from Kanter's list)

HR – Sickness, Stability of staff, Relationships

Thirteen out of nineteen items were categories under HR. Attitudes to work as well as satisfaction for how the work is organised was covered in this topic.

Sustainability – frequent involvement in improvement activities by front line staff

Nine out of nineteen items were covered under this topic. Similar to HR - they covered attitudes to work and other members of the team, as well as resource allocation (important for releasing time for quality improvement). No questions specifically addressed issues around releasing time for staff to be involved in quality improvement work (characteristics 2,3 and 7).

Innovation – front line staff in meetings and projects

Eight out of nineteen items were covered under innovation. The items are similar to sustainability and no questions specifically address staff ability to make suggestions and follow through changes (characteristics 2,3 and 7). Some of this is discussed in the staff interviews.

Identification of missing items was undertaken. Missing items were derived from Kanter's list and are identified in table below.

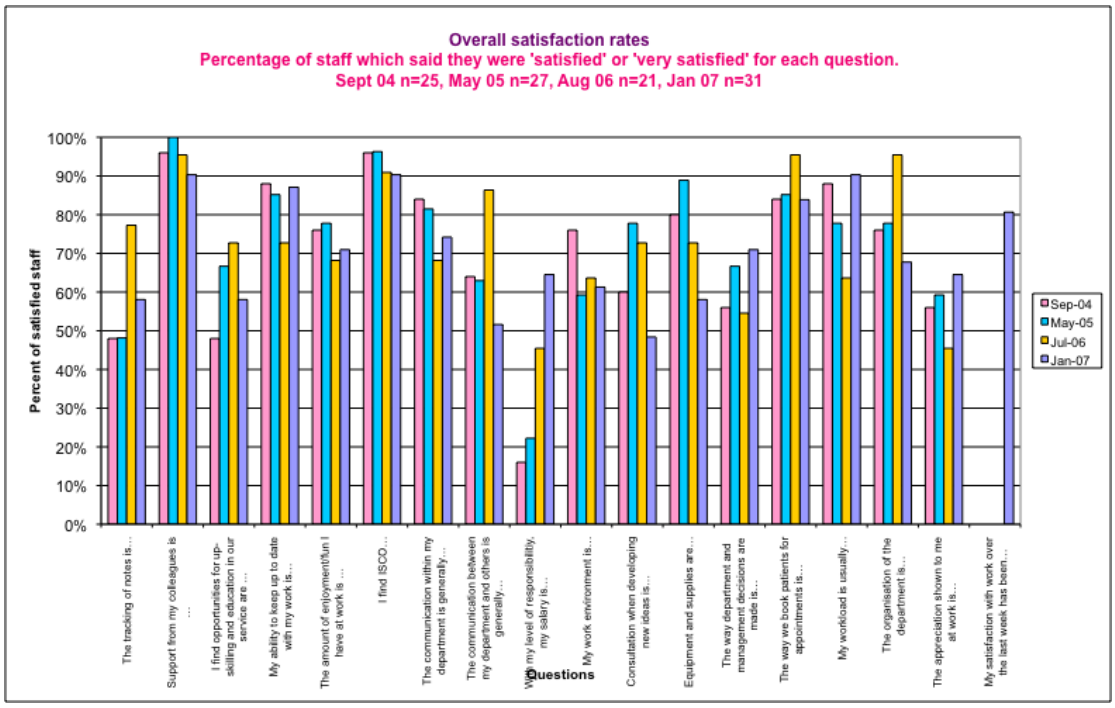
Items not well represented in case study one survey from Kanter's list

Kanter's characteristics for an integrative culture	**Examples of potential items**
Holistic problem solving	Satisfaction with the resolution of problems
Team orientation and co-operation	Satisfaction with team work/ how conflict is resolved
Mechanisms for ideas generation and exchange	Satisfaction with how staff contributions were received and actioned
Sense of purpose and direction	Satisfaction with the direction the dept./service is heading in the next year.
Ability to overthrow history and precedent	Satisfaction with the rate and speed of change. Satisfaction with the level of autonomy felt to make changes in the work place and the
Use of internal and external networks	Satisfaction with how the entire department was functioning and perceived by the organisation,

Person and creation centred	Satisfaction with attitude to new ideas
Results oriented	Satisfaction with the type and frequency of feedback on personal performance and department performance

Source: (Kanter cited (as this is such a crucial piece in your study, I recommend use the main source? in Buchanan, Fitzgerald et al. 2007, p53)

Many of the examples of potential items from the list related to the quality of relationships e.g. how staff contributions were received and actioned, how conflict was resolved. Some related to perceived attitudes of the managers e.g. attitude to new ideas, level of autonomy.



Medical Records - Staff Satisfaction Survery Comments for January 2007

Question	Comments from staff
The tracking of notes is...	1. Certain departments do not track at all.
	4. Outreach are not very good at tracking.
	19. Could be better.
	25. They are just not being tracked.
Support from my colleagues is ...	
I find opportunities for up-skilling and education in our service are ...	12. Not really looked into these opportunities so N/A.
	19. Would like to see Welsh re-instated and basic computer literacy before moving to ECDL.
My ability to keep up to date with my work is...	4. Too much too soon.
	12. As long as I concentrate all day.
The amount of enjoyment/fun I have at work is ...	16. Work type ok but working solo. Don't see or talk to anyone.
I find ISCO...	2. Very slow.
	12. Very slow
	16. I only use for locating and tracking notes.
	17. Slow at times.
	19. Quite often patients just assume that transport is booked without asking. It would be helpful if ISCO could register all transport users (i.e. pop up) so that we can check with the patient if they need it.
The communication within my department is generally...	16. By way of leaving notes back and forth.
The communication between my department and others is generally...	16. Does not really apply to me.
	25. Very unsatisfactory especially with the wards.
With my level of responsibilitiy, my salary is...	4. Very stressful job for the wage.
My work environment is...	2. Very hot in summer with no air con.
	11. Too hot in summer.
	26. Could have more adequate ventilation.
	28. Toilets are unclean and smelly.
Consultation when developing new ideas is...	16. Does not really apply to me.
Equipment and supplies are...	
The way department and management decisions are made is...	
The way we book patients for appointments is...	16. Does not apply.
My workload is usually...	4. Very unsatisfactory/unsatisfactory.
The organisation of the department is...	16. Satisfactory from what I see.
The appreciation shown to me at work is...	16. Sorry have to ask my colleagues.
My satisfaction with work over the last week has been...	4. I have been unhappy in the last week.
	8. Always seem to be catching up.

Appendix 16: Case study 1 – Interview template and repertory grid statements

Question	Ranking	Reason why ranked at that level	Barrier to Improving	What would it look like at higher performance

Quality Group

What is good about the Quality Group?

What is bad about the Quality Group?

Staff Survey

What is good about the Staff Survey?

What is bad about the Staff Survey?

Which Quality Improvement Tool could help to improve performance against each statement?

Statement	Quality Group	Staff Newsletter	Staff Survey

	Case study one questions by group	Managers	Medical Records Frontline staff	Outpatients Frontline staff	Patient/Carer
Actor involvement	Improvement work should involve front line staff		Y		
	Managers work with staff ot improve services				
Confidence	Staff fix problems				Y
	Managers fix problems				Y
	Managers know how to improve things			y	Y
Goal alignment	Staff want to improve patient care				Y
	Staff are encouraged to improve their services		Y	y	
	Manager and staff work together to make improvements	Y	Y	y	
	Staff see the need to improve their work	Y			
	Staff see improving their work as part of their job	Y			
	Staff are committed to improving care		Y		
	Managers want to improve patient care				Y
Knowledge	Staff know how well their unit/department is performing	Y			
	Staff get feedback on quality issues	Y		y	
Priorities	It is clear what managers see as priorities	Y		y	
	manager and staff priorities are the same				
Trust	Staff trust managers	Y	Y	y	
	Managers trust staff	Y	Y	y	
	Patients trust NHS staff				Y
	Patients trust NHS managers				Y
	Managers do what they say they will do	Y		y	
	Managers are concerned about the views of their staff	Y	Y	y	

Findings of adapted repertory grid, case study one (n=9)

Case study one - results of adapted repertory grid		Actor involvement	Confidence			Goal alignment							Knowledge		Priorities		Trust					
		Improvement work should involve front line staff	Staff fix problems	Managers fix problems	Managers know how to improve things	Staff want to improve patient care	Staff are encouraged to improve their services	Manager and staff work together to make improvements	Staff see the need to improve their work	Staff see improving their work as part of their job	Staff are committed to improving care	Managers want to improve patient care	Staff know how well their unit/department is performing	Staff get feedback on quality issues	It is clear what managers see as priorities	manager and staff priorities are the same	Staff trust managers	Managers trust staff	Patients trust NHS staff	Patients trust NHS managers	Managers do what they say they will do	Managers are concerned about the views of their staff
Never	CS 1 frontline staf																					
							2	1										1				1
sometimes					1		1	1						2			1				1	1
					1												2	1				
mostly		1						2			2				1		2	2				
		1						1							1			1				1
always		1					2				1										1	2
Never	CS 1 managers																					
sometimes																						
										1								1				
mostly									1	1			2		2		2	1				
									1													1
always								2						2								1
Never	CS 1 pt carer																					
sometimes				2	1																	
					1														1			
mostly			1															2	1			
			1																			
always						2						2										

Appendix 17: Summary of difference and similarities of document analysis and interviews

Definition of code	Evidence sought	Issues raised in Document analysis	What interviews revealed
Total quality management			
Type of improvement undertaken	Key themes	Important service issues were discussed and documented	Issues important to the services were discussed however interviews revealed that priorities were made by managers.
Process of improvement	Structured approach	Analysis of data, PDSA cycles and a focus on identification of risks was evident in all three strategies.	Interviewees did not refer to any tools and techniques used.
Who is involved in the work	Range of staff, patients and managers	There was evidence that the three strategies included staff, patient/care giver and managers	Staff confirmed that there was inclusion of staff, patient/carer and managers involvement.
Change management theories			
Honourable	Intentions	Information sharing, discussion/opinion, plan to change work processes and review of data/information was evident in the three strategies.	Positive statements from interviewees regarding the intentions of the three strategies however this was not always apparent in manager behaviours (as viewed by front-line staff).
Trustworthy	Group harmony and resiliency	Identified issues with gauging the speed of change, the level of autonomy to make change, the	Staff reported that managers did not follow up on actions after meetings and feedback from the staff survey. There was strong dissent of the staff survey

		attitude to new ideas, the type and frequency of feedback, this satisfaction with how staff contributions are received and actioned and the resolution of problems.	from interviewees who were mostly positive about the other strategies. Managers voiced reservations about the motives of staff in the staff survey.
Legitimate	Does the work meet a need	The strategies were assessed as meeting both communication and service improvement needs	Patient and carer reported improvements had come as a result of the group Staff reported that the type of improvement work being done was determined by managers and not themselves. Managers reported that some of the work was determined by staff (internal) and some external.
Leadership theories/feedback on leadership style			
Credible	Collaboration, group support	Evidence of working collaboratively in each of the three strategies	The Quality Group and the Newsletter were viewed as credible activities by the staff. Staff viewed the survey poorly due to poor follow up by managers. The strategies were viewed as top down not bottom up.
Visionary	Clear ambitions, goals	Inherent in the three strategies was a focus upon improving services and working with staff in a collaborative	Front line staff did not link reducing waiting time in outpatients to their involvement in the quality group. Staff also did not link changes to structure and

		way.	personnel as a result of feedback from the staff survey.
Reliable	Follow through	Recurrent themes identified on-going work to improve services.	Managers close to staff were seen as more trustworthy than those further away.

Appendix 18: Case study two-interview schedule

Interview Schedule

(Clinical Staff)

The aim of this on-going research is to understand how change in your work place has impacted upon you. To achieve this I will be interviewing a number of managers and clinical staff to identify different perspectives, experience and actions in relation to the change. Participants will be interviewed using a structured approach based on the following questions:

Section 1
What changes have occurred in your work area over the last year/18 months?
What do you think about the changes?

- From your personal perspective
- From your professional perspective
- From you organisations' perspective

How has this changed what you do in your job?

Based on your experience prior to the change, what difference if any, has the change made to your clinical practice?

Based on your experience prior to the change, what difference if any, has the change made to the service that your ward/area provides to patient and their families?

Section 2
Each interviewee is given a set of statements typed onto card. You will be asked to place each statement on the word that best reflected their answer.

The words were ‘never’, ‘sometimes’, ‘usually’ and ‘always’. The following statements typed onto cards are given to each staff member.

Each participant will be asked to discuss their choice.

Statements

1. Managers trust staff
2. Staff are encouraged to improve their services
3. Managers and staff work together to make improvements in care
4. Manager and staff priorities are the same
5. Managers are concerned about the views of their staff

Interview Schedule

(Manager)

The aim of this research is to understand how change in your work place has impacted upon you. To achieve this I will be interviewing a number of managers and clinical staff to identify different perspectives, experience and actions in relation to the change. Participants will be interviewed using a semi-structured approach based on the following questions:

Section 1

What changes have occurred in your service over the last year/18 months?

What do you think about the changes?

- From your personal perspective
- From your professional perspective
- From you organisations’ perspective

How has this changed what you do in your job?

Based on your experience prior to the change, what difference if any, has the change made to the staff delivering clinical care?

Based on your experience prior to the change, what difference if any, has the change made to the service that your ward/area provides to patient and their families?

Section 2
Each interviewee is given a set of statements typed onto card. You will be asked to place each statement on the word that best reflected their answer.

The words were ‘never’, ‘sometimes’, ‘usually’ and ‘always’. The following statements typed onto cards are given to each staff member.

Each participant will be asked to discuss their choice.

Statements

1. Managers trust staff
2. Staff are encouraged to improve their services
3. Managers and staff work together to make improvements in care
4. Manager and staff priorities are the same
5. Managers are concerned about the views of their staff

Appendix 19: Case study 2 - Shorter stay in Emergency Departments NZ Newsletter: Shorter stays in Emergency Departments health target, March 2010

EMERGENCY HOSPITAL

Emergency Departments

SHORTER STAYS IN EMERGENCY DEPARTMENTS HEALTH TARGET — UPDATE #2 MARCH 2010

Message from Mike Ardagh, National Clinical Director, ED Services

Shorter stays in Emergency Departments

It must be fixed. We must fix it. We can fix it.

When an acquaintance tells you about their recent use of the acute services at your hospital, do you cringe at the anticipated tale of delays, confusion, pressured staff and crowded facilities? Perhaps you take some solace in their observation that 'Gosh you guys are busy' and then point the finger at the managers, or the politicians, or clinicians in other departments as the reason both you and your acquaintance are victims. I have.

Of course, the quality of care our hospitals deliver is comparatively excellent. The individuals providing care are among the best in the world, and are better than most. But our patients don't receive acute care from an excellent individual, nor even from an excellent team, but from many excellent individuals and many teams, as part of a cobbled-together continuum of care in a complex system. The links in this complex system have been exposed as our services have been pushed to capacity, and the consequences for our patients include longer hospital stays, adverse outcomes and higher mortality. The consequences for us are frustration and conflict as we suffer and debate the daily consequences of the circumstances in which we work. Acute health care should be better for our patients and for us. It must be fixed.

How do we fix it? The details of structure and planning are taking shape around the country under the umbrella of the Shorter Stays in Emergency Departments (ED) Health Target. But no matter what the approach looks like on paper, we can't fix it without clinicians, across acute care, grabbing it by the horns. Physicians, surgeons, other medical specialists, nurses in wards and departments, allied health professionals, registrars and house surgeons know the issues, can devise the solutions, and can weld the important horizontal links in the patient journey. No one else can. *We* must fix it.

There remains a vein of cynicism about our potential to do so. Is a target the right stimulus for genuine quality? Can we improve things without massive investment? Will this target push problems elsewhere? Now, just over 6 months under the influence of an explicit acute care Health Target:

- all DHBs have submitted Delivery Plans for Shorter Stays in ED describing how they are going about the pursuit of better acute care
- the Shorter Stays in ED team has visited most DHBs and intends to visit the remainder by the end of this financial year
- DHBs are finalising their district annual plans, which will formalise the intentions of their delivery plans and their commitment to achieving the target by July 2011.

The work being done around the country is impressive, and is achieving genuine improvements in the quality of acute care without realising the cynicism. Acute care must be fixed, and we, the clinicians, need to drive this for our patients' and our own sakes. We can fix it.

Reporting of quarter 2 results

We have recently had the public reporting of DHBs' second quarter performance against the six national Health Targets.

The Shorter Stays in ED Health Target is defined as '95% of patients will be admitted, discharged or transferred from an Emergency Department within six hours.' The progress made by DHBs against this Health Target was generally pleasing, with an overall increase in performance from 81.8% in quarter 1 to 83.4% in quarter 2. Sixteen DHBs improved their individual performance compared to the first quarter, with the best improvement coming from Waikato DHB, which improved by an impressive 12 percentage points – great stuff!

We currently have six DHBs achieving the 95% target: West Coast, Nelson Marlborough, Wairarapa, Whanganui, Tairawhiti and South Canterbury. A further two DHBs, Counties Manukau and Taranaki, are just one percentage point off achieving the target at 94%. We look forward to these numbers increasing in coming quarters as DHBs continue to implement their delivery plans and work to improve the quality of their acute service.

More information on DHB's quarter 2 Health Targets performance can be found at www.moh.govt.nz/healthtargets.

MINISTRY OF HEALTH
MANATŪ HAUORA

EMERGENCY HOSPITAL Emergency Departments

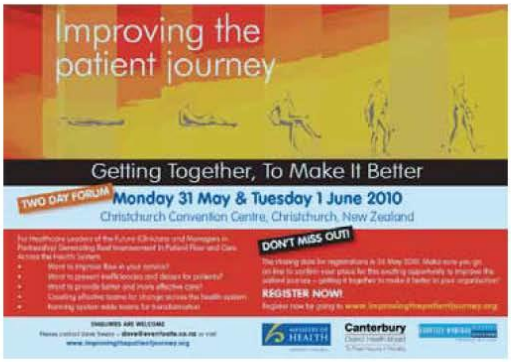
SHORTER STAYS IN EMERGENCY DEPARTMENTS HEALTH TARGET
UPDATE #2 MARCH 2010

Improving the Patient Journey

An Improving the Patient Journey: Getting Together, To Make it Better workshop, jointly organised by Canterbury DHB, Counties Manukau DHB and the Ministry, is being held at the Christchurch Convention Centre on Monday 31 May and Tuesday 1 June 2010. The Shorter Stays in ED Health Target will form a central part of the workshop, and the sessions will be designed to help participants modify their delivery plans for Shorter Stays in ED based on what they learn from the meeting.

We are very keen for all DHBs to be strongly represented at the workshop, particularly by their corporate and clinical champions for the Shorter Stays in ED Health Target, if possible.

You can register to attend the workshop at www.improvingthepatientjourney.org. Registrations close on 24 May 2010.



Important information on data collection and definitions

- Triage rates: From 1 July 2010 Hospital Benchmark Information (HBI) reports, which currently include triage rates, will no longer be produced. DHBs will instead be able to access data on triage rates through the National Non-admitted Patient Collection (NNPAC).
- Observation wards: The Shorter Stays in ED Health Target is defined as '95% of patients will be admitted, discharged or transferred from an Emergency Department within 6 hours'. A patient can be considered to have been 'admitted', and thus have their ED length-of-stay clock stopped, when they begin a period of formal observation and/or move to a short-stay unit (or units with a similar function). The key criteria to determine whether this applies is that the area or unit should have dedicated space, dedicated staffing, and patients in beds rather than on trolleys.
- '3-hour rule': There is a risk that the '3-hour-rule', which is used for funding and coding purposes and preceded the introduction of the 6 hour Shorter Stays in ED Health Target, may distort reporting of DHB performance against the target. The rule is that if a patient in the ED requires more than 3 hours of treatment, or a general anaesthetic, DHBs are required to enter a record in the NMDS (National Minimum Dataset). By doing so, the patient is being "admitted" to NMDS, but not necessarily being physically admitted to the hospital. In terms of overlap with 6-hour reporting, the 3-hour rule should only be a problem if the 'admission' to NMDS is used as the measure of 'admission' for the purposes of reporting against the Health Target (ie, if the 'admission' to NMDS at 3 hours stops the patient's ED length-of-stay clock, when in fact the patient remains in the ED receiving treatment). DHBs must ensure this does not occur.

Resources available on the ED website

www.moh.govt.nz/emergencydepartments

Remember to keep checking the emergency departments web pages because new resources, tools, links and case studies are being added on an ongoing basis. Below are just some of the documents currently available:

- Capital & Coast DHB's *Delivery Plan for Shorter Stays in ED*
- a presentation on Counties Manukau DHB's *6 Hours Can Be Hours* initiative
- a presentation on Auckland DHB's *Improving Acute Patient Flow* project
- Auckland City Hospital's *Alert Cascade*
- Lakes DHB's *Examples of Lean Thinking Work*
- *Engaging Physicians in a Shared Quality Agenda* – a paper by the Institute for Healthcare Improvement (2007)
- *Going Lean in Healthcare* – a paper by the Institute for Healthcare Improvement (2005)
- *Managing Acute Patient Flows* – a report by the Victorian Auditor-General
- Ministry of Health literature reviews on the impacts of ED overcrowding, solutions to ED overcrowding, and tools, checklists and guidelines for improving ED services.

Comments? Questions? Please contact the Ministry of Health's Shorter Stays in ED team by email: emergencydepartments@moh.govt.nz

MINISTRY OF HEALTH
MANATŪ HAUORA

Appendix 20: Sample of data spread sheet

footnote	Data and notes	Major category	Minor category	Name	Profession
91	[1] 5 min to help *individuals accept that helping each other out as part of what they do*	social support/ valued contacts	nurturing a high functioning team	Steve	RN
105	[1] 6 hour thing could be done safely – *they have had more staff – more units*	Concepts of care	beliefs about what care is	Sarah	RN
80	[1] 6 of them have just got here *unfair – unjustified criticism from senior staff*	unfair workload	unfair workload	Sarah	RN
133	[1] 80 year old – *showed that made a decision based on ethical decisions. Rules for where she should be – need to be obeyed – unless you have a really good reason.*	personal outcomes	a need to be proud of what you do	Steve	RN
2	[1] a big bonus *something unexpected as a result of the work*	personal outcomes	a need to be proud of what you do	Steve	RN
95	[1] A few tricks on how to get it to work *don't need to rely on a hero? Someone to save us? Someone to take responsibility and make it work*	skills and resources	skills and resources	Steve	RN
5	[1] A fight between HDU and us – *is there warfare between the departments? Breakown in relationships?*	at war	Defending the position	Sarah	RN
18	[1] a lot of pressure for the senior nursing staff.	personal outcomes	Pressure	Annabel	Manager
5	[1] a perception of previous failure	Doubts	Doubts	Vicky	Manager
4	[1] a perception that didn't think she would achieve the	Doubts	Doubts	Vicky	Manager
10	[1] a place for hearing and listening and a place for getting	perceptions about change	perceptions about change	Annabel	Manager
20	[1] a problem with cleaning that doesn't seem to be fixed.	unresolved issues	unresolved issues	Sarah	RN
17	[1] a push to move people quicker without things done as per usual *is 'move people quicker' a proxy for provide quicker treatment*	concepts of the care system	care defined by moving	Steve	RN
15	[1] Abuse – *bullying, power struggles in patient care*	Personal outcome	Bullying	Sarah	RN

footnote	Data item	Major category	Interim caategory	minor categor	Name	Profession
74	[1] *Charge nurses start getting really upset* – they feel like they have failed? They are not trusted? Respected?	Emotional	Concepts of care	Loss of control	Sarah	RN
73	[1] *all the phones start ringing* causing panic? Alarm? Anxiety?	Emotional	Personal outcome	Loss of control	Sarah	RN
59	[1] Feeling of stress because of ratio of nurses – but saying it's less busy – how do these two things co-exist	Emotional	Personal outcome	Loss of control	Sarah	RN
102	[1] *They have three* – unfair to us – not acceptable.	Emotional	Personal outcome	Loss of control	Sarah	RN
67	[1] but I haven't been here for a week no commmunication for longer absences?	Emotional	Personal outcome	Loss of control	Sarah	RN
50	[1] Uanble to prioritise – not fair because of the work load?	Emotional	Personal outcome	Loss of control	Sarah	RN
23	[1] *Even been seen* – not my fault – someone else shouldn't have put me in this position	Emotional	Personal outcome	Loss of control	Sarah	RN
154	[1] *letting off steam* – provide a confidential and safe haven?	Emotional	Personal outcome	Loss of control	Steve	RN
148	[1] *Loosing it* – becoming overwhelmed by the situation	Emotional	personal outcomes	Loss of control	Steve	RN
33	[1] *remember what you are there for* – mentally reframing the situation	Emotional	personal outcomes	Loss of control	Steve	RN
32	[1] *count to ten* - angry	Emotional	personal outcomes	Loss of control	Steve	RN
31	[1] *let out a bit of steam* - angry	Emotional	personal outcomes	Loss of control	Steve	RN
28	[1] shrugging their shoulders –out of my control – accepting?	Emotional	personal outcomes	Loss of control	Steve	RN
27	[1] *Well it's done* out of my control - fatalistic	Emotional	personal outcomes	Loss of control	Steve	RN
24	[1] *might be upsetting* – emotional – disaapointed? Frustrated?	Emotional	personal outcomes	Loss of control	Steve	RN
4	[1] *Not sitting bleeding on the ward* - I would have thought a doctor would determine the level of risk and make the final decision, ? derogatory to nurses on the ward?	Emotional	personal outcomes	Loss of control	Sarah	RN

footnote	Data item	Major category	Interim category	minor categor	Name	Profession
20	[1] a problem with cleaning that doesn't seem to be fixed.	Challenging roles	unresolved issues	Loss of control	Sarah	RN
78	[1] Sweeping movement indescriminate?	Challenging roles	personal outcomes	Loss of control	Annabell	Manager
43	[1] *getting to grips* – uncertainty within heirachy led to an opening to influence?	Challenging roles	personal outcomes	Loss of control	Annabell	Manager
49	*[1] New patient* – loss of control?	Challenging roles	Personal outcome	Loss of control	Sarah	RN
48	[1] *Patient has gone* – loss of control?	Challenging roles	Personal outcome	Loss of control	Sarah	RN
72	[1] good strict way and we will do it like this likes to have rules and set ways of doing things..	Challenging roles	Rules	Loss of control	Steve	RN
69	[1] *That they stick to them* ?doesnt mind when management come up with ideas – as long as they stick to them?	Challenging roles	Rules	Loss of control	Sarah	RN
26	*[1] they should be moved* – as in they are not in the right place for the 6 hour rules?	Challenging roles	Rules	Loss of control	Sarah	RN
9	*[1] Nah he's not allowed* – there are rules that must be obeyed?	Challenging roles	Rules	Loss of control	Sarah	RN
82	[1] do we have to identifying that some people are questioning his convictions?	Challenging roles	personal outcomes	Loss of control	Steve	RN
79	*[1] Sudden rush* – why is there a sudden rush? – were some things forgotten – were there other delays?	Challenging roles	personal outcomes	Loss of control	Steve	RN
77	[1] *Rushed* loss of control?	Challenging roles	personal outcomes	Loss of control	Steve	RN
63	[1] *High pressure* approach don't need to get angry with someone? Pull rank?	Challenging roles	personal outcomes	Loss of control	Steve	RN
39	[1] *forced* – indicates a reluctance?	Challenging roles	personal outcomes	Loss of control	Steve	RN
19	*[1] we found people were moved without things being done* - ...negative side – things are done to the patients?	Challenging roles	personal outcomes	Loss of control	Steve	RN
5	[1] patient moves without knowledge	Challenging roles	personal outcomes	Loss of control	Steve	RN

Appendix 21: Case study 1 - summary of quotations about quality group

What was good about the Front-Line Quality Group?
Good mix of people
Could exchange views and opinions
Problems bought to attention
Patient view instead of staff only view
Face to face communication instead of email
Less easy for Mangers to ignore patient views
Manager more likely to follow up before next meeting
Good - given an opportunity to contribute points
Open environment
Got to talk about issues that may only be discussed at a senior manager level

What was bad about the Front-Line Quality Group?
No major negatives
Not a good turn-out
To small a group - same staff each time
Not paid to attend when managers were[4]
Only 1 patient (and 1 carer) - not representative[5]
If patient couldn't attend, could have had a substitute patient that would have brought a different view
(Patient/Care giver) may not present true picture of patient experience
Should hold them every month
Chair[6] *drove the agenda to suit them*
Chair was controlling - not sufficient opportunity to discuss issues
Not held often enough
The people who get listened to are the ones who complain

[4] Staff were given an option to have time in lieu of working
[5] Patient was chair of the Patient Liaison Group at the hospital and was able to liaise with other patients.
[6] Chair was the researcher

Same issues every meeting – not a lot we could do about them
The time that it take to run effectively and properly
The time that it take to put actions into practice can be frustrating for all involved

The manager's views were included with the staff members because the views expressed were very similar. The patient and caregiver however reported a different view about the group therefore they are summarised in table y separately.

Summary of quotes from interviews from patient and carer about the quality group

What was good about the Front-Line Quality Group?
A first class initiative
Resulted in a lot of constructive meetings
I believe that things have improved because of them (Quality meetings)
Particularly effective because they allow for direct talks/debates to take place between staff, managers and patients.
Patients have found both staff and managers receptive to patient views
A success and should continue
A very good mix of people – important to understanding all points of view and generate effective ideas.
Enabled patients to gain the trust of staff and staff now speak openly in front of patients – in the group
The success of the group means that patient views are definitely taken into account and considered thus making these groups more than just a 'talking shop'
Really good idea especially now it is established
Initially I felt that there was a little bit of scepticism from staff as to why patients/carers were attending 'their meeting'. This dissolved when they realised that we weren't there to criticise but to help and

provide constructive ideas and feedback.
I feel comfortable attending the groups and feel that we are listened to.
Our involvement provides a 'different angle' to viewing things from a medical point of view
We can represent the patient more accurately
Main advantage is that you get a range of ideas and suggestions
Resulted in a lot of constructive meetings and services have improved and changed
I feel we are accepted well and if I raise a query or a suggestion then it is considered and taken seriously.

What was bad about the Front-Line Quality Group?
Lack of continuity in terms of when we have meetings
Cancellations affect the following up of actions from previous meetings.
Timing of the meeting is problematic as staff were being asked to attend in their own time.
Also continuity of who attends is important.
May not hear if an action has been resolved if the relevant staff member is not in attendance.
Minutes are not always produced and distributed prior to each meeting
Lack of movement against actions agreed.

Staff 1 - Interview with staff, 21st June

Question	Ranking	Reason why ranked at that level	Barrier to Improving	What would it look like at higher performance
Staff get feedback on quality issues	Sometimes	There are occasions where my manager will go to meetings with other mangers and we do not get any feedback as to what was said/agreed. Also we are not told how we are performing. This makes it difficult to improve our quality e.g. if we were performing poorly and we were not told we may not realise that an improvement needs to be made. 'We work hard within the department and it would be nice if our manager fed back as to our level of performance whether good or bad'.	Would definitely like to see it as always. The main barrier to being in the always column is communication between managers and staff. This could be in the form of a team meeting as we are a fairly small team or even an e-mail.	If this was as always we (the staff) would be much more motivated at work. Also the quality of your work would definitely improve. If you were performing well, and you were informed, you would continue at that level. Conversely if you were informed that there were some quality issues (as long as you were informed in a constructive manner) then you would strive to rectify these. Also positive feedback helps to motivate you. There would also be better team morale; this

				would further improve performance.
Managers know how to improve things	Sometimes	Although managers are professionally qualified, unless or until they have had actual experience of doing the job themselves, they do not necessarily know the best or most effective way of improving things. They need to discuss with staff i.e. frontline staff, what the reality of a situation is before they have the actual information and/or knowledge to fix certain problems. Listening to managers and there perception of what goes on within their department and what actually goes on are two different things. In my department we get an opportunity to meet with our manager every two weeks which is great. Sometimes managers have ideas of how to improve things but maybe don't know how to actually implement it as they don't fully understand what goes on at a day-today level. Managers definitely have the knowledge but can perhaps lack an understanding of the	Would like to see this ranked at 'always'. The barrier to it being at always is that there is not enough communication between managers and their staff. If there was more communication between managers and staff they would be more equipped to fix problems as they would better understand their department on the 'shop floor'.	If it was at always and managers always communicated with staff then performance would be better and working practices would become more efficient. Therefore this would lead to improved staff morale. If managers listened to our views more then we would feel more included and teamwork would improve.

		situation within their department in ‘real life’.		
It is clear what managers see as priorities	Mostly – Always	Our manager makes it quite clear what our priorities and the whole team is aware of our key objectives.	Should be ranked as always.	Knowing my managers priorities helps performance as we know where do devote our time and what targets to aim for. We know where to focus our efforts.

Appendix 22: Items selected by medical records staff for the staff survey

Risk - Assurance, Identification, Reduction	**Performance** - Delays, Productivity	**HR** - Sickness, Stability of staff, Relationships	**Sustainability** - frequent involvement in improvement activities by front line staff	**Innovation** - front line staff in meetings and projects
1 The tracking of notes is…	*1 The tracking of notes is…*			
		2 Support from my colleagues is	*2 Support from my colleagues is*	*2 Support from my colleagues is*
3 I find opportunities for up-skilling and education in our services are	*3 I find opportunities for up-skilling and education in our services are*	*3 I find opportunities for up-skilling and education in our services are*	*3 I find opportunities for up-skilling and education in our services are*	*3 I find opportunities for up-skilling and education in our services are*
4 My ability to keep up to date with my work	*4 My ability to keep up to date with my work is*	*4 My ability to keep up to date with my work is*	*4 My ability to keep up to date with my work is*	*4 My ability to keep up to date with my work is*
		5 The amount of enjoyment/fun I have at work is		
6 I find ISCO	*6 I find ISCO*			
		7 The communication within my department is generally	*7 The communication within my department is generally*	*7 The communication within my department is generally*
8 The communication between my department and others is generally	*8 The communication between my department and others is generally*	*8 The communication between my department and others is generally*	*8 The communication between my department and others is generally*	*8 The communication between my department and others is generally*
		9 With my level of		

		responsibility, my salary is		
10 My work environment is	*10 My work environment is*	*10 My work environment is*		
11 Consultation when developing new ideas is			*11 Consultation when developing new ideas is*	*11 Consultation when developing new ideas is*
12 Equipment and supplies are	*12 Equipment and supplies are*	*12 Equipment and supplies are*		
13 The way department and management decisions are made is			*13 The way department and management decisions are made is*	*13 The way department and management decisions are made is*
14 The way we book patients for appointments is	*14 The way we book patients for appointments is*			
15 My workload is usually	*15 My workload is usually*	*15 My workload is usually*	*15 My workload is usually*	*15 My workload is usually*
	16 The organisation of the department is	*16 The organisation of the department is*	*16 The organisation of the department is*	
		17 The appreciation shown to me at work is	*17 The appreciation shown to me at work is*	*17 The appreciation shown to me at work is*

Appendix 23: items selected by the outpatient staff for the survey

Risk - Assurance, Identification, Reduction	**Performance** - Delays, Productivity	**HR** - Sickness, Stability of staff, Relationships	**Sustainability** - frequent involvement in improvement activities by front line staff	**Innovation** - front line staff in meetings and projects
1 The number of patients seen is generally…	*1 The number of patients seen is generally…*		*1 The number of patients seen is generally…*	
2 Staffing levels are	*2 Staffing levels are*	*2 Staffing levels are*		
3 Consistency in staffing is	*3 Consistency in staffing is*	*3 Consistency in staffing is*		
4 Privacy for patients				
5 The information given to patients on their first visit is				
	6 Morale in the department is	*6 Morale in the department is*	*6 Morale in the department is*	*6 Morale in the department is*
	7 Communication is	*7 Communication is*	*7 Communication is*	*7 Communication is*
		8 Team work is	*8 Team work is*	*8 Team work is*
		9 The working atmosphere is	*9 The working atmosphere is*	*9 The working atmosphere is*
		10 Support from colleagues is	*10 Support from colleagues is*	*10 Support from colleagues is*
		11 Support from your line manager is	*11 Support from your line manager is*	*11 Support from your line manager is*
12 Safety practice in outpatients are				

13 Cleanliness is				
14 Equipment and supplies are	*14 Equipment and supplies are*			
		15 Your salary for your level of responsibility is		
16 Allocation of work is	*16 Allocation of work is*	*16 Allocation of work is*		
17 The roster is	*17 The roster is*	*17 The roster is*		
18 The ability to develop new skills is	*18 The ability to develop new skills is*	*18 The ability to develop new skills is*	*18 The ability to develop new skills is*	*18 The ability to develop new skills is*
		19 Your satisfaction with work over the last week has been	*19 Your satisfaction with work over the last week has been*	*19 Your satisfaction with work over the last week has been*

Appendix 24: Statements from interviews with front-line staff on survey

Theses statements are summarised from the interviews with front-line staff concerning their views on the staff satisfaction survey

What was good about the staff satisfaction survey?
Give views and opinions
Comments anonymous
Really good that it is anonymous because then we are more likely to be honest
Everyone can be honest
Gives honest views and opinions about the service, our managers and the hospital
Questionnaire covered different areas
Could be completed in own time

What was bad about the staff satisfaction survey?
No benefit
Should be good – but not that good here
Staff don't complete the survey
Some staff can't be bothered
No feedback
No change
Nothing happens
Had feedback, but no actions to resolve problems
Feedback but no actions
Less motivated to complete the next survey
Managers just want to tick the box
Waste of time, they (survey) are a joke
Waste of time as nothing positive has changed following them.
We give our opinions and then nothing is introduced as a result of these opinions and therefore nothing ever gets better.
We never get feedback from my manager as to any planned actions following the survey.

Appendix 24: Statement from interview with managers on survey

Theses statements are summarised from the interviews with managers concerning their views on the staff satisfaction survey

What was good about the staff satisfaction survey?
Provides a forum for staff to comment anonymously.
Shows that managers are open to constructive criticism and feedback
The survey has a good visual format, easy to understand the information
Can demonstrate whether or not changes implemented by managers have worked or not.
The survey can help motivate managers to get a 'better score'.

What was bad about the staff satisfaction survey?
Don't get full compliance
Can get negative comments to 'home in on' and thus loose sight of any positive comments.
Circumstance other than department issues can effect the results e.g. if someone had just received a just received a poor job banding - they may complete the survey in a negative frame of mind.
Staff could just put down all their complaints.

Complaints might be fine however may not get to the real problems.
Need to be balanced and you may not get that.
May not be as constructive as it could be.

Appendix 25: Case study one - adapted repertory grid

Case study one questions by group	Managers	Medical Records Frontline staff	Outpatients Frontline staff	Patient/Carer	Never	sometimes	mostly	always	Never	sometimes	mostly	always	Never	sometimes	mostly	always
					CS 1 frontline staf				CS 1 pt carer				CS 1 managers			
Improvement work should involve front line staff		Y					1	1								
Staff fix problems				Y							1	1				
Managers fix problems				Y						2						
Managers know how to improve things			y	Y		1	1			1	1					
Staff want to improve patient care				Y								2				
Staff are encouraged to improve their services		Y	y		2	1		2								
Manager and staff work together to make improvements	Y	Y	y		1	1	2	1								2
Staff see the need to improve their work	Y														1	1
Staff see improving their work as part of their job	Y												1	1		
Staff are committed to improving care		Y					2	1								
Managers want to improve patient care				Y								2				
Staff know how well their unit/department is performing	Y													2		
Staff get feedback on quality issues	Y		y			2										2
It is clear what managers see as priorities	Y		y				1	1						2		
manager and staff priorities are the same																
Staff trust managers	Y	Y	y			1	2	2						2		
Managers trust staff	Y	Y	y		1		1	2	1				1	1		
Patients trust NHS staff				Y							2					
Patients trust NHS managers				Y						1	1					
Managers do what they say they will do	Y		y			1		1								
Managers are concerned about the views of their staff	Y	Y	y		1	1		1	2						1	1

Appendix 26: Excerpt from Case study two interviews

Transcript shows the footnotes with my notes which were subsequently themed.

Do you have an idea about the proportion of the time that you think this is achieved?

Not really because every patient is different. On Sunday night I worked and we had a patient here for nearly 24 hours but there was a fight1 between HDU and us and it was a big fight. But that night I had 3 septic patients and I knew this gentleman was going to stay under the surgeon's which was why I booked him a bed. The minute that bed came up the charge nurses were at my throat2 to get him to the ward. He was hypotensive he was tachy-cardiac I could not for the life of me get his temperature below 39 and he was post, he was 3 weeks post surgery. His blood results were completely off the chart and it was 'get him out get him out'3. No – I want him to have his CT and come back here4. Nah, he's not allowed5, he can go to CT and then straight to the ward. That's what I don't agree with at all. Yes not giving our treatment time to work6. I know adults don't get better really quick we need to give our treatment a little bit more time to kick in before...

Was he in monitored?

He was monitored

---

1 A fight between HDU and us - *is there warfare between the departments? Breakown in relationships?*
2 At my throat - *agressive interaction, conflict*
3 get him out get him out - *evicted, not wanted, the patient is tresspassing?*
4 I want him to come back here - *why? Was he too sick to go to the ward, are the ward not able to look after him?*
5 Nah he's not allowed - *there are rules that must be obeyed?*
6 Not giving our treatment time to work - *what is expected of the ED department?*

Appendix 27: Challengers and liberators, case study two

Draft statement summaries from challenger and liberator list

Challengers:

1. Managers shouldn't tell nurses and doctors about moving patients or how to do patient care
2. Managers appear only when things are not going well.
3. ~~Managers do not give the treatment time to work~~
4. Managers want the system changed and now nursing is just numbers and paperwork
5. Managers try to force ideas
6. Manager and staff priorities are different
7. ~~Managers don't recognise that we need more staff~~ (covered by point 11)
8. Managers allow everyone to make changes which means every shift something has changed which is stressful
9. ~~It is alarming when it gets busy because managers come and start interfering with the work.~~ (covered by point 2)
10. Managers abuse staff to make them do what they want them to do
11. Managers don't listen to what staff say or they ignore what staff say
12. No one should be allowed to cheat to improve the measures

Liberators:

13. Managers promote the 'granny test'
14. Managers have a good rapport with staff
15. Managers are good at updating us
16. Managers are visible everyday
17. Managers do the difficult jobs initially then handed them on when they become less difficult
18. ~~Managers are always approachable~~ (covered under rapport)
19. Managers always listen to front-line staff
20. Managers and staff don't see eye to eye but they still talk
21. ~~Managers spend time with front-line staff~~ (covered under rapport)
22. Managers show respect to front-line staff

23. Managers keep trying
24. Unauthorised feedback to managers bypasses usual hierarchies and is necessary
25. Translation of what a goal means for managers, staff and patients is advertised and socialised
26. Managers need backstage information to have a reflexive approach
27. Lots of people need to do lots of things.

Appendix 28: Chapter 14, Organisational Lessons from Systemisation

CHAPTER 14

Organisational lessons from systematisation: the experience of HealthCare Otago

Allan Cumming and Janine Cochrane

As we have seen in this book, integrated care pathways (ICPs) have been widely adopted as a way of systematising clinical practice. Fully developed ICPs are seen as desirable in the delivery of cost efficient high quality patient care.[1] But for some 'it is questionable whether care pathways are a universal response to the requirement for modernisation and service redesign in the NHS'.[2] They have been seen by some trust managements as largely irrelevant to the change agenda or, worse, as adding costs in an already difficult financial climate.

Many of the experiences described elsewhere in this volume are concerned with the essential clinical dimensions of systemisation. In this chapter, we consider organisational factors and specifically their importance in the very positive experience of introducing ICPs in Otago, New Zealand.

BACKGROUND

Between 1994 and 1998 HealthCare Otago, a tertiary teaching hospital serving a small population in the South Island of New Zealand, underwent a major transformation. Using a combination of an unusual management structure, a focus on integrated care pathways, and a commitment to continuous quality improvement, HealthCare Otago transformed an organisation with severe financial challenges into a hospital 'in the black'.

The 1991 health reforms in New Zealand were launched by the green and white paper, *Your health and the public health*.[3] The reforms introduced a split between purchaser and provider: four Regional Health Authorities (RHAs) were set up to purchase services on a competitive basis from 23 Crown Health Enterprises (CHEs). The Crown Health Enterprises were commercial enterprises, with appointed Boards accountable to the Minister of Health and the Minister of Crown Owned Enterprises. HealthCare Otago came into

being as a crown owned company operating under commercial finance rules on 1 July 1993.

In early 1995 a new chief executive officer was appointed to HealthCare Otago, and in October 1995 a new senior management structure was introduced. This became fully functional with the appointment of general managers in December 1995. With the exception of the chief financial officer who had been in the post for 12 months, all the senior management posts were filled from outside the organisation. At this time, the organisation was in severe financial difficulties, facing an annual deficit of NZ$24 million, and the Chief Executive was determined to adopt a radical new approach to running the organisation. This approach was based on three main factors: a new management structure that engaged with clinical staff, a commitment to continuous quality improvement, and the use of integrated care pathways to systematise the delivery of care. These, combined with a performance system that provided fully allocated costs to the patient level, assisted the organisation to reach a positive financial position within four years.

This change in fortunes was not achieved without difficulty. Changes to the nursing management structure, and the appointment of some younger consultants to management posts, caused conflict between clinical staff and the new management structure early in the process. There was some resistance to the 'intrusion' of management into clinical care when the ICP programme started. This extended into the relationship between the management of the hospital and management of the medical school, where a number of the consultant staff had joint appointments. Ultimately, a change in the membership of the CHE Board led to the departure of the Chief Executive and the senior management team, and a reversion over the following 12 months to a more traditional style of management.

The story of pathway development in HealthCare Otago does not end with the counter revolutionary arrival of the new management structure in 1999. Although some things changed, what made the HealthCare Otago experience unusual was that the ICP work had become central to the way that clinical staff worked. Pathway work continued without the active encouragement, or even the continued explicit support, of the new senior team.

What led pathways to remain a significant factor in the delivery of efficient healthcare 10 years after their introduction? The three main factors in the change process were the management philosophy, the use of a quality improvement methodology and the widespread use of ICPs. These were not independent strategies. The management structure and philosophy was based on devolvement to Clinical Practice Groups (CPGs) jointly managed with clinical staff. This devolvement meant that accountability for performance was placed with the CPG staff who were given the authority to develop solutions to financial and clinical problems. The quality improvement methodology was central to this devolvement of responsibility, giving both the philosophical basis for devolved authority to 'fix problems' and the analytical tools to enable

workplace staff to identify causes of problems, and develop solutions. The ICP programme was the application of the quality improvement methodology to clinical practice: quality improvement methods and tools were used by staff to develop ICPs, and the use of ICPs was seen as the way for the CPGs to achieve their improvement in performance. ICP development would not have occurred without the devolvement of authority to the CPG; neither would the more general quality improvement work. The devolvement of accountability could not have been effective without the tools to deliver change. These interdependencies were telling, as we shall see.

THE CLINICAL PRACTICE GROUP STRUCTURE

The new management structure introduced in January 1996 had three main features that distinguished it from its predecessor: it denied traditional medical/surgical boundaries, developed dual accountability and leadership, and provided very devolved structures and responsibilities.

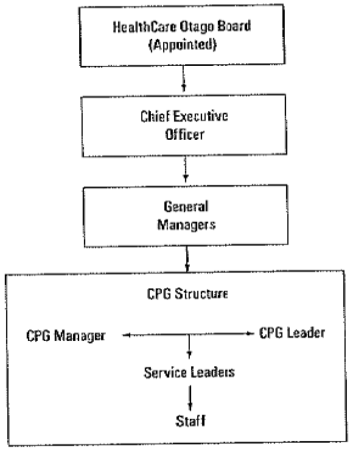


FIGURE 14.1 HealthCare Otago management structure

Overcoming the medical/surgical boundaries

The basic unit of the new structure was the Clinical Practice Group (CPG). Unlike previous structures that followed the traditional division of the hospital into medical specialities and surgical specialties, the CPG structure instead divided the hospital by 'body systems'. Initial CPGs included a Musculoskeletal CPG, containing orthopaedic surgery, rheumatology and physiotherapy, a Cardiothoracic CPG including cardiac surgery, cardiology, thoracic surgery and respiratory medicine, and a Head and Neck CPG including neurology, neurosurgery, ophthalmology, ENT, and maxillofacial surgery.

The CPG structure expressed a belief that the role of the medical consultant was changing and historical boundaries between medicine as diagnostic and surgery as interventional was no longer true. With services such as rheumatology, dermatology and cardiology conducting more interventions and minor procedures, it was apparent to the CEO that services such as cardiology and cardiac surgery had more in common than was previously acknowledged.

Although there was resistance to the structure from some specialities (e.g. neurology was initially reluctant to be combined with neurosurgery), such resistance dissolved. Over time, all clinical support services became part of the CPG that they were most closely aligned to, and CPGs merged and reformed as clinical interests became more clearly integrated. Initially, for example, a number of medical specialities were grouped with General Medicine; however, eventually the specialities grouped with the cardiothoracic group, with General Medicine aligning with Care of the Elderly services, although remaining as a separate CPG.

Leadership in the CPGs

A key feature of the CPG structure was its management and leadership. The CEO decided at the outset that it was essential to involve the clinical staff, and particularly the medical staff, in the new structure. He also acknowledged that not all doctors were interested in the details of day-to-day management, especially some of the potentially difficult decisions that would have to be made over service configuration. To deal with this dilemma, he introduced dual accountability.

Each CPG was headed by a full-time Clinical Practice Group Manager, full-time but in most cases with responsible for more than one CPG, and a Clinical Practice Group Leader, who devoted 20% of their time to management and retained their clinical duties for the remainder. In most (but not all) cases the CPG Leader was a medical consultant. The job descriptions for the CPG Manager and the CPG Leader were essentially identical, with the two being equally accountable for all clinical, financial and managerial aspects of the service. Both attended meetings together and decisions were made jointly. This meant that the clinical staff were fully involved in all aspects of their services, but had the ability to share the managerial tasks and pain. Equally, the CPG Manager was accountable for clinical quality on an equal footing with the clinicians, avoiding the often seen clinician-manager split of accountabilities.

Another feature in the appointment of staff to these new roles was the selection of relatively junior consultants for a number of posts. A generation

of clinical staff was skipped in some areas, leading to some conflict but a fresh approach to many problems.

Devolving responsibility

The third feature of the structure was a significant devolution of responsibility compared to its predecessors. The intention was to turn each CPG into a self-managing service, a 'hospital within a hospital'; thus it took responsibility for all aspects of the service including the configuration of services and contracts with funders. Over time, nearly all previously centralised support services were devolved into the CPG structure to support this delivery model. Clinical coding, human resources, most financial support and all training, audit, education and quality staff were placed within the CPGs. Central support functions were limited to a small central finance team, management of the case-mix and full-cost allocation accounting system, and the information technology departments, with a small HR support team managing collective staff contracts and recruitment of junior medical staff. Using the problem solving approach set out in the quality improvement training all management staff were required to attend, staff within CPGs were expected to come up with solutions to performance problems rather than have solutions imposed from above. In most cases, as long as the CPG met its targets for delivery of contract volume within agreed budgets, there were few decisions that were routinely required to go to corporate managers.

FROM QUALITY CONTROL TO QUALITY IMPROVEMENT

The second leg of the tripod supporting the turnaround at HealthCare Otago was the Quality Improvement Programme. The CPG structure placed responsibility for quality firmly with the CPGs and the central quality unit was disbanded and its staff moved into CPGs. The general manager for Medicine and Surgery commissioned the Juran Institute, an American-based consultancy offering training in continuous quality improvement methodologies.

Juran believed that quality improvement and a problem solving approach were important to the management philosophy, that it was the responsibility of all staff to identify and fix performance and quality problems, be they financial or clinical. Senior management set the direction for the organisation, and provided both the authority and the tools to achieve the goals set; but it was the staff within the CPG that had the authority and the knowledge to deliver results. Thus *all* staff with any management responsibility were required to attend a four day training programme, conducted with visible commitment by the CEO and senior management team, and had to deliver quality improvement projects as part of the performance review process. Overall the Juran training programme brought to all levels (including the front line) a higher understanding of the importance of data analysis and the ability to understand and interpret data.

INTEGRATED CARE PATHWAYS AS A WAY OF DELIVERING CHANGE

The third leg of the HealthCare Otago change process was the widespread introduction of integrated care pathways to systematise the delivery of clinical care. It was the ICP work that outlasted the more structural changes: seven years after it officially ended, nearly all of the pathways developed in the period 1996 to 1998 were still in use, and most were being regularly reviewed and updated.

Integrated care pathways were first introduced under the new management structure in January 1996 when the General Manager of Medicine and Surgery appointed a Care Pathway Coordinator. The ICP Coordinator's role was to facilitate the introduction of pathways within the new CPG structure, and to ensure a common standard and approach to pathways development. The role was one of the very few appointments that sat outside the CPG structure. Pathways were seen as essential to the process of driving down length of stay and costs through the reduction in variation and systemisation of practice. Pathways were also seen as clinical embodiment of the CQI process supported by the Juran approach to data management and interpretation.[4]

There was initial resistance to the pathway approach from both clinical and management staff. Managers could not see the immediate relevance of pathways to achieving cost and length of stay performance targets and clinical staff were concerned about management interference in clinical care. The CPG structure lessened this resistance because, while the freedom to 'not do ICPs' was not an option, the development of the ICPs lay with the clinical team within the CPG. Although the format was mandated (to maintain consistency across the hospital) and the initial conditions were chosen by senior management (on volume-cost basis), all staff within the CPG were involved in the development of pathways in their specialities. At the time the programme was launched, it was supported by experiences in pathway development in Australia and the United States; indeed, American work of pathway development for cardiac surgery appeared to be key in convincing that group of consultants of the value of the work.[5]

The first two pathways were for Coronary Artery Bypass Graft (CABG) within the Cardiothoracic CPG and for Total Knee Replacement (TKR) within the Musculoskeletal CPG. Each took some six months to develop, and the experience of developing these initial pathways eventually led to the development of a Four Meeting Model which would allow a new pathway to be developed in two months.

The introduction of pathways to the organisation took place on a number of different levels. A Pathway Steering Group was set up. This group included medical, nursing, allied health and managers. The Steering Group recommended content of training, agreed the approach for development and oversaw the pace of roll-out. Training in pathways, data analysis and understanding variation

was carried out in addition to the monthly hospital-wide CQI training. Training in pathway development was directed mainly at educators, nurse specialists and senior nursing and allied health staff. Medical staff were approached personally and through CQI training. Each professional group was responsible for educating its colleagues. The nursing staff paid particular attention to making sure that each member of staff on day, evening or night shift had an education session. The medical staff education usually took place at a breakfast meeting. It was identified early that pathways needed to be viewed as 'what we do around here'; not using pathways in the day-to-day management of routine care was not an option for any staff, no matter how senior.

In one clinical area use of the pathways was part of the review of the junior house staff. Ongoing training and orientation to the ward was carried out by the staff educators (who were usually from a nursing background, but who covered all staff including medical). It was also recognised that 'pathway police' were required to ensure that they were appropriately and routinely used. This role was usually taken on by senior nursing and educator staff.

The content of the pathway was developed using the CQI approach (and testing theories as to what situations led to poor outcomes or caused patient and system variation). A multidisciplinary team was selected and given the mandate to work with the group and their own professional colleagues. This process of local development, which was seen as important as it led to an understanding of how local micro-systems worked, involved three stages.

1 Identifying the start and finish of the pathway, discharge criteria, all the stages of the pathway as well as a list of anecdotal problems with current care.
2 Testing the suspected problems (e.g. comorbidities, laboratory turnaround, discharge obstacles) and developing theories of what caused them both to address what needed to be incorporated into the new pathway and to dispel myths about the problems contributing to an increased length of stay.
3 Reviewing each discipline's inputs and expectations for each stage of the pathway based on systematised evaluation of evidence to achieve consensus of practice between consultants – a difficult exercise for staff not least as traditional documentation focused upon inputs such as 'taking the patient's temperature' rather than outputs such as 'the patient's temperature was between x and y'.

The development of a common standard and approach meant that each pathway had the same look and feel developed with feedback from staff. Each replaced the traditional progress notes and used exception reporting. The documentation used either a day-by-day progress pathway in which each day's activities and outcomes were described (used primarily for predictable elective procedures) or a staged pathway where in order for a patient to progress through the pathway they had to meet certain criteria (used where there was more variation and less predictability in length of stay; e.g. many medical

conditions and cardiac surgery). Where daily examinations were carried out (usually by junior medical staff), a pro-forma layout was used. Each pathway document had a graph on the front cover which plotted 'criteria to achieve' on the vertical axis and days (or hours for day surgery) on the horizontal axis. A plot for the expected recovery was printed on the graph. The patient's progress was plotted daily. If the patient was tracking above the pre-printed line, the patient was recovering faster than expected. If the patient was tracking below, the patient's recovery was delayed.

The recording of variations was the most challenging feature of the pathways. Where variations were captured electronically, they were found to be extremely valuable in both ensuring that guidelines were met, and focusing on common problems patients experienced and in which new guidelines were required. Each item signed off on the pathway could generate a variation if the patient did not achieve a particular outcome. At discharge, a patient's inpatient documentation was repatriated to his or her main medical file and the clerical ward staff identified the patient on the pathway database and entered coded variations.

A pathway database to capture variations was developed in Microsoft Access®. Reports could be generated to show the percentage of patients with a particular variation, and the average length of stay for patients that had a variation and those that did not (to see if there was any difference). As patients were expected to have achieved standardised discharge criteria, length of stay was settled on as a reasonable proxy for measuring outcome. The types of variations that appeared to affect length of stay included nausea and vomiting, pain and mobilisation. These activities tended to be the responsibility of the junior doctors and nurses. Prior to the variance analysis from the pathways there was no routine monitoring of guidance compliance. The pathway provided feedback to the entire team. Unlike pathways developed elsewhere, variances were not sent to an audit department but remained part of the chronological patient record. The capture of variances electronically was achieved by training clerical staff to transfer information from the patient documentation.

Some suggest that the language and concepts used when discussing pathways is important in gaining doctor involvement.[6] In Otago the reason for doing pathways was to reduce unwanted, unintended and unnecessary variation. It was important to differentiate between reducing length of stay and reducing unnecessary length of stay (after discharge criteria had been achieved). It was important to focus on improving quality of care as an outcome, not reducing tests or other costs. Only one pathway set out explicitly to reduce length of stay (cardiac surgery). The aim for the other pathways was to improve the quality of care and patient experience. Despite this, all the pathways reduced length of stay within six months of introduction (by approximately one day). Most pathways demonstrated a reduced variability in length of stay post pathway introduction.

The involvement of medical staff in achieving systematisation was important.

This was accomplished using one-to-one meetings with the general manager and consultants, providing peer reviewed articles of other experience with pathways and advertising success in the clinical areas. These strategies support the findings of Mathie about which factors influence doctors' behaviour.[7] As junior medical staff were the most reluctant to engage with pathways, senior consultant involvement was vital. One issue frequently raised by junior medical and nursing staff was the defensibility of the pathway in court. This was dealt with by obtaining a legal opinion from the CHE solicitor which outlined benefits and harm for both the organisation and individual in using pathways. The evidence at the time suggested that if the pathways had been developed in an explicit manner (with staff identified) and outlined a clear plan of care, this was far more defensible than no written plan (which was traditionally often the case).

Systematisation using pathways was integrated into the organisation in an extremely focused way. The role of the general manager in pathway development was key to maintaining this momentum; the pathway remained the way to deliver the latest imperative from the Ministry of Health. Tight delivery constraints meant that the phenomenon of staff attending meetings and then nothing happening or changing was less likely to happen. Staff attendance at meetings was assured, as pathway meetings were seen as the most important non-patient work that clinical staff undertook.

WHAT RESULTS WERE ACHIEVED, AND HOW HAVE THEY BEEN SUSTAINED?

In preparing this chapter, a number of former and current staff of HealthCare Otago were interviewed. Additionally, length of stay data were analysed for the period 1992 (four years prior to the initiative) through to 2005 (six years after the management abandonment of the initiative). Data were analysed for several of the high volume pathways, as well as speciality level length of stay data to determine the impact on specialities as a whole.

Coronary artery bypass graft

Selected because of the high cost and high volume of the procedure, pathway work was completed in 1996, and median length of stay reduced from 14 days to 10 days by 1999. Changes to the provision of this surgery in the past three years, with a differentiation between straightforward cases (now done outside Dunedin Hospital) and complex cases (still done within Dunedin Hospital) has led to a halving of the volume of surgery undertaken in Dunedin Hospital. It is unclear whether the changing case-mix or the reduced bed pressure explains the increase in length of stay since 2002. Although the pathway is still in use within both the public hospital and the private facility which manages nearly 50% of the volume of elective cases, the analysis of the variance database and the regular variance review has not been undertaken for some time.

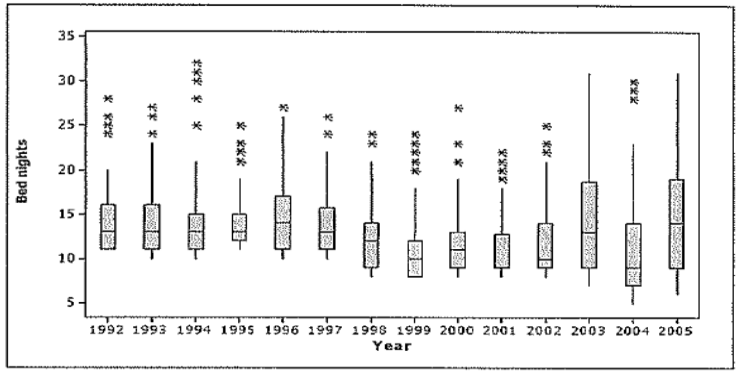


FIGURE 14.2 CABG boxplot of bed nights by year

Elective total hip and knee replacement

The pathways were developed in 1996 and due to the high volume of cases which were undertaken, the impact was seen relatively quickly. These two pathways show reductions in the median length of stay and the inter-quartile range. For the total hip replacement pathway median length of stay reduced from 11 days (1996) to seven days in 2000, and reduction in variation reflected in the inter-quartile range going from five days to two days. For the total knee replacement pathways the reductions in the median were from 11 days to eight days and the inter-quartile range from five days to two days over the same period. This reduction is similar to that found in other studies. Munoz, *et al.* found a reduction from 19.4 days ALOS to 10.1 days ALOS after six years.[8]

The pathways developed within the musculoskeletal CPG are still under review, with annual variance analysis undertaken by the multidisciplinary team and the pathway being modified to reflect subsequent changes in practice. This update of pathways is reflected in the continued improvement in performance for both pathways. The reduction in variation should indicate a tight clinical audit of the variance data to ensure that the majority of patients are maintained on the pathway.

Transurethral resection of the prostate pathway

Pathways were also developed for General Surgery procedures such as transurethral resection of the prostate. Pathway work commenced in 1997, later than the cardiac and orthopaedic pathways. While the median length of stay did not significantly reduce initially, the impact of the pathway was seen in the short stay patients, with the lower quartile dropping from four days in

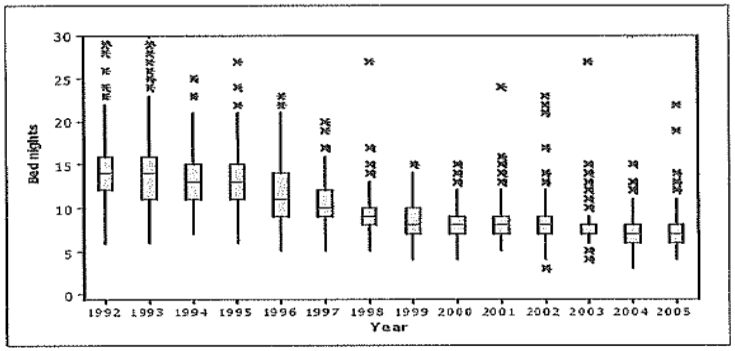


FIGURE 14.3 Elective total hip replacement boxplot of length of stay by year

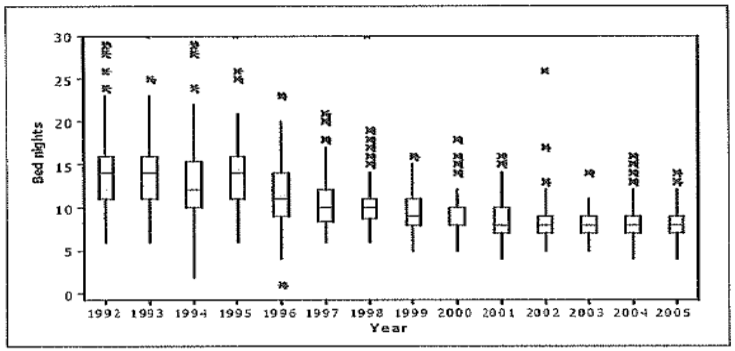


FIGURE 14.4 Elective total knee replacement boxplot of length of stay by year

1997 to three days in 1998, two days in 2000, and one day in 2003. Although the staff in the area maintain that the pathways are still used and regularly reviewed, analysis of the variance data is not undertaken regularly as in some other specialities, and this may explain the increasing length of stay over the last two years.

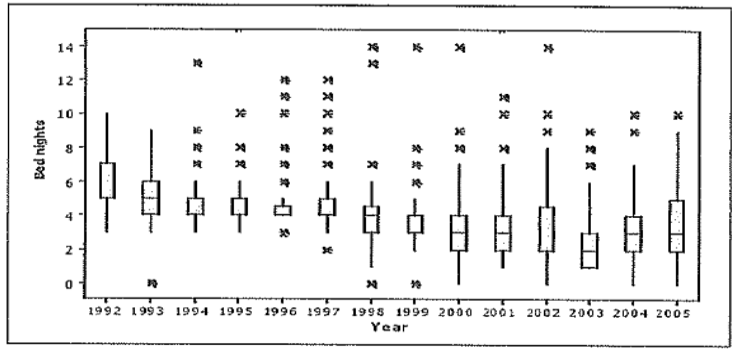


FIGURE 14.5 Transurethral resection of the prostate pathway boxplot of bed nights by year

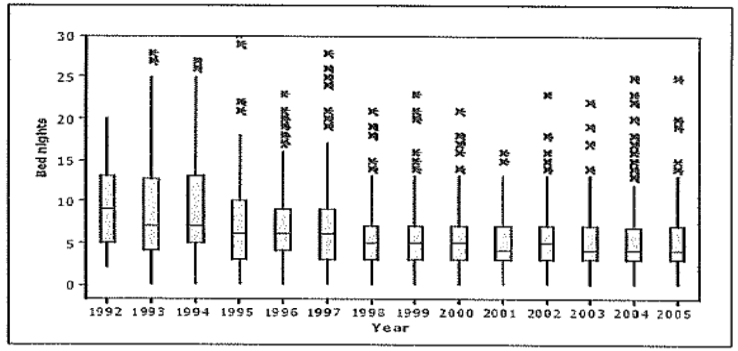


FIGURE 14.6 COPD pathway boxplot of bed nights by year

Respiratory medicine: COPD

Pathways in the medical specialities are often seen as more difficult to implement, but pathways developed for respiratory medicine are still in use and reviewed regularly. The chronic obstructive pulmonary disease (COPD) pathway was developed in 1997, and while immediate reductions in the median

length of stay were not as apparent as in some pathways due to reductions achieved through improvement in previous years, the variation between patients was reduced and this reduction in variation has been held since 1998.

Average length of stay (ALOS)

The impact of ICPs and other associated continuous quality improvement work[9] on average length of stay can be seen when ALOS data for whole specialities is analysed. The average length of stay for all patients discharged live, both emergency and elective admissions, is presented for four of the key specialities. While all four specialities show the best performance in 1998, the final year of the CPG management structure, most results have remained lower than the pre-1996 figures through to the present day. These length-of-stay figures include all patients, those included on pathways and those not, indicating that the reductions are significant enough to affect the whole department. For example, if the 2392 patients discharged from orthopaedics in 2000 had stayed the ALOS seen in 1995, an additional 2618 bed days would have been used. At the ALOS of 4.35 days achieved in 2000, this equates to capacity to admit an additional 600 patients.

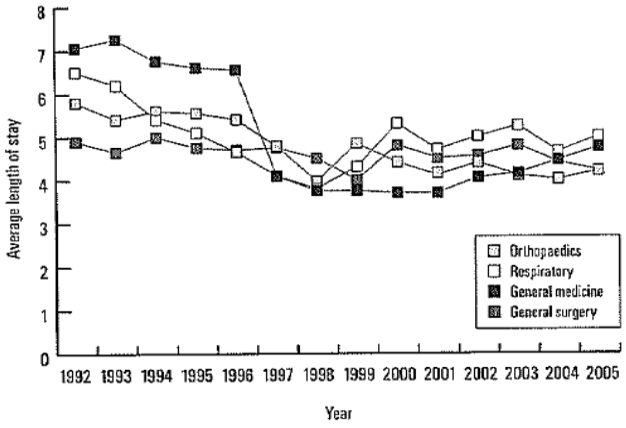


FIGURE 14.7 Average length of stay for four key specialties

CONCLUSIONS: THE ORGANISATIONAL FACTORS

The pathways introduced into HealthCare Otago were effective in reducing length of stay and therefore cost. These impacts were significant. In the two musculoskeletal pathways described, reductions of length of stay in 2000 compared to 1995 (the last full year before development began) meant that

a total of 1386 bed days were saved. In the COPD pathway, if the patients treated in 2000 had experienced the same length of stay as those patients admitted in 1995, an additional 300 bed days would have been used. In the cardiac surgery pathway the saving would have been 334 days; in the TURP pathway, 184 days. The number of bed days saved by pathways at HealthCare Otago has been significant.

The impact of pathways on performance continued long after management moved onto other initiatives. This is largely due to the fact that the clinical staff using the pathways on a daily basis found them to be an improved way of delivering clinical care. In those areas where regular pathway review has continued, pathways continue to be improved, and length of stay continues to reduce.

Yet the pathway success at HealthCare Otago was at least partly due to the position that pathways played in the organisation. And there are at least five organisational lessons for others interested in implementing pathways as part of clinical management improvement. First, they were seen as core to the way the organisation did its business of delivering healthcare. They were supported by senior management, both clinical and non-clinical, and were clearly identified as one way that the organisation would meet its performance objectives. Second, the pathway initiative was led by the senior management team. As core business, the visible support of the executive was central to delivering pathways. Third, the pathway programme was inextricably linked into other strategies pursued by the organisation. In particular, pathway development fitted into the devolved management structure by giving performance tools to clinical staff; it was also the clinical embodiment of the quality improvement programme that affected other areas of the hospital. Fourth, in HealthCare Otago, pathways were developed from the start by multidisciplinary teams, including clerical, medical, allied health profession and nursing staff. No profession dominated this process and none was left to undertake it alone. Finally, and above all, in HealthCare Otago, pathways were seen as a means to deliver better clinical outcomes; they were never ends in themselves.

ACKNOWLEDGEMENTS

We would like to thank the following current and former HealthCare Otago staff for agreeing to be interviewed for this chapter: J Ayling, C Barker, M Boivin, R Bunton, S Christie, J Hewson, G Martin, A van Rij, J-C Theis, C Wong.

REFERENCES

1 Schmid K, Conen D. Integrated patient pathways: 'mipp' – a tool for quality improvement and cost management in health care. Pilot study on the pathway Acute Myocardial Infarction. *Int J Health Care Quality Assurance*. 2000; 13: 87–92.

2 Bragato L, Jacobs K. Care pathways: the road to better health services? *J Health Organ Management*. 2003; 17: 164–80.
3 Upton S. *Your Health and the Public Health*. Wellington: Ministry of Health; 1991.
4 Juran Institute. *Quality Improvement: health care*. Wilton: Juran Institute Inc; 1993.
5 Bunton R. Personal interview. Dunedin; 2006.
6 Mathie AZ. Doctors and change. *J Management Med*. 1997; 11: 342–56.
7 Ibid.
8 Munoz A, Garcia M, Perez M, *et al*. Clinical pathway for hip arthroplasty six years after introduction. *Int J Health Care Quality Assurance*. 1997; 19: 237–45.
9 Rae B, Busby W, Millard P. Fast-tracking acute hospital care: from bed crisis to bed crisis. *Australian Health Review*. 2007; 31: 50.

Appendix 29: Code of conduct for Institute of Health Management (2013)

Code for mapping	Insititue for Health Management
	Managing self: to ensure a consistent and authentic approach
	Managers are expected to:
1	• Strive for excellence at all times
2	• Exemplify the highest standards of professional behaviour and performance
3	• Remain accountable for their actions
4	• Disclose any personal interest which may affect their managerial decisions
5	• Act only within the level of competence and advise otherwise when asked to act beyond it
6	• Continue to develop management competences and keep up to date with best practice
7	• Safeguard confidential information and not seek personal advantage from it
8	• Act reasonably and justifiably in identifying and resolving conflicts of values, including those of an ethical nature
	Managing the organisation: providing a framework within which excellence can be delivered and patients/clients will be safe
	Managers are expected to provide:
9	• Clarity of purpose – in ways that are simply expressed in ways that staff and the public can understand and relate to. Seek to reconcile personal and corporate valuesand uphold the organisational objectives and how identified outcomes contribute to those objectives
10	• Structures: that enable staff to be engaged in decisions about themselves and theirwork and understand structures, procedures and controls that enhance efficiency and effectiveness
11	• Clear unambiguous guidelines about: recruitment; training and development; appropriate challenge; building and sustaining teams in a blame free culture, together with the importance of upholding lawful policies and practices that further the interests of good management
12	• Excellent communication
13	• Involvement: engagement of all staff, other organisations, the public about decisions affecting themselves
14	• Regular and routine performance appraisal including career development and the maintenance of a work/life balance
15	• A secure environment, to enable staff to do their job and make a contribution to the organisation
16	• Openness-ensuring transparency
17	• A robust and meaningful governance structure and strategy that safeguards the reputaton and assets of the organisation
	Managing people: to build and sustain trust, commitment and engagement between managers and who they manage.
	Managers are expected to show:
18	• Competence as a person, manager and leader
19	• Attentiveness: non-prejudicial and non-discriminatory, accepting the diverse interests and backgrounds of people. Ability to actively listen and respond appropriately, motivate and encourage others in interactions
20	• Honesty and trustworthiness: transparency in all actions. Working with integrity and able to make reliable judgments and act consistently and fairly when addressing performance and behaviour issues
21	• Selflessness: humility and fairness
22	• Politeness and courtesy in any interaction
23	• Excellent communication skills, using the various communication channels effectively and appropriate non- verbal communication at all times. The ability to communicate clearly, effectively and openly is paramount
24	• Empathy and sympathy towards individuals
25	• Intellectual flexibility: emotional intelligence; ability to negotiate; mediate and deliver solutions that have buy in.
26	• Support colleagues to fully understand their responsibilities, areas of authority and accountability
27	• The ability to develop skills and qualities within individuals and teams and recognise achievements
28	• Reliability: to deliver with honesty and clarity, acknowledging mistakes and misunderstandings. Apologising where necessary
29	• An ability to resolve conflicts and disputes in a timely manner
30	• A regard for the physical and mental health and well being of colleagues
	Managing the service: to build, sustain and deliver high quality health and care services.
	Effective managers are expected to demonstrate:
31	• governance
32	• The delivery of a service that has appropriate and effective interventions, meets individual, community and corporate needs; guarantees value and efficiency and patient/client satisfaction
33	• An awareness of the impact on society, and how to moderate that impact to society's benefit. Contributing to a sustainable health and care service
34	• The promotion of health and well being within the service
35	• The prevention of harm, taking appropriate actions to prevent or limit the risks of harm in society arising from any health and care activity and making judgments aboutthe use of sensitive and confidential information in the public and society's interest.
36	• Respect the natural environment and seek to conserve resources wherever possible

Appendix 30: Example of a code of conduct from a school

Code for mapping

Our Staff Relationship Guidelines

Overall Objective:

The Staff Relationship Guidelines (SRGs) are the scaffolding to achieving our values of; respect, integrity and positive attitude and they underpin all our work at the school.
We need people with high levels of Emotional Intelligence (EI). In essence, this means people who can correctly recognise how they feel at any moment in time and manage these feelings in a socially acceptable way: and simultaneously, people who can recognise how others might be feeling and manage their interaction with them in a sensitive and skilled way.

The guidelines:

A • Say what you mean, in an appropriate way - moaning / negative comments bring people down;

B • Treat yourself and others with dignity and respect;

C • Take responsibility for your own thinking, feeling and behaviour – don't blame others for what you do. You always have a choice;

D • Communicate to resolve issues, rather than speaking to prove you are right; active listening is essential;

E • Give, accept and ask for positive and constructive feedback/dialogue;

F • In a conflict, communicate only with those people who can help you resolve it –negative comments make a conflict worse – go back to the person; and

G • Forgive and let go- people make mistakes. Our energy needs to go into getting the next steps right.

Our Positive Behaviour Policy

At Swiss Cottage we believe that:

H Pupils want to behave well. We believe that our pupils are happy when they behave well and when that behaviour is recognized by adults and their peers.

I Pupils can learn to improve their behaviour. Our pupils find learning difficult. Learning new behaviour is a task, just like learning to read or write.

J Mistakes are part of the learning process. We understand poor behaviour as a mistake which can be rectified. We don't make a judgement about it – instead we support our pupils to get it right. Practice improves performance.

K All adults can learn strategies to support pupils to improve their behaviour. Most adults have evolved ways of dealing with children's behaviour based usually on their experience of being parented or parenting. In most cases, these are either a barrier or not sufficiently thought through to be helpful in addressing the, sometimes, challenging behaviour of our pupils. Developing an understanding of why children behave as they do, a positive attitude to the child and his/her behaviour and effective strategies for managing that behaviour is a core requirement of the job. It requires a real commitment to on-going professional development. As for the child, constant practice improves performance.

We adults can support our pupils by:

L Actively building trust and rapport – they have to be earned; they're not given

M Demonstrating belief in the pupil – that's/he can succeed. Let the pupil know this

N Treating the pupil with dignity and respect at all times e.g. By saying 'thank you'; by listening carefully

O Listening respectfully to the pupil, and make a judgement about how/when to respond

P Enjoying his/her company – have fun together, where and when appropriate

Q Hearing the message behind the word/behaviour; ask yourself why the pupil is behaving in this way – there will always be a reason; the behaviour is a symptom

R Seeing things through e.g. If pupils have to make up time, the teacher concerned must help them to do this during morning break/lunch time/after school

S Keeping our word – do whatever we say we will do

T Telling the truth at all times – never lie to a pupil

U Looking for the good in the pupil – identify it with the child and build on it.

V Apologising if you make a mistake – you are modelling this for the pupil and you will earn respect

W Naming and managing your own emotional reactions to pupils' behaviour i.e. demonstrate emotionally intelligent behaviour at all times

X Letting go of your memory/feelings of a pupil's previous bad behaviour – its unhelpful history. Focus instead on getting it right in the future

Y Quietly but firmly holding appropriate boundaries for the pupils. Never letting pupils do whatever they want, when this would infringe the rights or comfort of others.

Appendix 31: New Zealand Nurses code of conduct

Appendix 32: Mapping themes of research to IHM, School and Nursing codes of conduct

Mapping emerging themes to current code of conducts	Emerging themes from case study one and two	Institue of Health Managers code of conduct	School code of conduct	New Zealand Nursing Council Code of Conduct	ILM 1	ILM 2	ILM 3	School 1	School 2	School 3	School 4	School 5	Nursing 1	Nursing 1
1	Managers abuse staff to make them do what they want them to do	8, 20, 30	N,B,C	6	• Act reasonably and justifiably in identifying and resolving conflicts of values, including those of an ethical nature	• Honesty and trustworthiness: transparency in all actions. Working with integrity and able to make reliable judgments and act consistently and fairly when addressing performance and behaviour issues	• A regard for the physical and mental health and well being of colleagues	Treating the staff with dignity and respect at all times e.g. By saying 'thank you'; by listening carefully	Treat yourself and others with dignity and respect;	Take responsibility for your own thinking, feeling and behaviour – don't blame others for what you do. You always have a choice;			Principle 6: Work respectfully iwth colleagues to best meet health consumers needs	
2	No one should be allowed to cheat to improve the measures	3, 8, 20	T		• Remain accountable for their actions	• Act reasonably and justifiably in identifying and resolving conflicts of values, including those of an ethical nature	• Honesty and trustworthiness: transparency in all actions. Working with integrity and able to make reliable judgments and act consistently and fairly when addressing performance and behaviour issues	Telling the truth at all times – never lie to a staff member						
3	Managers shouldn't tell nurses and doctors about moving patients or how to do patient care	5, 13	D		• Act only within the level of competence and advise otherwise when asked to act beyond it	• Involvement: engagement of all staff, other organisations, the public about decisions affecting themselves		Communicate to resolve issues, rather than speaking to prove you are right; active listening is essential;						
4	Managers appear only when things are not going well.		M					Demonstrating belief in front-line staff – that's/he can succeed. Let the staff know this						
5	Managers listen to what staff say and then ignore what staff say		O	6				Listening respectfully to staff and make a judgement about how/when to respond					Principle 6: Work respectfully iwth colleagues to best meet health consumers needs	
6	Managers are highly visible													
7	Managers want the system changed and now nursing is just numbers and paperwork		D	1,3				Communicate to resolve issues, rather than speaking to prove you are right; active listening is essential;					Principle 1: Resepect the dignity and individuality of health consumers	Work in partnership with health consumers to promote and protect their well being
8	Managers try to force ideas		F	6				In a conflict, communicate only with those people who can help you resolve it –negative comments make a conflict worse – go back to the person; and					Principle 6: Work respectfully iwth colleagues to best meet health consumers needs	
9	Managers allow everyone to make changes which means every shift something has changed which is stressful													

10	Lots of people need to do lots of things.		I, K					front line staff can learn to improve the services they provide. All staff find change difficult. Learning how to undertake change is a task, just like learning to read or write.	All managers can learn strategies to support staff to undertake service improvement and change. Most managers have evolved ways of dealing with front-line staff and difficulties with change based on their own experience of being part of a change process. In most cases, these are either a barrier or not sufficiently thought through to be helpful in addressing the, sometimes, challenging circumstance of change. Developing an understanding of why staff behave as they do, a positive attitude to staff and their responses to change and effective strategies for managing that behaviour is a core requirement of the job. It requires a real commitment to on-going professional development					
11	Manager and staff priorities are different	32			• The delivery of a service that has appropriate and effective interventions, meets individual, community and corporate needs; guarantees value and efficiency and patient/client satisfaction									
12	Managers are good at updating us	9			• Clarity of purpose – in ways that are simply expressed in ways that staff and the public can understand and relate to. Seek to reconcile personal and corporate valuesand uphold the organisational objectives and how identified outcomes contribute to those objectives									
13	Managers have a good rapport with staff	19	L, M, P		• Attentiveness: non-prejudicial and non-discriminatory, accepting the diverse interests and backgrounds of people. Ability to actively listen and respond appropriately, motivate and encourage others in interactions			Actively building trust and rapport – they have to be earned; they're not given	Demonstrating belief in front-line staff – that's/he can succeed. Let the staff know this	Enjoying his/her company – have fun together, where and when appropriate				
14	Managers show respect to front-line staff	22,28	O,	6	• Politeness and courtesy in any interaction	• Reliability: to deliver with honesty and clarity, acknowledging mistakes and misunderstandings. Apologising where necessary		Listening respectfully to staff and make a judgement about how/when to respond					Principle 6: Work respectfully iwth colleagues to best meet health consumers needs	

15	Managers promote the 'granny test'	9, 35	H, Q	1,3	• Clarity of purpose – in ways that are simply expressed in ways that staff and the public can understand and relate to. Seek to reconcile personal and corporate valuesand uphold the organisational objectives and how identified outcomes contribute to those objectives	• The prevention of harm, taking appropriate actions to prevent or limit the risks of harm in society arising from any health and care activity and making judgments aboutthe use of sensitive and confidential information in the public and society's interest.		Staff want to behave well. We believe that our staff are happy when they deliver excellent health carel and when that is recognized by managers and their peers.	Hearing the message behind the word/behaviour; ask yourself why the staff member is behaving in this way – there will always be a reason; the behaviour is a symptom				Principle 1: Resepect the dignity and individuality of health consumers	Work in partnership with health consumers to promote and protect their well being
16	Managers do the difficult jobs initially then handed them on when they become less difficult													
17	Translation of what a goal means for managers, staff and patients is advertised and socialised	26			• Support colleagues to fully understand their responsibilities, areas of authority and accountability									
18	Managers need backstage information to have a reflexive approach		E,J, G, V, X					Give, accept and ask for positive and constructive feedback/dialogue;	Mistakes are part of the learning process. We understand poor health service is a mistake which can be rectified. We don't make a judgement about it – instead we support our staff to get it right. Practice improves performance.	Forgive and let go- people make mistakes. Our energy needs to go into getting the next steps right.	Apologising if you make a mistake – you are modelling this for the team and you will earn respect	Letting go of your memory/feelings of a staffs' previous bad behaviour – its unhelpful history. Focus instead on getting it right in the future		
19	Managers and staff don't see eye to eye but they still talk		H, Q, R, W					Staff want to behave well. We believe that our staff are happy when they deliver excellent health carel and when that is recognized by managers and their peers.	Hearing the message behind the word/behaviour; ask yourself why the staff member is behaving in this way – there will always be a reason; the behaviour is a symptom	Seeing things through e.g. If staff have to undertake difficult tasks, the manager concerned must help them to do this	Naming and managing your own emotional reactions to staffs' behaviour i.e. demonstrate emotionally intelligent behaviour at all times			
20	Unauthorised feedback to managers bypasses usual hierarchies and is necessary		E					Give, accept and ask for positive and constructive feedback/dialogue;						
21	Managers keep trying		R					Seeing things through e.g. If staff have to undertake difficult tasks, the manager concerned must help them to do this						
22	Managers always listen to front-line staff	19	L, O		• Attentiveness: non-prejudicial and non-discriminatory, accepting the diverse interests and backgrounds of people. Ability to actively listen and respond appropriately, motivate and encourage others in interactions			Actively building trust and rapport – they have to be earned; they're not given	Listening respectfully to staff and make a judgement about how/when to respond					
23	The newsletter did not engage staff in change although is was percieved to be useful by staff and manager/leaders													

24	The quality meeting was seen as high vlaue by front-line staff and manager/leaders		R, O, M	6				Seeing things through e.g. If staff have to undertake difficult tasks, the manager concerned must help them to do this	Listening respectfully to staff and make a judgement about how/when to respond	Demonstrating belief in front-line staff – that's/he can succeed. Let the staff know this			Principle 6: Work respectfully iwth colleagues to best meet health consumers needs
25	Front-line staff saw managers 'controlling' the quality group and there was limited front-line staff led initiative.		W, D					Naming and managing your own emotional reactions to staffs' behaviour i.e. demonstrate emotionally intelligent behaviour at all times	Communicate to resolve issues, rather than speaking to prove you are right; active listening is essential;				
26	Staff satisfaction surveys were seen as high value strategies for managers but low value for staff due to percieved lack of response from managers		R, S					Seeing things through e.g. If staff have to undertake difficult tasks, the manager concerned must help them to do this	Seeing things through e.g. If staff have to undertake difficult tasks, the manager concerned must help them to do this				
27	Perceptions of effectiveness of the three strategies were higher with managers than with front-line staff.		E					Give, accept and ask for positive and constructive feedback/dialogue;					
28	Manager/leader intentions regarding engagement were misinterpreted resulting in suspicion and motives and ethics were substandard.		L					Actively building trust and rapport – they have to be earned; they're not given					

Appendix 33: Detailed analysis of front-line perception of management interference (case study two).

Upper right quadrant – positive interference and positive impact upon change (ie pro-change, positive involvement).

Manager/leader interference	Researcher notes and explanation	Impact on change/impact on front-line staff
Managers/leaders are good at updating us	This provides feedback and if positive – assists team dynamics and pride, if negative may increase uncertainty.	Low positive impact on change (1) and low positive management interference (3)
Managers/leaders have a good rapport with staff	This means that front-line staff form a relationship with higher management and not all feedback and communication needs to work through the formal hierarchies, the impact of this is a more egalitarian approach and potential for raising issues outside of the usual hierarchies.	High positive impact on change (8) and medium positive management interference (4)
Managers/leaders show respect to front-line staff	Regardless of personal and professional views of front line staff, managers/leaders need to hold a higher mantel and show respect to all staff.	High positive impact on change (7) and medium positive management interference (4)
Managers/leaders promote the 'granny test'	The idea that patients should be treated like a member of your family rings true for both front-line staff and managers.	Medium positive impact on change (5) and medium positive management interference (5)
Managers/leaders do the difficult jobs initially then handed them on when they become less difficult	Breaking new boundaries is scary for everyone, sometimes front-line staff appreciate that this has been carried out by managers/leaders thus not putting staff in positions of conflict and uncertainty.	High positive impact on change (7) and medium positive management interference (5)
Translation of what a goal means for managers/leaders, staff and patients is advertised and socialised	It is important that goals are translated for all three groups even when it seem obvious. The aims need to be what each group – really want – like to create more space for staff to work in, to reduce waiting time for pain relief for patients	High positive impact on change (7.5) and medium positive management interference (5)
Managers/leaders need backstage information to have a reflexive approach	Recognising that who attends meetings and what is said at meetings is the tip of the iceberg is important. What staff think is only found by having good rapport with staff who tell you things.	High positive impact on change (8) and medium positive management interference (5)
Managers/leaders and staff don't see eye to eye but they still talk	The way conflict is dealt with by managers is important. Keeping open communication after disagreements is essential to having on going opportunities to interact and work together.	Medium positive impact on change (8) and high positive management interference (6)
Unauthorised feedback to managers/leaders bypasses usual hierarchies and is necessary	Hierarchies stop information flow if people from different levels are unable to speak with each other. Visibility of managers and managers having a rapport with front-line staff avoids	High positive impact on change (9) and high positive management interference (7)

	information being held at different levels. The importance of unofficial information is to feed managers to be more reflexive in approaches thus avoiding 'brewing' of discontent – striking while the iron is hot is a perfect analogy of being reflexive.	
Managers/leaders keep trying	Focus, persistence and resilience in managers appeared to be important in reducing uncertainty and anxiety in front-line staff and also reinforcing the direction for the team.	High positive impact on change (8) and high positive management interference (8)
Managers/leaders always listen to front-line staff	The ability to listen without always being able to change things appears to be important. If managers are unable to change things, sometimes they stop listening. Listening also seems to serve as a function to show support for front-line staff 'blowing off steam'.	Low positive impact on change (2) and high positive management interference (10)

The upper right quadrant carries items that have been categorised as win/win i.e. pro-change and positive involvement. They are desired by front-line staff and appear to have a positive contribution to making change. The items described here were a mixture of behaviours exhibited by managers and descriptions of how relationships were viewed. These views were derived from the front-line participant data. None of these themes emerged from the manager/leader interviews.

Upper left quadrant – negative interference and positive impact upon change (highly interfering and pro-change)

Manager/leader interference	**Researcher notes and explanation**	**Impact on change/impact on front-line staff**
Managers/leaders shouldn't tell nurses and doctors about moving patients or how to do patient care	Engaging with staff involves observing how work gets done and working with staff to systematise how work gets done. Sometimes this may involve managers working with staff in clinical area which results in 'interfering' with clinical decisions. Engagement with staff means being where staff are, not sitting in a meeting discussing what happens.	High positive impact on change (7) and high negative management interference (-7)
Managers/leaders appear only when things are not going well.	This may be a legitimate activity to offer assistance, support or to understand what happens when work builds up and counter measures may be required. Managers may be able to assist by working across boundaries.	Low positive impact on change (2) and medium negative management interference (-6)
Managers/leaders are highly visible	This has potential to be a double edged sword, on the one hand the manager knows more about the	High positive impact on change (7) and medium

	business and on the other – they have an opportunity to interfere more with the clinical work	negative management interference (-5)
Managers/leaders want the system changed and now nursing is just numbers and paperwork	Change in roles and accountabilities is inevitable, especially if coordination and oversight of time is required.	Medium positive impact on change (5) and medium negative management interference (-4)
Managers/leaders try to force ideas	It is the roll of managers to influence and change the way everyone looks at processes	High positive impact on change (7) and medium negative management interference (-4)
Managers/leaders allow everyone to make changes which means every shift something has changed which is stressful	The consequence of more front-line staff involvement is more change more frequently. Empowerment of staff means that the threshold for undertaking change and piloting ideas is dropped. The complexity of health systems means that small changes and piloting ideas is appropriate. There may be a high failure rate which means that there is even more change occurring.	High positive impact on change (8) and low negative management interference (-3)
Lots of people need to do lots of things.	As above	High positive impact on change (9) and low negative management interference (-3)
Manager/leader and staff priorities are different	The consequence of diverse looking priorities is a problem. What the priorities mean for each group needs to be articulated and socialised so that all groups understand the multiple perspectives	Low positive impact on change (2) and low negative management interference (-1)

The above table describes themes that emerged where they were viewed as negative from a front-line staff point of view however they appeared to have a positive contribution in making change. Whilst they mainly describe behaviours of managers in a negative way they give insight into the constantly negotiated and re-negotiated realities for staff. My research notes provide an explanation as to what might be happening here and what is it that people are trying to achieve.

Lower left quadrant – negative interference negative impact upon change

Manager/leader interference	**Researcher notes and explanation**	**Impact on change/impact on front-line staff**
Managers/leaders abuse staff to make them do what they want them to do	Performance management and providing feedback to staff who are in the middle of a shift may look and feel more like bullying regardless of how it is	High negative impact (-7) on change and high negative management interference (-

	handled. This is especially pertinent if managers are involved and on the clinical work floor. When emotions run high – it becomes even less obvious how someone's decisions impacted upon the system. Managing new ways of working during real shifts (there is no ability to practice), means that the ability of senior staff to provide feedback, support and coach is limited resulting in high stress behaviours where staff may feel like they are being bullied. Some staff under a new regime may not be suited to a high stress environment. At the end of the day however, it is not acceptable to have staff feeling like they are being bullied. In the long run bullying will not assist in achieving good change.	10)
No one should be allowed to cheat to improve the measures	The temptation to 'click on the patient' is understandably high if the patient is just waiting to be moved and it will make the difference between meeting a target or not. It is however never acceptable even when trying to give the team a boost. Cheating relates to trust and it is never ok to be untrustworthy in a caring environment.	High negative impact (-9) on change and high negative management interference (-7)
Managers/leaders listen to what staff say and then ignore what staff say	Managers/leaders are unable to respond to every request or suggestion. Without a strategy to provide feedback (to show that manager/leaders have listened), this can become a negative area and reduce the impact of a change process.	Medium negative impact (-5) and medium negative management interference (-5)

The above table contains the loose/loose themes from the research which appear to be ineffective in achieving change and are unethical. They describe a dark reality that both conscious and unconscious behaviours can have.

Appendix 34: Draft guidance mapping table

Ref	Draft Code of Conduct for reflexive middle managers		IHM	Sch	Serv
Core beliefs		**Supportive actions from middle managers**			
1a	Front-line staff want to provide excellent care.	We believe that our staff do their best when they are part of a team that works together and is supported by each other and middle managers.			3
1b	Learning new behaviours and ways to undertake change is a task just like learning to read or write.	Front-line staff and middle managers can learn to improve their ability to undertake change and improve care together by improving processes on a regular basis.			4
1c	Mistakes are part of the learning process.	Middle managers understand that some changes are mistakes and these can be rectified. Middle managers don't make a judgement about it – instead they support the front line team to get it right. Practice improves performance.			3
1d	Front-line staff and	Most staff and managers have evolved ways of dealing with change based on			7

	managers can learn strategies to support teams to improve the process involved in change	their previous experience of being changed or leading change. In many cases these are either a barrier or not sufficiently thought through to be helpful in addressing the sometimes-challenging behaviours of all team members undergoing change. Developing an understanding of why teams behave as the do, a positive attitude to the team and developing effective strategies for the team is a core requirement of a middle manager's job.			
The middle manager behaviours		**Supportive actions from middle managers**			
2a	Actively builds trust and rapport with front-line staff	Trust and rapport have to be earned; they're not given. Spending time learning from front-line staff builds rapport and shared understandings			1
2b	Demonstrates belief in the team	Front-line staff want to see middle management as one of 'us', who does it for us, helps the team work together and makes us matter (adapted from Haslam, Reicher et al. 2001, pxxii).			6
2c	Treats the front-line staff with	By saying thank you, listening carefully, asking for advice. The middle manager never shouts or threatens front-line staff even if feeling upset,			2

	dignity and respect	stressed or angry.			
2d	Listens respectfully	And makes a judgement about how/when to respond.			1
2e	Enjoys being with front-line staff	Is courteous, warm and friendly towards front-line staff even when there is disagreement about an issue.			5
2f	Hears the message behind the word/behaviour	Thinks about why the person is behaving this this way – there will always be a reason; the behaviour is a symptom.			2
2g	Sees things through	Keeps trying, is tenacious with difficult problems and issues.			8
2h	Keeps their word	Does whatever they say they will do			9
2i	Tells the truth	Never lie to front-line staff			3
2j	Looks for the good	Identifies the good with the team and builds on it			4
2k	Apologises if they	Model humility and apologise			9

	make a mistake				
2l	Manage their own emotional reactions to events	Identify and name your own reactions thus monitoring your own emotionally intelligent behaviour at all times.			3
2m	Let go of your memory/feelings when you feel you have been unfairly treated by front-line staff	Focus on working with front-line staff to get it right in the future.			10
Conflict		**Supportive actions from middle managers**			
3a	Quietly but firmly holds appropriate boundaries for front-line staff	Never let front-line staff do whatever they want, when this would infringe upon the rights or comfort of other staff or services for patients.			8
3b	Normalise conflict	Conflict is normal, expected and healthy. Increase communication with front-line staff when there is conflict, don't avoid the team. Acknowledge that everyone is right (to some extent) and recognise that no one person has all the answers. Stay humble and positive.			9

3c	Unpopular conflict	Sometimes middle managers will be required to hold a stance that is unpopular. Middle managers will seek feedback, allow front line staff to convey their concerns and seek the real concerns beyond what is said. In conjunction with the front-line team, middle managers will work to maximise the benefits by proposing alternatives if feasible. Middle managers will work with the front line team to minimise the negative impacts upon patient care and team function. Middle managers will ensure that all front line staff understand the principles/aims of the change and in turn, they understand the full range of issues that have been raised by front-line staff. With the front-line team, the middle manager will clarify how this will positively and negatively impact upon patient care and team working.			8

Appendix 35: Presentation slides for seminar on research and code of conduct

24/08/14

Exploring transformative engagement of managers, clinical staff and patients

…. in other words –trying to integrate quality improvement with operational management

A project submitted to Middlesex University in partial fulfilment of the requirements for the degree of Doctor of Professional Studies

Janine Cochrane

Background

- Policy directives and the new NHS constitution require managers and leaders to adopt strategies that motivate and encourage teams to work collaboratively with staff and patients.
- These innovative ways of working are seen as a means of improving the quality and coordination of patient care, thus impacting on the patients' experience.

Why is this important?

- Despite this focus, the evidence for what constitutes and therefore what can deliver effective collaboration between managers, staff and patients is sparse.
- This study aims to identify a conceptual model of effective management strategies and behaviours that will assist in achieving partnership and collaborative working.

Research Question

What knowledge do health sector middle managers require to undertake transformative engagement with staff and patients?

- Are there changes to the team as a result of the implementation of change strategies?
- What features of the strategies were important for managers and front line staff?
- Were the strategies perceived as useful and sustainable?
- What 'governance' themes emerged following implementation of the strategies?

Mid Staffordshire

- *"It is not clear how many patients died as a direct result of the failures but the Commission found that mortality rates in emergency care were between 27 per cent and 45 per cent higher than would be expected, equating to between 400 and 1,200 excess deaths"* (Smith and Bingham 2009; online source)
- *"…The trust was more concerned with hitting targets, gaining Foundation Trust status and marketing and had 'lost sight' of its responsibilities for patient care, the report said."* (Smith and Bingham 2009; online source)

… and it went on…

- *"The Care Quality Commission (CQC) found that poor nursing, filthy wards and lack of leadership at Basildon and Thurrock University NHS Hospitals Foundation Trust contributed to 400 avoidable deaths in a year.*
- *Among the worst failings were a lack of basic nursing skills, curtains spattered with blood on wards, mold in vital equipment and patients being left in A&E for up to 10 hours."*
- (Smith and Bingham 2009; online source)

1

24/08/14

Could it happen here?

- Mmm
- Hofstede's (2014) power distance index (PDI), New Zealand is ranked at fourth lowest at 22 PDI (after Austria, Israel and Denmark).
  - *"New Zealand scores very low on this dimension (22). Within organizations, hierarchy is established for convenience, superiors are always accessible and managers rely on individual employees and teams for their expertise. Both managers and employees expect to be consulted and information is shared frequently. At the same time, communication is informal, direct and participative".* (The Hofstede Centre 2014)
- The United Kingdom has a power index of 35 (10th lowest).

But…

- DHB ratings - 30% of members surveyed thought their DHB was genuinely committed to distributive clinical leadership, 47% felt their DHB was not, and the remaining 23% were not sure. Just two DHBs scored higher than 50% - Canterbury (62%) and Lakes (56%). The worst results were recorded for Wairarapa, Hutt Valley, Southern, Bay of Plenty, and Auckland DHBs (Powell 2014)

How important is epistemology in thinking about management?

- Managerialism (New Public Management) *'help to identify and eliminate waste, to concentrate resources where benefits can be seen to be greatest, and give a clearer display of how the money is spent'* Cnmd 9058 (1983, pg3)
- Managerialism subscribes to the belief that there is one truth – that there is a right and wrong answer – should we look for alternatives to this?.

Scientific management versus ?

- Middle managers appear to be the 'buffer' between front-line staff and senior management in that they understand managerialism (targets, goals, efficiency) and at the same time they work with the complexity and messiness of influencing front-line staff.

Method

- This research is based in the real world which is complex and uncertain.
- The methodological approach is a qualitative case study.
- Data was collected from an NHS Trust based in Wales and compared with current practice at a District Health Board in New Zealand.

Two case studies, two countries,

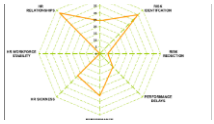
three jobs, 6 houses, 1 baby, 3 au pairs, 4 alpaca

Case study one (Wales)	Case study two (NZ)
Cancer Hospital Outpatients and Medical Record Departments (60 staff – nurses, Care workers and clerical staff).	Emergency Department 120 staff (Drs, nurses, care worker, clerical staff)
Introduction of 3 strategies over 2-3 years	2-3 years
Staff satisfaction survey	Improvement project to meet the 6 hour target in the Emergency Department
Staff newsletter (like a monthly report)	
Staff and Patient Quality group	

24/08/14

Case Study One	Case Study Two
Document review	Interviews
thematic analysis of survey, newsletter and minutes of the staff and patient quality group	3 front-line staff (Nurses) 3 manager/clinical leaders
Interviews with staff re their view on strategies	

Findings: Staff Newsletter



Staff generally thought Newsletter was useful

Findings from Quality meeting

- Good attendance from staff
- 51% related to topics about improving waiting times in outpatients
- 34% related to risk
- 12% related to adding features into outpatietns
- 2% related to sustainability

Findings from Quality Group

- *"Because it"s face to face it"s all very real and its less easy for managers to ignore patients views especially as the patients representatives sitting in front of them"* Mary, front-line staff member in outpatients (case study 2).
- *"Initially felt that there was a little bit of scepticism from staff as to why patients/carers were attending "their meeting" however this quickly dissolved when they realised that we weren"t there to criticise but to help and to provide constructive ideas and feedback from our and other patients" personal experiences. It is now felt very comfortable attending the groups and feel that we are listened to".* Joanne, patient/carer representative in outpatients.

Findings from the Quality Group

- *"The other good point was that it was a very open environment and we got to talk about issues that it would imagine within other departments were only discussed at senior Management level"* Jane, front-line staff member in outpatients
- *"...it felt the chair always drove the agenda to suit them...also it thought that the chair of the meeting was a bit controlling and didn't give us sufficient opportunity to discuss issues that we wanted to."* Jane, front-line staff member in outpatients

Staff satisfaction survey

- Covered areas of
- Performance, HR, Risk
- Omitted items included rate and spread of change, level of autonomy, attitude to new ideas, type and frequency of feedback, satisfaction with how staff contributions are received and actioned, resolution of problems etc.

3

24/08/14

Findings from the staff satisfaction survey

- *"…myexperienceat…$s$that$every$me$$have$completed$a$survey$$havehadno$feedback$whatsoeverastomycomments$and$$have$never$witnessed$anything$actually$change$as$a$resultofpeople$comple3ng$a$staff$survey."* Mary, Outpatient front-line staff

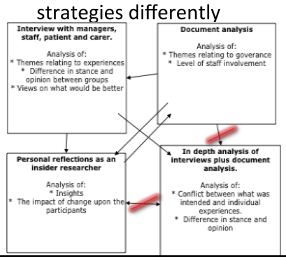
$

- *"The$staff$surveys$that$$have$completed$have$been$a$waste$of$3me$as$nothing$posi3vehaschanged$following$them.$$This$s$becausewegiveouropinionsandthen$nothing$s$introduced$as$a$resultofthese$opinions$and$therefore$nothing$ever$gets$beVer."*$Sharon Medical Records, front-line staff.

Findings from Staff Survey

- *"The$results$ofthesurveycandemonstrate$whether$ornotchanges$that$have$been$implementedbymanagersforexample,$have$actually$worked$or$not.$$Finally,$staff$surveyscanhelptomo3vate$managers$as$obviously$you$want$togeta$"beVer$score"$from$staff$from$each$survey."* Margaret, Manager

Problem – managers and staff viewed strategies differently



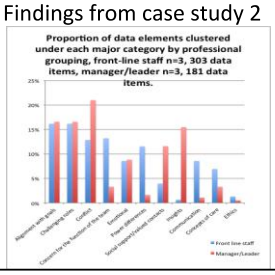
Case study 2

- Emergency Department – interviews with 3 front-line staff and 3 manager/leaders (medical and nursing)

Findings from case study two

Count of Themes from Case Study 2 interviews major themes)	Column
Row Labels	Total
Alignment with goals	79
Challenging roles	79
Conflict	77
Concern for the function of the team	46
Emotional	42
Power differences	38
Social support/valued contacts	33
Insights	30
Communication	28
Concepts of care	27
Ethics	5
Grand Total	484

Findings from case study 2



4

Challenging roles

- *"(nurse) coordinators have become computer watches to manage the flow of patients"* Lucy, Nurse, ED
- *"All through our training I think you were always taught to focus on what's coming in. And to make sure at they're safe and it's always the priority the people coming in. And (the Manager) really taught us that you can't look after those guys until you make space and to make space you need to concentrate on the ones going out and getting them to where they need to be"* Daisy, Manager/Leader

Challenging roles

- *"That I should just be in my office and that if I wanted anything to change I should talk to him and (the Nurse Manager) and they would make change and to just get off the floor. "* Annabel, Manager/Leader

Conflict

- "*We are concerned but not able to act on everything – staff may perceive that we are not concerned about what they think." …. "a place for hearing and listening and place for getting on with it"* Annabel, Manager/Leader
- Quote from Annabel, manager - "*my underlying ethos is about providing the best care I can with the resources that there are*".
- Quote from Sarah, RN - "*Manager and staff priorities are completely different – they have their aims and we have ours*".

Emotional

- *"But the abuse, I wouldn't say abuse it is a big word, but sometimes it has been. We've had some nurses cry here a lot over the last couple of years. From being bantered about getting patients out. I don't think it's particularly nice at all.* Sarah, Nurse, ED

Power differences

- *"In monitored (a section of the emergency department which has patients continuously monitored) your charge nurse can come up and giving you absolute nonsense in front of everybody about getting patients out"* Sarah, Nurse, ED
- *"Sometimes there are changes and we don't get time to get used to them. They're trying to do the visual handover thing at the moment. We had PowerPoint, I did the presentation 3 times and it lasted 2 weeks and it's now out the window. You can guarantee next week they're going to throw something else let us and we're just getting confused"…* Sarah, Nurse, ED

Social support and valued contacts

- *"And so you really are the messenger and you have to be able to sit in both camps and it's very difficult sometimes…. You are in the middle – you are a buffer between the two camps."* Daisy, Manager/Leader

24/08/14

Insights

- *"So if you want to make change you have to make lots of changes and you have to try different things and you also have to engage a lot of people."* Vicki, Manager/leader

Communication

- *"I could say hey look managers/leaders I've talked to the charge nurses but I think you need to talk to them. So I think these are the issues but I think it is more appropriate that you speak with him. I could say like I've talked to them but I think they need to IVle help"* Steve, Nurse, ED
- *"At the me of the change, definitely, definitely and they are always approachable, even if they don't like what you have to say"……"Yes. Manager/leader X and I agree not to agree some3mes. We agree that we're both here for the best outcomes, we don't see eye to eye, but we 3ll talk."* Steve, Nurse, ED

Ethics

- *"…and what I don't like all so ss if they are geF ng close in 3me and the orderlies are busy or whatever, they get swiped out so it looks good on the computer but the pa3ent ss 3ll siF ng there. I totally disagree with it"* Lucy RN, ED

Balancing between...

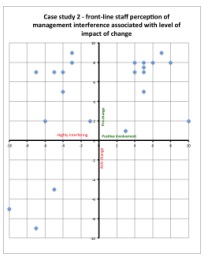
- *A spectrum of management interference from nega3ve to posi3ve*
- *And - a spectrum of the strategies as having an impact on change from no change to lots of change*

Front line staff perception of management interference

Upper right quadrant – positive interference and positive impact upon change (ie pro-change, positive involvement).

Upper left quadrant – negative interference and positive impact upon change (highly interfering and pro-change)

Lower left quadrant – negative interference negative impact upon change

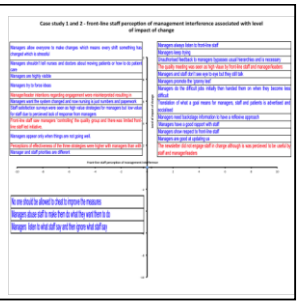


Case studies 1 and 2

6

24/08/14

Case studies 1 and 2



Witting and unwitting governance

positive and negative aspects of change

Typology of power

Table 2 Typology of power relations

Type of power relation	*Balance*	*Imbalance*
Having power 'over'	A depends on B but B also depends on A, so A and B have power over each other = mutual dependency	A depends on B but B does not depend on A, so B has power over A = one-sided dependency
Having 'more' or 'less' power	A mobilizes more resources than B, but A and B have goals that are collective or co-exist = co-existence/ cooperation	A mobilizes more resources than B, while A and B have mutually exclusive goals = competition
Having a 'different' power	A exercise power in such a way that it enables and enforces the power exercised by B = synergy	A exercises power in such a way that it disrupts or prevents power exercised by B = antagonism

Reprinted with permission from Sage publishing (Avelino & Rotmans 2009, p557)

Organisation as a machine?

- What has been described (in mangerialism since 1980s) is a metaphor for organisation as a machine:
- *The emphasis is on predetermined goals and objectives and the organization is expected to operate in a systematic, efficient and predictable manner* (Kernick 2004, p85).

Or an eco-system?

- Kernick however proposes that a more fitting metaphor for the NHS/hospitals if one really observes what happens, is as an ecosystem (or a complex adaptive system). This metaphor recognises local networks as non-linear and always changing (Kernick 2004, prologue pxv). It denies the possibility of a "top-down" approach by proposing that power and influence from the top is limited (although not impossible).

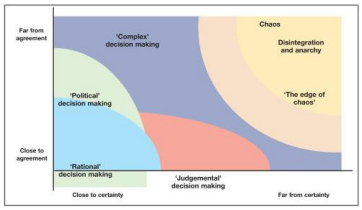
Or an eco-system?

- *"a collection of individual agents with freedom to act in ways that are not always totally predictable, and whose actions are interconnected so that one agent's action changes the context for other agents".* (Plsek and Greenhalgh 2001, p625)

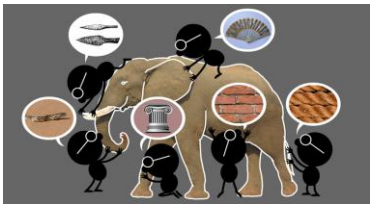
7

24/08/14'

Edge'of'chaos'–'why'things'are'far'from'predictable'and'ra6onal'and'easy'(R'Stacey)'



Everyone'has'a'different'reality'



Ethics'of'management'

Ethical competence framework (Schrijver & Maeschalck, 2013 p37)

	Knowledge	Skill	Attitudes
Rule abidance	Law, ethical code, rules and procedures (1)	Applying rules (2)	Importance of rules (3)
Moral sensitivity	Position in the organisation and society (4)	Defining a situation as an ethical one. Seeing different solutions (5)	Empathy. Perspective-taking (6)
Moral reasoning	Moral arguments: - rules - consequences for others - consequences for oneself (7)	Using different moral arguments - rules - consequences for others - consequences for oneself (8)	Attitude of flexibility: - not only rules - not only consequences for others - not only consequences for oneself (9)
Moral motivation and character	Rules and consequences for others are more important than consequences for oneself (10)	Priority to rules and consequences for others in what you choose to do (11)	Autonomy Ego-strength (12)

Findings'about'ethics''

- Didn't'realise'implica6ons'of'not'being'reliable'and'consistent'
- Lapses'in'rules'to'meet'target'
- Not'aware'of'affects'of'broken''psychological'contracts''
- Not'always'aware'of'implica6ons'of'power'differences'

Summary'of'Findings'

- The'findings'support'a'move'from'a'managerialist'approach'(where'managers'are'target'driven,'transac6onal'and'administer'ac6vity)'to'a'more'reflexive,'egalitarian'transforma6onal'approach'that'can'be'adapted'to'cope'with'complex'environments'and'func6on'successfully'in'the'zone'of'chaos'(where'problems'are'ill'defined'and'messy).''

Summary'of'findings'(2)'

- The'ability'to'interpret'context'and'operate'a'balanced'approach'to'that'context'would'appear'to'be'key'to'enable'managers'to'be'effec6ve'in'naviga6ng'a'constantly'changing'environment.''
- This'study'supports'adop6on'of'a'servant'leadership'model'and'proposes'a'code'of'conduct'for'middle'managers'undertaking'change'who'desire'*phronesis*'(prac6cal'wisdom).'''

'

8'

24/08/14

How do you learn stuff?

- Can't wait 20 years
- Need to convey complexity to the unconsciously incompetent and the consciosuly incompetent

Reviewing codes of conduct

Mapping emerging themes to central nods of similarity	Emerging themes from case study one and two	Institue of Health Managers code of conduct	School code of conduct	New Zealand Nursing Council Code of Conduct
1	Managers abuse staff to make them do what they want them to do	8, 20, 30	N,B,C	6
2	No one should be allowed to cheat to improve the measures	3, 8, 20	T	
3	Managers shouldn't tell nurses and doctors about moving patients or how to do patient care	5, 13	D	
4	Managers appear only when things are not going well.		M	
5	Managers listen to what staff say and then ignore what staff say		D	6
6	Managers are highly visible			
7	Managers want the system changed and now nursing is just numbers and paperwork		D	1,3
8	Managers try to force ideas		F	6

Gaps in 3 codes of conduct reviewed

- When managers get involved in the day to day work
- How managers appear to ignore what staff say
- The will of managers over front-line staff
- How managers can help staff with change
- How managers can be reflexive and change the strategy
- Maintaining relationships when there is conflict
- When communication goes wrong
- Problems with trust

Summary of ethical analysis for proposed code of conduct

- Ethical dilemma in care provided in the NHS and the process undertaken by managers and leaders in making change
- Findings from the thematic analysis in this research indicated that managers were unaware of some of the consequences of change on the team (on page 183).
- Review of findings using typology of power relations (on page 199) – balance/imbalance (Avelino & Rotmans 2009, p557)
- Review of findings using staff perception of management interference and impact of change (front-line staff view) (on page 228)
- Review of findings using positive and negative aspects of change – witting and unwitting governance (on page 230).
- Review of findings using *six moral principles and corresponding duties* (Patankar et al, 2005, p4) (on page 235)
- Review of findings mapping three codes of conduct to data from this research (on page 242)

Code of conduct (1)

Core beliefs	Supportive actions
Front-line staff want to provide excellent care	We believe that staff do their best when they are part of a team that works together and is supported by each other and managers
Learning new behaviours and ways to do things is part of life. We all like learning to read or write	We can learn to improve our ability to undertake change together by doing it on a regular basis.
Mistakes are part of the learning process	Managers understand that some changes you mistakes and can be rectified. Managers don't make a judgement about it but will support the work of the team to get it right. Monitor monitors performance.
We can learn strategies to support teams to improve the change process	Most staff and managers have evolved ways of dealing with change based on their previous experience of being changed or leading change. In many cases these are either a harder or not sufficiently thought through to be helpful in addressing the sometimes challenging behaviours of all team members. Developing an understanding of why teams behave as they do, a positive attitude to the team and developing effective strategies for the team is a core requirement of a manager's job.
Manager behaviour	**Supportive actions from managers**
Actively builds trust and respect with staff	Trust and support have to be earned: they're not a given. Spending time learning from front-line staff builds support and shared understanding.
Demonstrates belief in the team	Staff want to see managers as one of "us", who does it for "us", helps the team work together and makes us better.
Treats staff with dignity and respect	By staying think you, listening carefully, asking for advice. The manager never shouts or threatens staff even if they feel upset, stressed or angry.
Listens respectfully	…And makes a judgement about how/when to respond.
Enjoys being with front-line staff	Is courteous, warm and friendly towards staff even when there is disagreement about an issue.
"Have like a magic behind the desk" behaviour	"thinks about why the person is behaving like way – there will always be a reason; the behaviour is a symptom.
Sees things through	Keeps trying, is tenacious with difficult problems and issues
Keeps their word	Does what they say they will do
Tells the truth	Never lie to staff

Code of conduct (2)

2j	**Looks for the good**	**Identifies the good with the team and builds on it**
2k	Apologises if they make a mistake	Model humility and apologise
2l	Manages their own emotional reactions to events	Identify and name your own reactions thus monitoring your own emotionally intelligent behaviour at all times.
2m	Let go of your memory/feelings when you feel you have been unfairly treated by front-line staff	Focus on working with front-line staff to get it right in the future.
Conflict		**Supportive actions from middle managers**
3a	Quietly but firmly holds appropriate boundaries for front-line staff	Never let anyone do whatever they want (including yourself) when this would infringe upon the rights or comfort of other staff or services for patients.
3b	Normalise conflict	We believe conflict is normal, expected and healthy. Middle managers will increase communication with front-line staff when there is conflict, they will keep the dialogue going and won't avoid the team. Acknowledge that everyone is right (to some extent) and recognise that no one person has all the answers. Stay humble and positive.

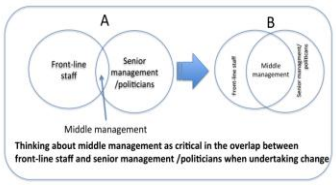
9

24/08/14

Code of conduct (3)

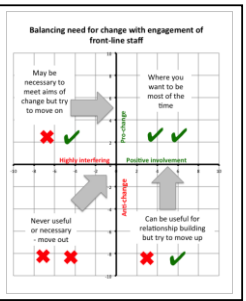
3.	Unpopular conflict	Sometimes middle managers will be required to hold a stance that is unpopular. Middle managers will seek feedback, allow front line staff to convey their concerns and seek the real concerns beyond what is said. In conjunction with the front-line team, middle managers will work to maximise the benefits by proposing alternatives if feasible. Middle managers will work with the front line team to minimise the negative impacts upon patient care and team function. Middle managers will ensure that all front line staff understand the principles/aims of the change and in turn, they understand the full range of issues that have been raised by front-line staff. With the front-line team, the middle manager will clarify how this will positively and negatively impact upon patient care and team working.

Proposed model for moving middle management to increase engagement



Thinking about middle management as critical in the overlap between front-line staff and senior management /politicians when undertaking change

Navigating on the edges of chaos



A change in focus from top down

- Distributing leadership to followers,
- A pragmatic approach to wicked problems,
- Upsetting traditions of power – necessary and sufficient
- Creating environments to allow people to develop phronesis.

R/Q What knowledge do health sector middle managers require to undertake transformative engagement with staff and patients?

- As each context (group of staff, set of circumstances and group of patients is different), the generalist principles and tools in managerialism appear to be of limited use and do not explicitly recognise the views of front-line staff as an important evaluation factor in achieving effective change.

Are there changes to the team as a result of the implementation of change strategies?

- The variation between what managers thought were the values of strategies and the outcomes of events were not supported by the front-line staff who tended to have a more negative view (seen in case study one).
- Front-line staff whilst acknowledging the improvements the strategies had made, on a personal level, they found the change difficult and in some circumstances abusive.

10

What features of the strategies were important for managers and front line staff?

- A number of areas were identified as being useful to change processes however they may not have been seen as positive from the front-line staff point of view

iii Were the strategies perceived as useful and sustainable?

- Whilst most front-line staff in case study one identified that the strategies were theoretically useful, their experience in implementation was variable and in some cases destructive.
- A top down approach of the strategies implemented in case study one and two provided some insight into how on one level there were positive changes with regard to changes for patients. On the other hand the change experience for staff was not always positive.

What 'governance' themes emerge following implementation of the strategies?

- The behaviours observed by front-line staff were perceived to be in conflict with what managers thought they were doing.
- What is different is that this code of conduct proposes the idea that serving front-line staff in the context of uncertainty is of key concern. It proposes that the underpinning of servant leadership may be useful to observe.
- The code stresses that understanding where matters go wrong and involving front-line staff in learning from mistakes is the key component of the role of a manager.

Follow-up

- Present you with the proposed code of conduct for feedback – via survey monkey
- Communities of learning
- Questions

Appendix 36: Feedback survey on draft guidance

From: Janine Cochrane
Sent: Sunday, August 24, 2014 9:49 AM
To: Brendon Rae; Robert West; Lynley Irvine; Cherie McConville (nee Wells); Jenny Hanson; Victoria May; Belinda Green; Blair McLaren; Lynda Dagg; Sharon Mason; Sally O'Connor; Lance Elder; Marian Rillstone; Elaine Chisnall; Gary Hume
Cc: janine.cochrane@icloud.com
Subject: Survey from Janine Cochrane's seminar - CLOSES Friday 29th August

Dear all

At the seminar where I presented the findings from my research, I requested I send you a survey monkey as way of receiving feedback on the Code of Conduct generated from my research data.

The code of conduct is directed at middle managers (as this was the study focus) to help managers perfect assisting teams to undertake change. Whilst for some of you this is 'cold calling' in that you weren't able to attend and don't have the background, I would really appreciate 10-15 mins of your time to provide some feedback on items selected so far. Each has yes/no response and space for text.

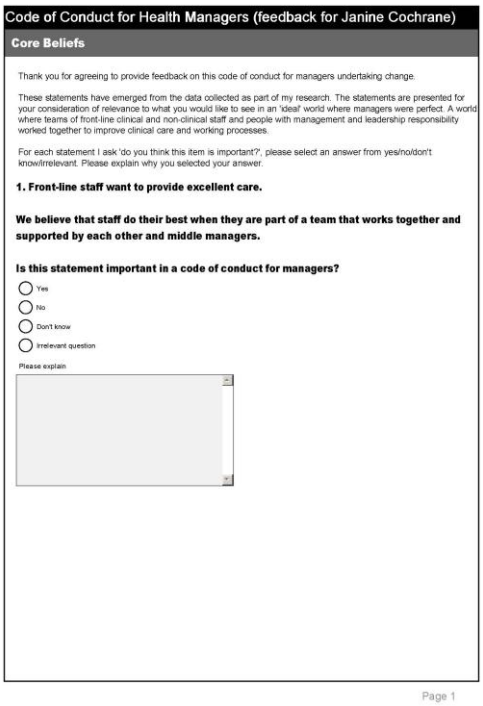
All your responses are anonymous - so have no fear you are offending me by either not responding or providing criticism :-). I appreciate your honesty.

https://www.surveymonkey.com/s/VVXX7FS

I will take the seminar down on Friday 29th August. If you prefer to discuss this with me or provide feedback in a different way, I would be delighted to discuss.

Many thanks for your time and please get in touch with any problems.

Kind regards
Janine


Code of Conduct for Health Managers (feedback for Janine Cochrane)

Core Beliefs

Thank you for agreeing to provide feedback on this code of conduct for managers undertaking change.

These statements have emerged from the data collected as part of my research. The statements are presented for your consideration of relevance to what you would like to see in an 'ideal' world where managers were perfect. A world where teams of front-line clinical and non-clinical staff and people with management and leadership responsibility worked together to improve clinical care and working processes.

For each statement I ask 'do you think this item is important?', please select an answer from yes/no/don't know/irrelevant. Please explain why you selected your answer.

1. Front-line staff want to provide excellent care.

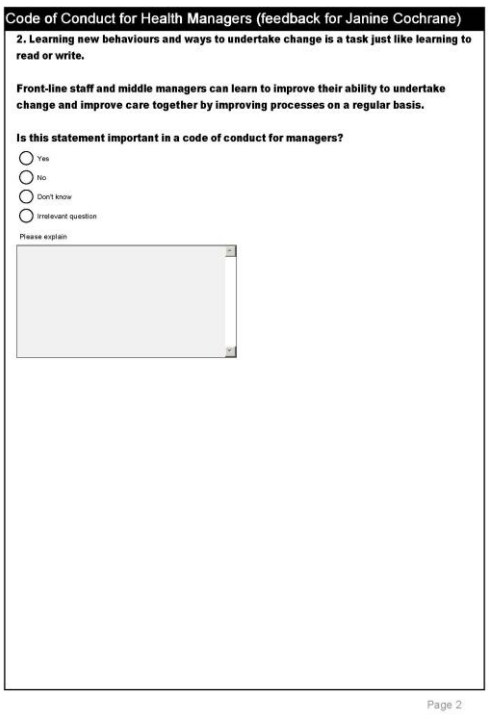
We believe that staff do their best when they are part of a team that works together and supported by each other and middle managers.

Is this statement important in a code of conduct for managers?

Yes
No
Don't know
Irrelevant question

Please explain

Page 1


Code of Conduct for Health Managers (feedback for Janine Cochrane)

2. Learning new behaviours and ways to undertake change is a task just like learning to read or write.

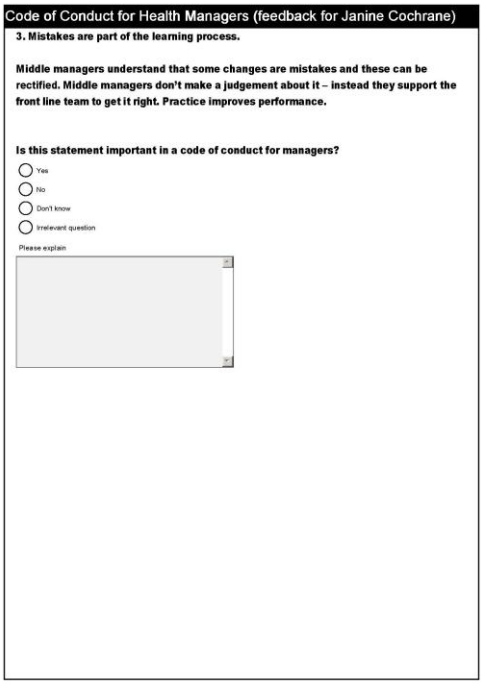
Front-line staff and middle managers can learn to improve their ability to undertake change and improve care together by improving processes on a regular basis.

Is this statement important in a code of conduct for managers?

Yes
No
Don't know
Irrelevant question

Please explain

Page 2



Code of Conduct for Health Managers (feedback for Janine Cochrane)

3. Mistakes are part of the learning process.

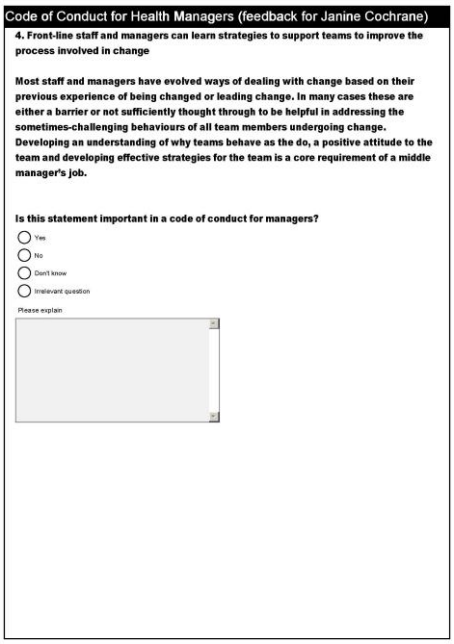
Middle managers understand that some changes are mistakes and these can be rectified. Middle managers don't make a judgement about it – instead they support the front line team to get it right. Practice improves performance.

Is this statement important in a code of conduct for managers?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Irrelevant question

Please explain

Page 3



Code of Conduct for Health Managers (feedback for Janine Cochrane)

4. Front-line staff and managers can learn strategies to support teams to improve the process involved in change

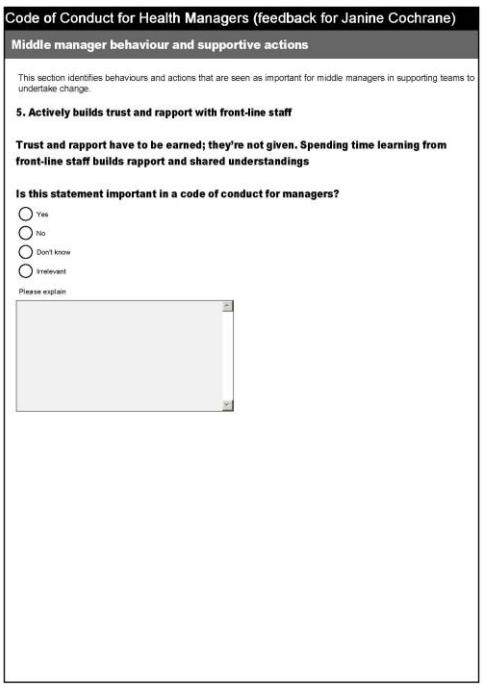
Most staff and managers have evolved ways of dealing with change based on their previous experience of being changed or leading change. In many cases these are either a barrier or not sufficiently thought through to be helpful in addressing the sometimes-challenging behaviours of all team members undergoing change. Developing an understanding of why teams behave as the do, a positive attitude to the team and developing effective strategies for the team is a core requirement of a middle manager's job.

Is this statement important in a code of conduct for managers?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Irrelevant question

Please explain

Page 4



Code of Conduct for Health Managers (feedback for Janine Cochrane)

Middle manager behaviour and supportive actions

This section identifies behaviours and actions that are seen as important for middle managers in supporting teams to undertake change.

5. Actively builds trust and rapport with front-line staff

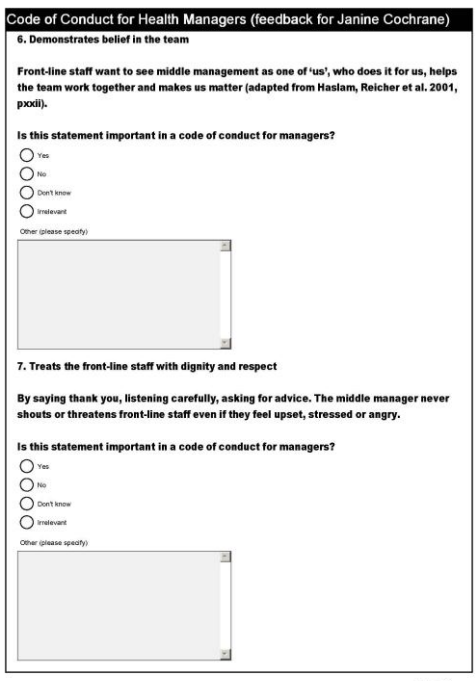
Trust and rapport have to be earned; they're not given. Spending time learning from front-line staff builds rapport and shared understandings

Is this statement important in a code of conduct for managers?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Irrelevant

Please explain

Page 5



Code of Conduct for Health Managers (feedback for Janine Cochrane)

6. Demonstrates belief in the team

Front-line staff want to see middle management as one of 'us', who does it for us, helps the team work together and makes us matter (adapted from Haslam, Reicher et al. 2001, pxxii).

Is this statement important in a code of conduct for managers?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Irrelevant

Other (please specify)

7. Treats the front-line staff with dignity and respect

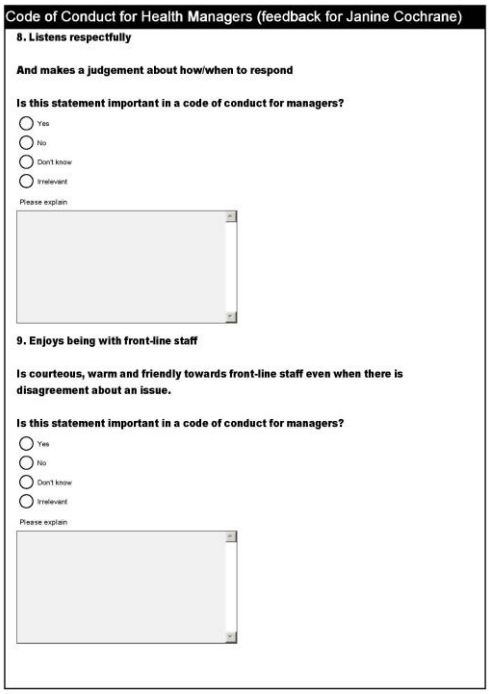
By saying thank you, listening carefully, asking for advice. The middle manager never shouts or threatens front-line staff even if they feel upset, stressed or angry.

Is this statement important in a code of conduct for managers?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Irrelevant

Other (please specify)

Page 6



Code of Conduct for Health Managers (feedback for Janine Cochrane)

8. Listens respectfully

And makes a judgement about how/when to respond

Is this statement important in a code of conduct for managers?

Yes
No
Don't know
Irrelevant

Please explain

9. Enjoys being with front-line staff

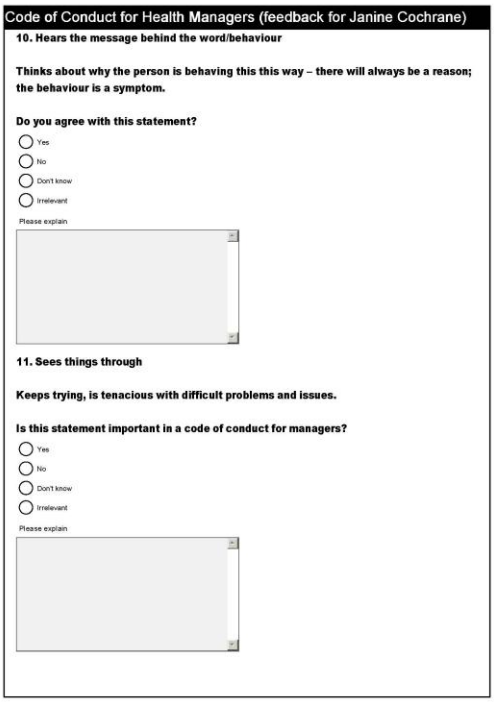
Is courteous, warm and friendly towards front-line staff even when there is disagreement about an issue.

Is this statement important in a code of conduct for managers?

Yes
No
Don't know
Irrelevant

Please explain

Page 7



Code of Conduct for Health Managers (feedback for Janine Cochrane)

10. Hears the message behind the word/behaviour

Thinks about why the person is behaving this this way – there will always be a reason; the behaviour is a symptom.

Do you agree with this statement?

Yes
No
Don't know
Irrelevant

Please explain

11. Sees things through

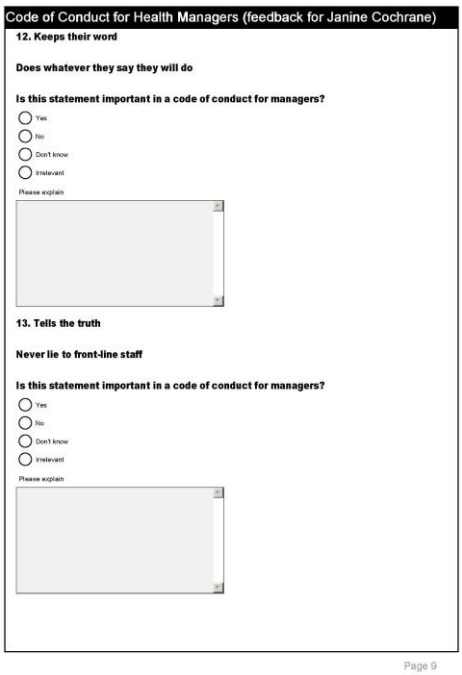
Keeps trying, is tenacious with difficult problems and issues.

Is this statement important in a code of conduct for managers?

Yes
No
Don't know
Irrelevant

Please explain

Page 8



Code of Conduct for Health Managers (feedback for Janine Cochrane)

12. Keeps their word

Does whatever they say they will do

Is this statement important in a code of conduct for managers?

Yes
No
Don't know
Irrelevant

Please explain

13. Tells the truth

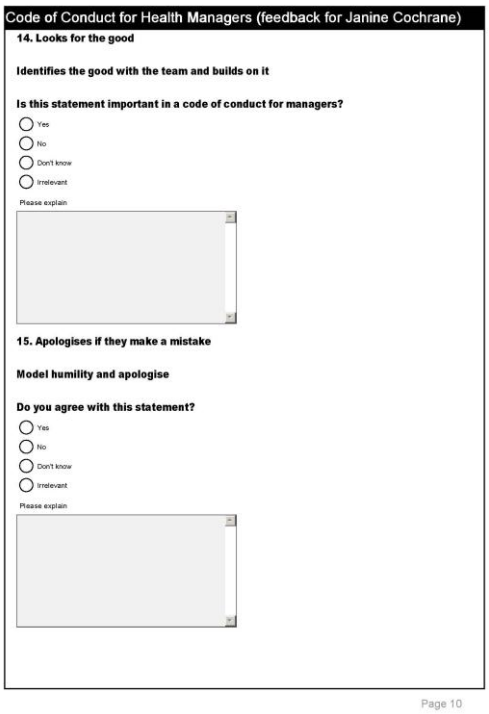
Never lie to front-line staff

Is this statement important in a code of conduct for managers?

Yes
No
Don't know
Irrelevant

Please explain

Page 9



Code of Conduct for Health Managers (feedback for Janine Cochrane)

14. Looks for the good

Identifies the good with the team and builds on it

Is this statement important in a code of conduct for managers?

Yes
No
Don't know
Irrelevant

Please explain

15. Apologises if they make a mistake

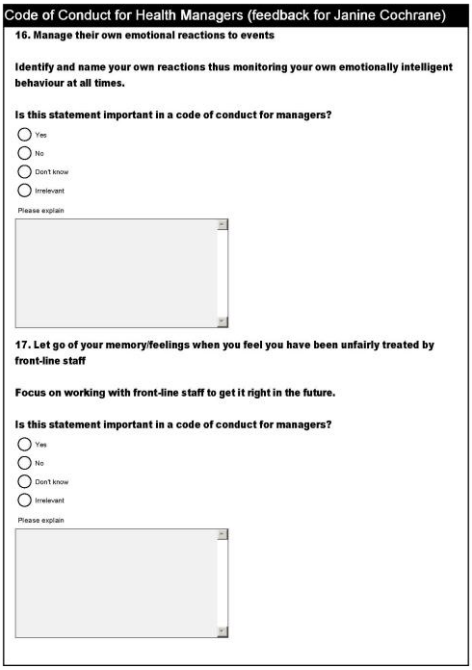
Model humility and apologise

Do you agree with this statement?

Yes
No
Don't know
Irrelevant

Please explain

Page 10



Code of Conduct for Health Managers (feedback for Janine Cochrane)

16. Manage their own emotional reactions to events

Identify and name your own reactions thus monitoring your own emotionally intelligent behaviour at all times.

Is this statement important in a code of conduct for managers?

Yes
No
Don't know
Irrelevant

Please explain

17. Let go of your memory/feelings when you feel you have been unfairly treated by front-line staff

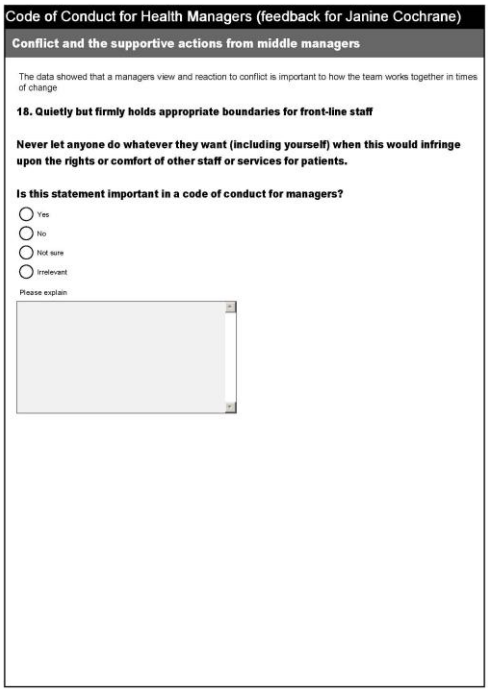
Focus on working with front-line staff to get it right in the future.

Is this statement important in a code of conduct for managers?

Yes
No
Don't know
Irrelevant

Please explain

Page 11



Code of Conduct for Health Managers (feedback for Janine Cochrane)

Conflict and the supportive actions from middle managers

The data showed that a managers view and reaction to conflict is important to how the team works together in times of change

18. Quietly but firmly holds appropriate boundaries for front-line staff

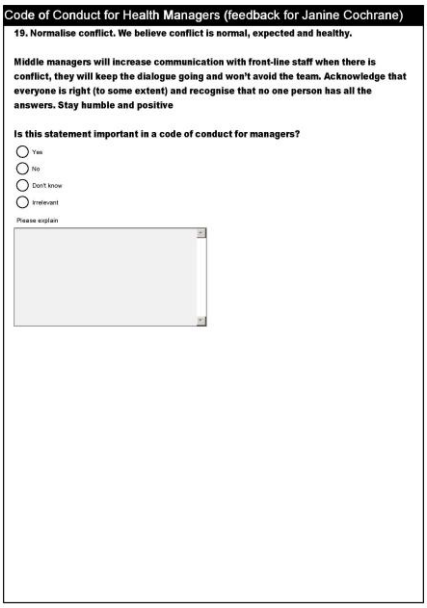
Never let anyone do whatever they want (including yourself) when this would infringe upon the rights or comfort of other staff or services for patients.

Is this statement important in a code of conduct for managers?

Yes
No
Not sure
Irrelevant

Please explain

Page 12



Code of Conduct for Health Managers (feedback for Janine Cochrane)

19. Normalise conflict. We believe conflict is normal, expected and healthy.

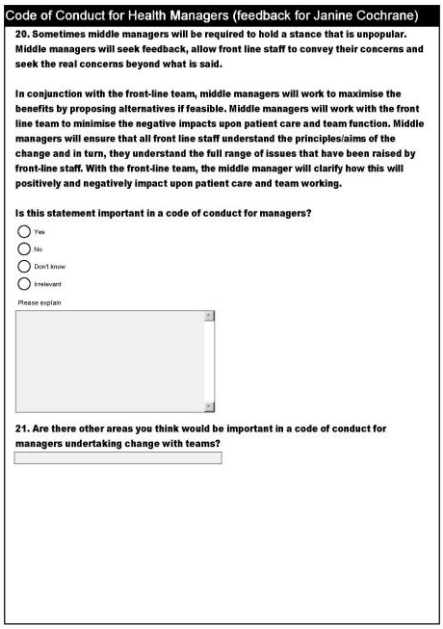
Middle managers will increase communication with front-line staff when there is conflict, they will keep the dialogue going and won't avoid the team. Acknowledge that everyone is right (to some extent) and recognise that no one person has all the answers. Stay humble and positive

Is this statement important in a code of conduct for managers?

Yes
No
Don't know
Irrelevant

Please explain

Page 13



Code of Conduct for Health Managers (feedback for Janine Cochrane)

20. Sometimes middle managers will be required to hold a stance that is unpopular. Middle managers will seek feedback, allow front line staff to convey their concerns and seek the real concerns beyond what is said.

In conjunction with the front-line team, middle managers will work to maximise the benefits by proposing alternatives if feasible. Middle managers will work with the front line team to minimise the negative impacts upon patient care and team function. Middle managers will ensure that all front line staff understand the principles/aims of the change and in turn, they understand the full range of issues that have been raised by front-line staff. With the front-line team, the middle manager will clarify how this will positively and negatively impact upon patient care and team working.

Is this statement important in a code of conduct for managers?

Yes
No
Don't know
Irrelevant

Please explain

21. Are there other areas you think would be important in a code of conduct for managers undertaking change with teams?

Page 14

Appendix 37 Feedback on draft guidance

RespondentID	1 Front-line staff want to provide excellent care. We believe that staff do their best when they are part of a team that works together and supported by each other and middle managers. Is this statement important in a code of conduct for managers?		2 Learning new behaviours and ways to undertake change is a task just like learning to read or write. Front-line staff and middle managers can learn to improve their ability to undertake change and improve care together by improving processes on a regular basis. Is this statement important in a code of conduct for managers?	
	?	Please explain	?	Please explain
1	Yes		Yes	yes, to a degree. Some are better at it than others.
2	Yes		Yes	Basic code of conduct - improvement in all spheres of practice, which supports people's innate desire to learn, grow and change.
3	Yes	Encourgages engagement, the best ideas can be generated from a team and often the staff really know what the problems are- they need support to find soluations. having it stated n a code of conduct outlines organisational expectations	Yes	Yes- impt for code of conduct as it outlines expectations re managers learning to manage change
4	Yes	Managers need to believe that staff want to provide excellent care. Generally speaking this is fact although sometimes managers may lose sight of that fact	Yes	If we cease to want to learn we stagnate. Stagnation disempowers and doesn't seek to improve
5	Yes	Embedding concepts such as teamwork, cooperation and collaboration very important	Yes	The idea is correct but the wording of this statement could be improved eg Learning new behaviours and ways to undertake change is an essential task. FLS and MM should undertake change and improve care by regularly working together to review and enhance processes (or some such thing)
6	Yes	Most managers come from a technical expert background and remain focussed on the clinical or technical environment, they may not consider what it means to "manage staff and the service" as a function in itself. This statement would bring this idea to the fore.	No	A code should be simple and relevant and just stick to the most fundamental aspects which should be broad enough to encompass ideas like this without having to state them separately. Too much info will overload and minimise the use of the code.
7	Yes	Staff working at the coal face are there to make a difference. There are many opportunities provided to offer support and education to paitents. With clinical observation skills and knowledge they need to know that the care they can offer is being supported by their line managers.	Yes	It is important not to work in a reactionary way, but to discuss issues that arise with teams that contain a variety of skills and knowledge

8	Yes		Yes	
9	Yes		Yes	
10	Yes		Yes	
11	Yes	I think it's important for staff to feel that they are suppported by their manager and that staff will be more invested in doing the best that they can if they believe they have a manger who is equally invested in the same.	Yes	I see this as leading by example. I think it's important for mangers to model the behaviour they wodul like to see in their staff and if staff see their manager striving for improvement and approaching change with confidence, they will be more likely to do the same.
12	Yes	if the managers do not believe that front line staff want to do their best, they will not treat them with respect	Yes	Managers have to believe that by working with front line staff they can make changes and improvement. If they do not, they will try to impose change from above
RespondentID	Mistakes are part of the learning process. Middle managers understand that some changes are mistakes and these can be rectified. Middle managers don't make a judgement about it – instead they support the front line team to get it right. Practice improves performance. Is this statement important in a code of conduct for managers?		Front-line staff and managers can learn strategies to support teams to improve the process involved in change Most staff and managers have evolved ways of dealing with change based on their previous experience of being changed or leading change. In many cases these are either a barrier or not sufficiently thought through to be helpful in addressing the sometimes-challenging behaviours of all team members undergoing change. Developing an understanding of why teams behave as the do, a positive attitude to the team and developing effective strategies for the team is a core requirement of a middle manager's job. Is this statement important in a code of conduct for managers?	
	?	Please explain	?	Please explain
1	Yes		Yes	
2	Yes	Mistakes (not patient safey of course) should be celebrated as helps progress, learning, growth.	Yes	
3	Yes	Impt in code of conduct as it outlines organisational expectations i.e it is okay to make a mistake as long as we learn and make improvements as a result. Sometimes organisations can make judgements and not see mistakes as a positive learnign experience	Yes	Impt as outlines expected behaviours related to change managment i.e positive attitude, development of strategies

4	Yes	Being non-judgemental and supportive are the key elements. Front line staff will be reticent to implement change if they know they will be balmed if it isn't successful	Don't know	Doesn't immediately have the same impact for me as statement 3. Is it important? The final sentence is but still not as powerful as statement 3
5	Yes	Need to acknowledge mistakes and learn from them	Yes	Perhaps note that experience important but flexibility in dealing with differing situations and personalities while valuing viewpoints of team members important (inclusivity)
6	Yes	The idea of not be a judge is great. Helps develop the ability for trust and transparency.	Yes	A fundamental aspect of successful management of people is the ability to develop and maintain robust relationships. Understanding, or even the desire to understand human behaviour is inherently required for this. In addition, the idea of "hope" is a pivotal part of maintaining positivity within teams and individuals and this requires the positive attitude from managers. (There is some great research in Canada based on this idea of "hope" FYI).
7	Yes	Any change needs to be reviewed, fine tuned or set aside. Mistakes or less than ideal acheivements (no matter how important they are considered.) need to be able to be discussed in an open forum,	Yes	In order to make changes sucessfully the desired outcome needs to be known by the whole team. Managers must also be able to understand why the present system is in place. The positives of the present system and the gaps in the present system.This will then give a platform for moving ahead.
8	Yes		Yes	
9	Yes		Yes	
10	Yes		Yes	
11	Yes	I think this is about staff being able to have confidence to make changes knowing that if the intervention doesn't end up having the desired effect their manager will be there to support them to remedy the situation. It's an acknowledgement mistakes are a part of the learning process.	Yes	Yes, I think this is important in a code of conduct but I think it takes a certain type of manager who is willing to admit they need to develop their skills in this area. I am not sure if all managers could recognise this need in theselves.
12	Yes	If people do not accept that mistakes are part of a learning process they will not take risks. They will instead opt for the status quo. This is a particular concern with front line staff	Yes	If people don't believe that new ways of undertaking change can be learned they will continue to use the ways that they have already learned.

RespondentID	Actively builds trust and rapport with front-line staff Trust and rapport have to be earned; they're not given. Spending time learning from front-line staff builds rapport and shared understandings Is this statement important in a code of conduct for managers?		Demonstrates belief in the team Front-line staff want to see middle management as one of 'us', who does it for us, helps the team work together and makes us matter (adapted from Haslam, Reicher et al. 2001, pxxii). Is this statement important in a code of conduct for managers?	
	?	Please explain	?	Other (please specify)
1	Yes		Don't know	
2	Yes		Yes	
3	Yes		Yes	
4	Yes	Very important. Without trust and rapport the relationship will be difficult. Learning from front-line staff is key	Yes	Falls into the same category as trust. Believing in your team - knowing they are there to do the best they can even when it doesn't feel that way is so important in the relationship with the team
5	Yes	Visibility important Spending time with and learning from	Yes	Perhaps "who does it with us" rather than for us
6	Yes	Yes BUT its not neccessarily the learning which is important but the active listening.	Yes	again BUT we need to be careful how this is expressed and demonstrated. Leadership is also about giving direction and providing that link between the front line staff and the broader organisation NOT form an "us and them" senario.
7	Yes	staff will not communicate with any member (including a manager) if they do not trust their integrity. Staff also need feedback on what is happening on issues that affect their service, and affect their delivery of care.	Yes	Middlemanagement not necessary seen as one of the frontline staff but more as a facilitator. They are required to ensure equality within in the team, but also support and grow each team member to increase their value.
8	Yes		Yes	
9	Yes		Yes	
10	Yes	in reality does not always happen in practise	No	I dont concur that front line staff want to see middle managers as one of us. They want managers to open and receptive

11	Yes	As you state trust and rapport have to be earned. Showing an interest and respect for the specialist knowledge of front line staff is key in this.	Yes	The team need to know their manager is 'batting for their team'. Only dysfunction can result from a team that doesn't feel their manager believes in them.
12	Yes	Essential for working with a front line team	Don't know	Not sure if this is a n aspect of management or simply an observation of how staff would like to see their immediate supervisor
RespondentID	Treats the front-line staff with dignity and respect By saying thank you, listening carefully, asking for advice. The middle manager never shouts or threatens front-line staff even if they feel upset, stressed or angry. Is this statement important in a code of conduct for managers?		Listens respectfully And makes a judgement about how/when to respond Is this statement important in a code of conduct for managers?	
	?	Other (please specify)	?	Please explain
1	Yes		Yes	
2	Yes	Basic humility, and emotional intelligence.	Yes	
3	Yes		Yes	
4	Yes	Absolutely goes without saying.	Don't know	Sort of tied up in the previous statement so as that one is so powerful, not sure this would be needed too
5	Yes	God yes - please don't yell	Yes	First line yes Not so sure about 2nd line
6	No	again should be encompassed by other descriptors.	No	again too much specific detail

7	Yes	By behaving poorly all you do is close doors which may never re-open. Managers must reflect on their own behaviour, being a listener is paramount as is being the first to apologise if the situation requires it.	Yes	See above. This is often difficult with deadlines, workload etc Plan to give yourself time to consider - don't be afraid to say I need to think about this further, or seek more advice.
8	Yes		Yes	
9	Yes		Yes	
10	Yes	the most important statement of all , basic common courtesey is lacking	Yes	a prtatcise that is not always viewed by staff
11	Don't know	I think this is a given for all staff at all levels not specifically managers.	Yes	I think it's important that a manager is prepared to listen and hear - it's part of being respectful to staff but also building that rapport and trust.
12	Yes	Basic respect	Yes	Basic respect
RespondentID	Enjoys being with front-line staff Is courteous, warm and friendly towards front-line staff even when there is disagreement about an issue. Is this statement important in a code of conduct for managers?		Hears the message behind the word/behaviour Thinks about why the person is behaving this this way – there will always be a reason; the behaviour is a symptom. Do you agree with this statement?	
	?	Please explain	?	Please explain
1	Yes		Yes	
2	Yes		Yes	
3	Yes		Yes	

4	Irrelevant	The first and second statements don't seem to go together really. You can be courteous, warm and friendly without enjoying being with someone. Granted it would be more superficial but the two don't seem to sit together	Yes	Things certainly aren't always what they seem so yes I do agree with that statement. It is easier said than done though!
5	No	Can't mandate how you must feel about people	Yes	Probably considers possible messages behind the words/ behaviour Contextualising behaviour impt
6	No	again too much specific detail	No	too much specific detail
7	Yes	Disagreement are upsetting to all parties and often are not as difficult as first percieved. Being open can alleviate obstructions to forward planning from both parties and lead onto a compromise or at least better understanding of issues.	Yes	Two sides to every story. Another reason why it is important not to be reactionary but to leave the door open for further discussion and consider other influences.
8	Yes		Yes	
9	Yes		Yes	
10	Yes		Yes	Important to always consider the bigger picture
11	Don't know	Being courteous, warm and friendly is different to enjoying being with staff - I think it is possible to be courteous etc without actually enjoying the process. I don't know that 'enjoying being with front line staff' is important in a code of conduct but being 'courteous, warm and friendly...' is.	Don't know	I agree with the statement 'Listens for the message behind the word/behaviour'. One can listen for the message but may not hear it... and I think even the best manager may not hear the message 100% of teh time but what is important is that they recognise there is a message behind the behaviour and that they listen for it.
12	Yes	Basic respect behaviour	Yes	Basic people management skills
RespondentID	Sees things through Keeps trying, is tenacious with difficult problems and issues. Is this statement important in a code of conduct for managers?		Keeps their word Does whatever they say they will do Is this statement important in a code of conduct for managers?	

	?	Please explain	?	Please explain
1	Yes		Don't know	Yes, should really be true - but sometime a decision needs to be made and the reason can't be explain and it's manager job to take the hit
2	Yes		Yes	
3	Yes		Yes	
4	Yes	This is really important for the staff group that the person is managing. Not seeing things through - or at least explaining why it can't happen - can seem as though the manager is disinterested	Yes	Oh yes!! Another that goes without saying and ties in with the trust ethos
5	Yes	Very important - essential for a manager to be a finisher	Yes	Or explains honestly and frankly why it is not possible
6	Yes	Leadership is about actions as much as information, staff need to see that the manager is actively contributing to the workplace.	Yes	Maintain transparent principles is key in any employment relationship
7			Yes	If you cannot carry out what is intended it is important to raise this as early as possible. Like wise staff need to be informed regarding progress or lack of.
8	Yes		Yes	
9	Yes		Yes	
10	Yes	importnat behavouir to role model	Yes	
11	Don't know	? Sometimes it may be better to stop something if it is not working.	Yes	
12	Yes	This is important to building up trust with front line staff, who otherwise will feel that managers don't really care about them	Yes	See response to 11

RespondentID	Tells the truth Never lie to front-line staff Is this statement important in a code of conduct for managers?		Looks for the good Identifies the good with the team and builds on it Is this statement important in a code of conduct for managers?	
	?	Please explain	?	Please explain
1	Yes		Yes	
2	Yes		Yes	
3	Yes		Yes	
4	Yes	Really important although sometimes very difficult to do especially in circumstances when what is happeing is outside the middle manager's control and the honesty may reflect badly on others	Don't know	Agree absolutely with the statement and the sentiment behind it. Important in the code of conduct? Not sure. Feel there are other statements here that reflect this and say it better
5	Yes	Although there are lies and economy with the truth. Out ands out lies definitely a no no	No	Accent perhaps more on - identifies strengths of individuals and the team and supports/develops them/ builds on them
6	No	should be encompassed a broader statement, maybe consider statement 12 and role into one descriptor about principles.	No	See response to 13
7	Yes	Never lie to anyone. If lying is easier than admitting you make mistakes then you are creating a non communicating environment.	Yes	We all need feedback. A lot of work is considered routine, but systems would fall over if not performed appropriately or shortcuts taken, especially important in healthcare.
8	Yes		Yes	

9	Yes		Yes	
10	Yes	absolutely and if a mistake is made with passing on information important to alert staff	Yes	
11	Yes		Yes	All teams have strengths and I think it is a managers job to find that and use it as the foundation for improvement.
12	Yes	See response to 11. However, sometimes you cannot tell the whole truth, and need to be clear that you cannot.	Don't know	Possibly not as important as some others
RespondentID	Apologises if they make a mistake Model humility and apologise Do you agree with this statement?		Manage their own emotional reactions to events Identify and name your own reactions thus monitoring your own emotionally intelligent behaviour at all times. Is this statement important in a code of conduct for managers?	
	?	Please explain	?	Please explain
1	Yes		No	
2	Yes		Yes	
3	Yes		Yes	
4	Yes	Absolutely agree with this statement. None of us should be afraid to apologise	Don't know	Have mixed views about this. This is vital however I'm not sure it needs to be in the code of conduct.
5	Yes		Yes	Calm is good
6	No	See response to 13	No	feel this and 17 below could be viewed as contradictory. Not sure what you are trying to achieve with the statements of 16 and 17

7	Yes	Managers make as many mistakes as anyone else. Reflection is important. If we don't acknowledge that we make mistakes we don't grow or change our behaviours.	Yes	Again self reflection. It is important to know what your beliefs are and what are your boundaries, how do they fit in with the team you are leading and the service you are providing.
8	Yes		Yes	
9	Yes		Yes	
10	Yes	key role modeling behavoiur for middel and senior manager	Yes	emotiuonal intelligence is key component of successful leadership
11	Yes	I think this is part of good modelling.	Yes	I think it is important to recognise that managers do have their own emotional reaction to events.
12	Yes	basic respect behaviour	Yes	It is important to remain detached from the emotional. While there are behaviours listed here that the manager will use when others become emotionally involved, you cannot assume that others have the skills to set aside your emotions.
RespondentID	Let go of your memory/feelings when you feel you have been unfairly treated by front-line staff Focus on working with front-line staff to get it right in the future. Is this statement important in a code of conduct for managers?		Quietly but firmly holds appropriate boundaries for front-line staff Never let anyone do whatever they want (including yourself) when this would infringe upon the rights or comfort of other staff or services for patients. Is this statement important in a code of conduct for managers?	
	?	Please explain	?	Please explain
1	Yes		Yes	
2	Yes		Yes	
3	Yes		Yes	

4	Don't know	Similar to the previous statement. Really important (wish I could do it!!) but in the code of conduct? On the fence with that one	Yes	Boundary setting is jkey to maintaining good relationships in the work sense
5	Irrelevant	Not sure this is essential for a code of conduct - possibly more aspirational than mandated	Yes	Wording of second line could be improved "ensure team members are aware of the rights of other staff and patients and that transgressing these is unacceptable" or something like that
6	No	see response to 16	Yes	reminds managers that they are expected to maintain these boundaries, particularily when many have come up from the ranks, then need this statement to allow them to undertake this task in their management roles.
7	Yes	It is important after any disagreement to move on and concentrate on the positives.	Yes	Especially in a changing world and social media it is important that the rights of staff and patients remain our focus.
8	Yes		Yes	
9	Yes		Yes	
10	Yes	harbouring feelings re past events is wasted energy	Yes	
11	Yes	This is essential in order that a manager can return day after day and keep doing a good job. Holding on to hurt will impair performance over time.	Yes	I think this is particularly important in order to protect the less vocal memebers of a team. Often this goes unchecked in teams, I suspect because it is 'too hard', and I've seen it become very damaging for the team.
12	Yes	Holding onto grudges is never going to help the process	Not sure	Not really clear what this one is getting at.
RespondentID	Normalise conflict. We believe conflict is normal, expected and healthy. Middle managers will increase communication with front-line staff when there is conflict, they will keep the dialogue going and won't avoid the team. Acknowledge that everyone is right (to some extent) and recognise that no one person has all the answers. Stay humble and positive Is this statement important in a code of conduct for managers?		Sometimes middle managers will be required to hold a stance that is unpopular. Middle managers will seek feedback, allow front line staff to convey their concerns and seek the real concerns beyond what is said. In conjunction with the front-line team, middle managers will work to maximise the benefits by proposing alternatives if feasible. Middle managers will work with the front line team to minimise the negative impacts upon patient care and team function. Middle managers will ensure that all front line staff understand	

			the principles/aims of the change and in turn, they understand the full range of issues that have been raised by front-line staff. With the front-line team, the middle manager will clarify how this will positively and negatively impact upon patient care and team working. Is this statement important in a code of conduct for managers?	
	?	Please explain	?	Please explain
1	Yes		Yes	
2	Yes		Yes	
3	Yes		Yes	
4	Yes	Initially I thought 'no' I suspect because I don't like conflict. However the statement is very appropriate to how middle managers should deal with situations	Yes	Very important especially around allowing teams to convey their concerns as well as seeking out the concerns beyond what is said.
5	Don't know	Rather than conflict - differences of opinion are normal, expected and healthy And there are times when not everyone is right - sometimes they are wrong but needs to be open dialogue and acknowledgement of differing views and work towards common goal	Yes	Generally good - place for honesty in this statement?
6	Yes	Avoidance and passive agressive behaviours are incredibly damaging by acknowledging and managing conflict this provides for a transparent environment to work.	Yes	It defines and recognises the position and role of a middle manager.
7	Yes	Sometimes there is a need to be prescriptive and this will cause some conflict. Feedback is very important in these situations in order to make progress.	Yes	Very important, sometimes keen ideas can be stalled and frustrations grow. Leading to front line staff not feeling valued. it is important that all staff know what the limitations of the environment they are working in. Equally middle management must not use this as a excuse for not raising issues and clarifing front line staff concerns.
8	Yes		Yes	
9	Yes		Yes	
10	Yes		Yes	

11	Yes		Yes	
12	Yes	conflict management is one of the most difficult aspects of the role	Yes	this is important, but is also a two way conduit - this implies the relationship with front line staff, but not to the staff above - implied in the term "middle"
RespondentID		Are there other areas you think would be important in a code of conduct for managers undertaking change with teams?		
		Open-Ended Response		
1				
2		Transparency and fairness but these are basically covered with the other statements above.		
3				
4		I'm sure there are but this has covered all those areas that are particularly important to me - especially around truth and respect		
5		Application for sainthood if a manager can hold to all these principles? Early engagement and collaborative approach to any significant change. Ensuring sense of ownership in process more likely to be successful. Focus on end result important while ensuring addressing "minor" concerns along the road. Establishing a realistic timeline and goal setting		
6				
7		Worn out - thinking.		
8				
9		given enough time to think the answer is yes.		
10		code of conduct applies to Board and Exec and cascades down through the organisation		
11				

12		Two issues: A lot of this is about management down, and as in 20, this is a "middle - what about managing up? Second, what are the responsibilities for change and improvement - they are implied by some of the qquestions, but not explicit.		

Appendix 38: Changes to draft guidance following feedback

	Code of Conduct for reflexive middle managers		Participant feedback (links to the response ID – appendix 30) and changes made
Core beliefs		**Supportive actions from middle managers**	
1	Front-line staff want to provide excellent care.	We believe that our staff do their best when they are part of a team that works together and is supported by each other and middle managers.	12/12 agreed with message. Egs of why included – outlines organisational expectations, difficult to keep sight of this, key to embedding teamwork, collaboration, helps 'manage staff and the service'.
2	Learning new behaviours and ways to undertake change is an essential task.	Front-line staff and middle managers should undertake change and improve care by regularly working together to review and enhance processes and work practice	11/12 agreed. One participant thought message too detailed (6). Adopted suggested wording from (5). Feedback that sets expectations (3) and alludes to avoiding making changes from above (12).
3	Mistakes are part of the learning process.	Middle managers understand that some changes are mistakes and these can be rectified. Middle managers don't make a judgement about it – instead they support the front line team to get it right. Practice improves performance.	12/12 agreed – no change. Feedback that if not part of conduct – people don't take risks (12), improves confidence in making changes (11), leads to openness, trust and transparency (6,7), avoids blame (4).
4	Front-line staff and managers can learn strategies to support teams to improve the process involved in change	Developing a positive attitude towards the team, an understanding of why teams behave as they do and effective strategies for working(?) with the team are all core requirements of a middle manager's job. Most staff and managers have evolved ways of dealing with change based on their previous experience of being changed or leading change. In many cases these are either a barrier or not sufficiently thought through to be helpful in addressing the sometimes-challenging behaviours of all team members undergoing change.	11/12 agreed. (4) felt that it didn't have the same impact as statement above.
5	Actively seeks to gain the trust of and build rapport with front-line staff and senior management	Gaining trust and building rapport are not a given. They have to be earned. Spending time learning from front-line staff builds rapport and shared understandings and gains trust.	12/12 agreed. Participant (12) suggested that managing 'up' is also important therefore statement has been changed.
6	Demonstrates belief in the team	Front-line staff want middle management to be "one of 'us', who does it with us, helps the team work together and makes us matter" (adapted from Haslam, Reicher et al. 2001, pxxii).	9/12 agreed. (6) concerned that creating 'us and them' may not be helpful. (10) said that front-line staff don't want managers as one of us – they want open and receptive. (12) was not sure this was an aspect of management but more about how staff might like to see their immediate supervisor.
7	Treats the front-line staff with dignity and respect	By saying thank you, listening carefully, asking for advice. The middle manager makes a judgement about how and when to respond but will never shout at or threaten front-line staff even if feeling upset, stressed or angry.	10/12 – no change. (6) thought should be encompassed by other descriptors, (11) said that it is a given for all staff not just managers
8	~~Listens respectfully~~	~~And.~~	10/12 agreed. (6) too specific. (5) not sure about second line. (4) could be combined with previous statement
9	Appreciates and understands the importance of, and benefits gained from, spending time with front-line staff	Is courteous, warm and friendly towards front-line staff even when there is disagreement about an issue.	8/12 (4) felt that the two statements don't go together. (5) stated that you can't mandate how you feel about people. (6) felt too much detail. (11) did not think 'enjoying being with staff was important but being courteous, warm and friendly is'.
10	Listens for the message behind the word/behaviour	Thinks about why the person is behaving in the way they are. There will always be a reason - the behaviour is a symptom.	10/12 agree. (6) again too much detail. (11) suggested that hearing could be changed to 'listens for the message behind the word/behaviour'.
11	Sees things through	Keeps trying, is tenacious with difficult problems and issues.	10/11 (1x skipped). No change. (11) suggested it may be better to stop something if not working.
12	Keeps their word	Does whatever they say they will do	11/12 agreed/. No change. (1) recognised that this can be complicated and not always easy.
13	Is always honest	Never lies to front-line staff and is seen as trustworthy. (	11/12 agreed. (6) thought that this could be rolled into descriptor 12. I do not think they are the same. (12), (5) and (4) referred to the complexity about telling the truth when matters are confidential, and multiple views about what is true. Needs to be reviewed.
14	Looks for the good	Identifies the good within the team and builds on it. Identifies (Recognises) the strengths both of the team and of individuals within the team and ensures appropriate support is available to develop (build on) those strengths.	8/12 agreed – (6) should be encompassed in broader statement. (4) covered by other statements. (5) suggests rewording.
15	Apologises when they make a mistake	Model humility and apologise	
16	Manage their own emotional reactions to events	Identify and name your own reactions thus monitoring your own emotionally intelligent behaviour at all times.	
17	Lets go of memory/feelings when they feel they have been unfairly treated by front-line staff or senior management	Focus on working with staff to get it right in the future.	9/12 – no change (4) and (5) not sure should be in code of conduct.
Conflict		**Supportive actions from middle managers**	
18	Quietly but firmly maintains appropriate boundaries with front-line staff	Never let front-line staff do whatever they want, when this could infringe upon the rights or comfort of services for patients or of other staff.	11/12 – (5) change wording (12) – not sure what statement is getting at
19	Normalises conflict	Conflict is normal, expected and healthy. Increase communication with front-line staff when there is conflict, don't avoid the team. Acknowledge that everyone is right (to some extent) and recognise that no one person has all the answers. Stay humble and positive.	11/12 – possible change. (5) differences of opinion instead of conflict.
20	Unpopular decisions and choices are made with knowledge and	Sometimes middle managers will be required to take a stance that is unpopular. Middle managers will seek feedback, allow front line staff	12/12 agreed

The middle manager behaviours		**Supportive actions from middle managers**	

	transparency	to convey their concerns and seek the real concerns beyond what is said. In conjunction with the front-line team, middle managers will work to maximise the benefits by proposing alternatives if feasible. Middle managers will work with the front line team to minimise the negative impacts upon patient care and team function. Middle managers will ensure that all front line staff understand the principles/aims of the change and in turn, they understand the full range of issues that have been raised by front-line staff. With the front-line team, the middle manager will clarify how this will positively and negatively impact upon patient care and team working.	
	Other		Participant (12) A lot of this is about management down, and as in 20, this is a "middle - what about managing up? Second, what are the responsibilities for change and improvement - they are implied by some of the questions, but not explicit.

Appendix 39: Short and Long version of final code of conduct

Guidelines for managers to engage front-line staff in change
(short version – page 1)

Core Beliefs:

- Front-line staff want to provide excellent care.
- Learning new behaviours and ways to undertake change is an essential task.
- Mistakes are part of the learning process
- Front-line staff and managers can learn strategies to support teams to improve the process involved in change

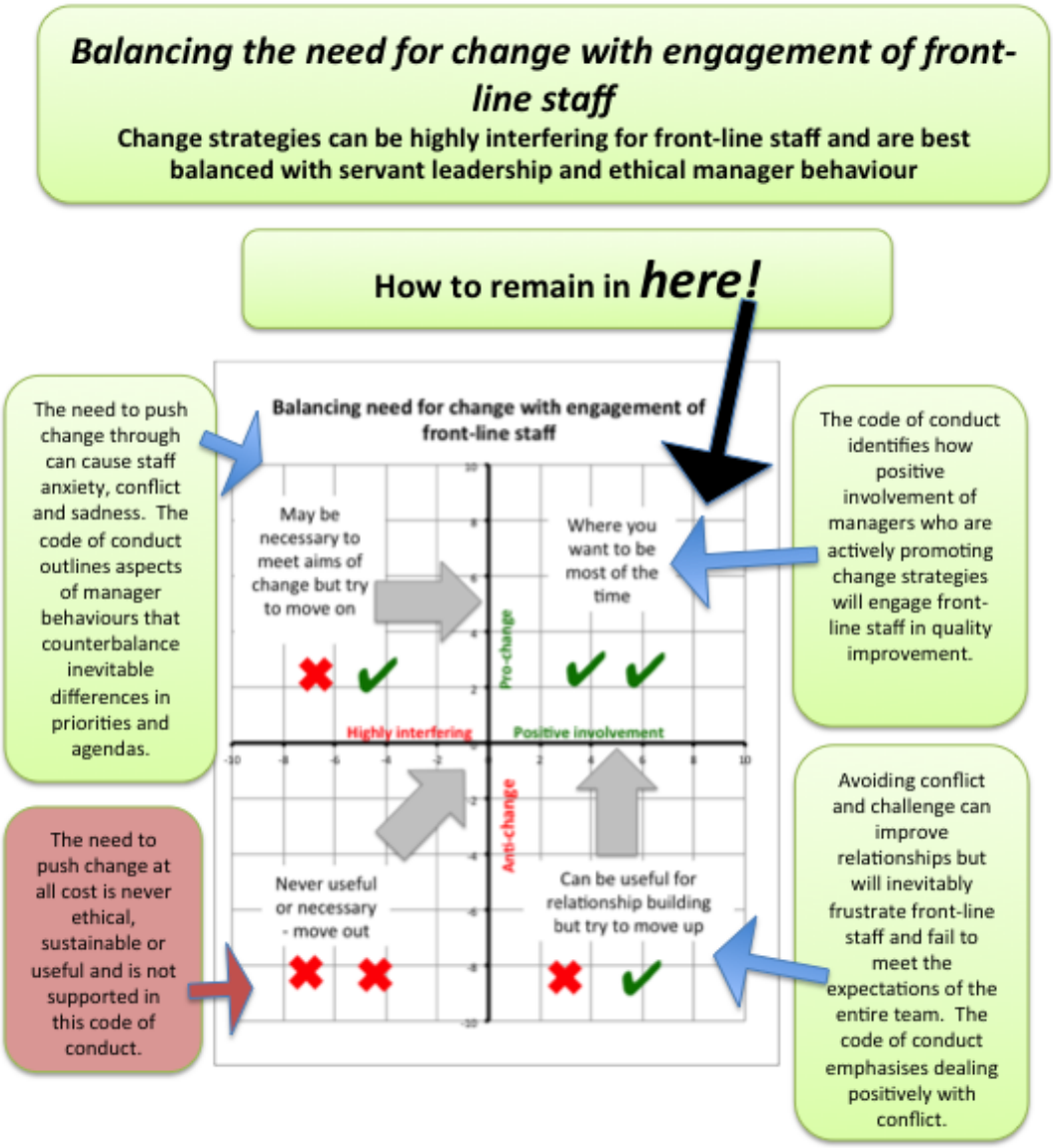
Core Behaviours of managers:

- Actively seeks to gain the trust of and build rapport with front-line staff and senior management
- Demonstrates belief in the team
- Treats the front-line staff with dignity and respect
- Appreciates and understands the importance of, and benefits gained from, spending time with front-line staff
- Listens for the message behind the word/behaviour
- Sees things through
- Keeps their word
- Is always honest
- Looks for the good
- Apologises when they make a mistake
- Manages their own emotional reactions to events
- Lets go of memory/feelings when they feel they have been unfairly treated by front-line staff or senior management
- Quietly but firmly maintains appropriate boundaries with front-line staff
- Normalises conflict
- Makes unpopular decisions and choices with knowledge and transparency

Balancing the need for change with engagement of front-line staff

Tools, techniques and strategies for change can be highly interfering to front-line staff and need to be balanced and supported by ethical manager behaviour. Ethical manager behaviours alone may not achieve the change necessary and need to be supplemented with tools, techniques and strategies.

Guidelines for managers to engage front-line staff in change
(short version - page 2)



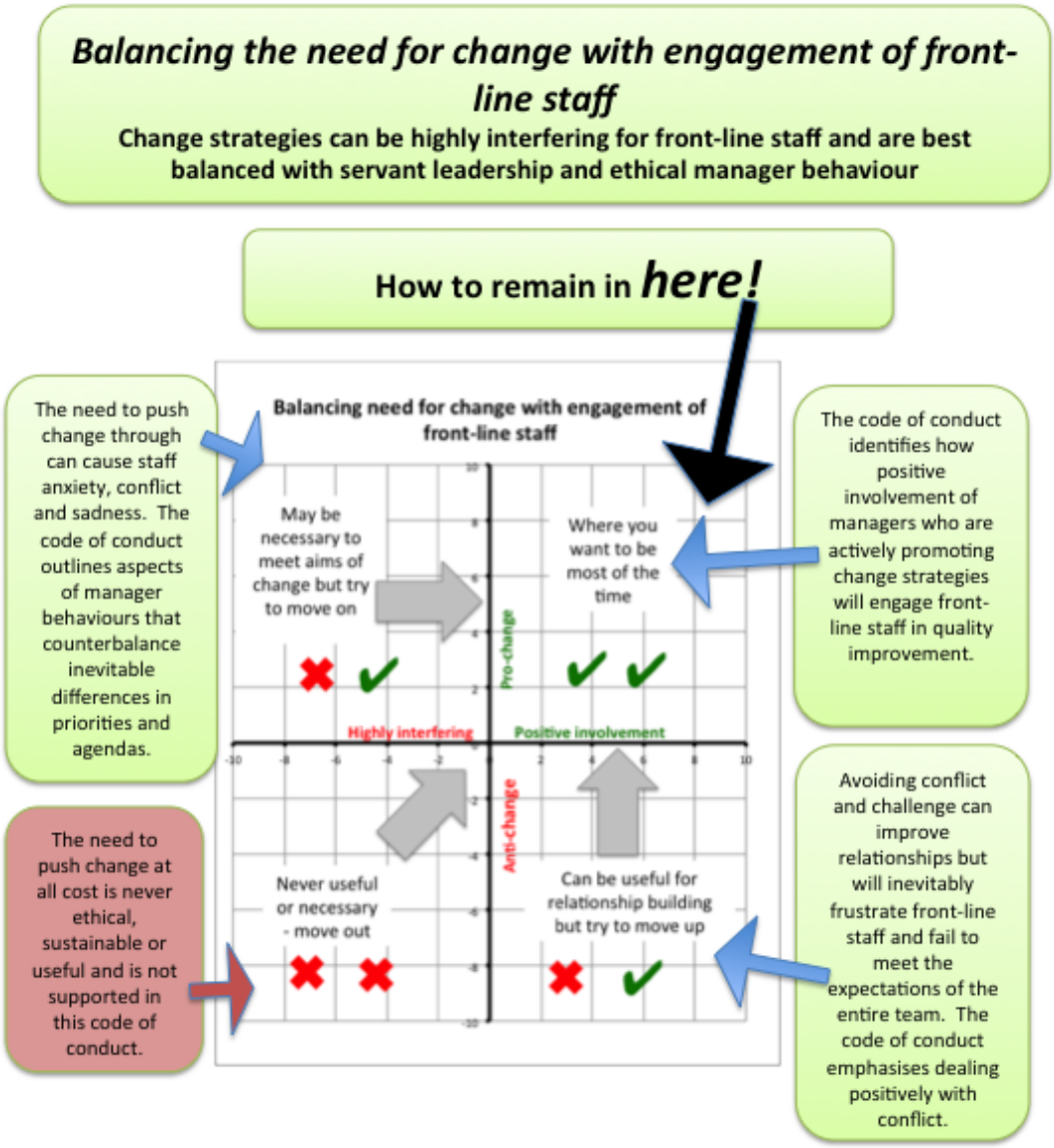
END of Short version

Guideline for managers to engage front-line staff in change
(long version – 4 pages)

	Core beliefs	Supportive actions from middle managers
1	Front-line staff want to provide excellent care.	We believe that our staff do their best when they are part of a team that works together and is supported by each other and middle managers.
2	Learning new behaviours and ways to undertake change is an essential task.	Front-line staff and middle managers should undertake change and improve care by regularly working together to review and enhance processes and work practice
3	Mistakes are part of the learning process.	Middle managers understand that some changes are mistakes and these can be rectified. Middle managers don't make a judgement about it – instead they support the front line team to get it right. Practice improves performance.
4	Front-line staff and managers can learn strategies to support teams to improve the process involved in change	Developing a positive attitude towards the team, an understanding of why teams behave as they do and effective strategies for working with the team are all core requirements of a middle manager's job. Most staff and managers have evolved ways of dealing with change based on their previous experience of being changed or leading change. In many cases these are either a barrier or not sufficiently thought through to be helpful in addressing the sometimes-challenging behaviours of all team members undergoing change.

	The middle manager behaviours	Supportive actions from middle managers
5	Actively seeks to gain the trust of and build rapport with front-line staff and senior management	Gaining trust and building rapport are not a given. They have to be earned. Spending time learning from front-line staff builds rapport and shared understandings and gains trust.
6	Demonstrates belief in the team	Front-line staff want middle management to be "one of 'us', who does it with us, helps the team work together and makes us matter" (adapted from Haslam, Reicher et al. 2001, pxxii).
7	Treats the front-line staff with dignity and respect	By saying thank you, listening carefully, asking for advice. The middle manager makes a judgement about how and when to respond but will never shout at or threaten front-line staff even if feeling upset, stressed or angry.
9	Appreciates and understands the importance of, and benefits gained from, spending time with front-line staff	Is courteous, warm and friendly towards front-line staff even when there is disagreement about an issue.
10	Listens for the message behind the word/behaviour	Thinks about why the person is behaving in the way they are. There will always be a reason - the behaviour is a symptom.
11	Sees things through	Keeps trying, is tenacious with difficult problems and issues.
12	Keeps their word	Does whatever they say they will do
13	Is always honest	Never lies to front-line staff and is seen as trustworthy.
14	Looks for the good	Identifies the good within the team and builds on it. Identifies (Recognises) the strengths both of the team and of individuals within the team and ensures appropriate support is available to develop (build on) those strengths.
15	Apologises when they	Model humility and apologise

	make a mistake	
16	Manage their own emotional reactions to events	Identify and name your own reactions thus monitoring your own emotionally intelligent behaviour at all times.
17	Lets go of memory/feelings when they feel they have been unfairly treated by front-line staff or senior management	Focus on working with staff to get it right in the future.
Conflict		**Supportive actions from middle managers**
18	Quietly but firmly maintains appropriate boundaries with front-line staff	Never let front-line staff do whatever they want, when this could infringe upon the rights or comfort of services for patients or of other staff .
19	Normalises conflict	Conflict is normal, expected and healthy. Increase communication with front-line staff when there is conflict, don't avoid the team. Acknowledge that everyone is right (to some extent) and recognise that no one person has all the answers. Stay humble and positive.
20	Makes unpopular decisions and choices with knowledge and transparency	Sometimes middle managers will be required to take a stance that is unpopular. Middle managers will seek feedback, allow front line staff to convey their concerns and seek the real concerns beyond what is said. In conjunction with the front-line team, middle managers will work to maximise the benefits by proposing alternatives if feasible. Middle managers will work with the front line team to minimise the negative impacts upon patient care and team function. Middle managers will ensure that all front line staff understand the principles/aims of the change and in turn, they understand the full range of issues that have been raised by front-line staff. With the front-line team, the middle manager will clarify how this will positively and negatively impact upon patient care and team working.



END of long version