An Action Research Study of Clinical Leadership, Engagement and Team Effectiveness in Working Across NHS Boundaries

Fran Woodard[a] and Gordon Weller[b1]

[a]*Kings Health Partners, UK,* [b]*Middlesex University, UK*

Abstract

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

Despite this focus, the evidence of what constitutes and therefore what can deliver effective inter-organisational clinical leadership and engagement within this context is sparse. This paper identifies the characteristics and impact of effective clinical leadership, clinical engagement and team effectiveness when working across organisational boundaries.

The paper demonstrates that there are significant improvements in the delivery of healthcare and patient experience when clinicians work effectively across the whole of the patient pathway, spanning organisational boundaries. Guidelines on critical areas for future development and sustainability is expounded upon as an outcome of this study

---

[1] Corresponding author. E-mail address: G.Weller@mdx.ac.uk

Introduction

This research sits within the complexity of UK Healthcare (NHS, private and voluntary sectors), characterised by its frequently changing environment, policy context and organisational strategies. Leadership of change is a highly complex activity, involving an array of skills such as setting a direction and motivating and aligning people as described by Kotter (1999). Oshagbemi and Gill (2004) noted that within a single organisation or department, the hierarchical structure could provide the leader with the authority and influence through which changes can be achieved. Schein (1997) demonstrates the relationship between leadership and culture, and highlights the influence a leader can have on creating a culture. However, many improvement initiatives in the current healthcare system cross several organisations within a healthcare economy, resulting in the existence of multiple leaders and varied cultures. In the United States, a report from the Institute of Medicine (2003) identified poor co-ordination of healthcare provision as a key and growing weakness of current healthcare delivery. Influential health policy advisors and academics in the UK (Ham, 2003; Shortell, 1998; Spurgeon, 2001) have commented upon the importance for clinicians of developing leadership qualities and managerial skills, however there is limited evidence of what would create effective clinical leadership of change across healthcare organisations (Gittell *et al,* 2005). There is also limited significant robust evidence of what constitutes effective cross-organisational clinical leadership and engagement. The intention of this paper is to contribute to the knowledge and understanding of these areas by examining a inter-organisational change project.

Political context

In July 2010, the new Coalition government published its white paper on equity and excellence: liberating the NHS (DoH, 2010) which outlined the vision and strategy for the NHS over the coming years. Key aspects of this vision were; an information revolution to support patient choice and accountability; mechanisms to enhance the public's choice and control of their own healthcare; clinical leadership to become a key driver of healthcare through General Practitioners commissioning care and pathways of care; and, the integration of health and social care. This policy directive is of significant importance to this paper. Its imperative is that service users (for the purposes of this paper "patient" and

"service user" have the same meaning) will have a louder and empowered voice in both accessing high quality care as well as driving appropriate service improvements. It provides a clear policy direction, promoting the development of partnership working, and ensuring that effective health and social provision is consistent across the patient pathway, rather than focusing on individual organisational elements of care.

In many recent policy directives including the latest white paper (DoH, 2010), leadership, especially clinical leadership, has been recognised as a critical component for the success of driving high quality, productive, efficient care and cross-organisational change. There is evidence to demonstrate the link between clinical leadership and improved patient care (Ham, 2003; Shortell, 1998; Spurgeon, 2001). However, after an extensive literature search and discussion with experts in the field, there was only limited knowledge, evidence or agreement found within the UK healthcare system of exactly what constitutes clinical leadership and engagement when working across traditional organisational boundaries.

Gittell *et al* (2005) supports this stating that within clinical networks there is limited evidence of what creates effective cross-boundary working. A core premise driving this work is that by gaining an understanding of what effective clinical leadership and engagement consists of, and sharing this understanding in a usable form, the findings of this study will be valuable across the NHS. The increasing importance of the policy direction of NHS partnerships, collaborative style of working, patient and service user involvement and feedback, demonstrates that this is a vital area to address in facilitating optimal patient outcomes and experience.

Clinical leadership

Many models of leadership are offered in the literature. A three-part model is offered by Beech (2002), who suggests trait, style and contingency theories of leadership. Trait theories advocate that there are particular characteristics in people that make them stand out as leaders (similar to Weber's charismatic model, 1947). Style theories suggest that groups perform more effectively with a democratic or supportive style of leadership. Contingency theories focus on circumstances and suggest that anyone can become an

effective leader through learning from a situation. Thus, it is unclear whether leadership qualities are primarily intrinsic to the individual or essentially extrinsic (and can be developed by anyone), or whether people are born with a predisposition to leadership (which needs to be developed within them).

Clinical leadership operates within the statutory sector of the National Health Service. In a large comparative study of how senior managers in the private and public sectors construct the attributes for leadership, Alimo-Metcalfe and colleagues found that 98.9% of the notions expressed were identical (Alimo-Metcalfe, 2004: 395). However, while the most significant construct in the public sector was integrity, the private sector included six constructs based on the fair distribution of rewards - factors that were not applicable to the public sector. In addition, the study reported that public sector organisations tended to be more 'people-intensive' with intrinsic rewards (*ibid*: 396), and more focused on job development than in the private sector. The concept of giving service to others was also given greater emphasis in the public sector.

This raises the question of whether clinical leadership is distinguishable as something specific. Siriwardena and Niroshan (2006) suggests features that one could apply to other sectors of the health service, although he acknowledges the unique power of doctors. Research by Rippon and Monaghan (2001) does not address the distinction at all. Govier (2004) also takes it as a given, and Cook and Leathard (2004: 436) observe:

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

Cook (1999: 306) defines clinical leadership thus:

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

Whilst the work of clinicians is unique, if there is a unique distinction to be found, it is within the context.

Dopson *et al.* (2002) commented that doctors still have a higher degree of power and autonomy over their working practices and clinical decision-making. This power and autonomy can at times manifest itself through resistance to changes and service developments, which may be affect current working practices (Fitzgerald *et al.,* 2002; Dopson *et al.,* 2003). These findings support the use of doctors as the key research participants in this study, as within the research setting doctors still held a high degree of power and autonomy, so became the change projects leads. Dopson *et al.* (2002) acknowledge the role of opinion leaders to generate change, which can be both positive and negative in their contribution. Within the study setting, these opinion leaders were largely doctors who used their position of power to influence others. However, as noted by Buchanan *et al.* (2007), clinical staff may be disadvantaged through a lack of skills such as influencing, resulting in a need to consider the development of such skills to enhance effectiveness.

There is a growing literature base on clinical / medical leadership and engagement (Spurgeon, 2001). Health educationalists such as Ham (2003) see leadership by doctors and other clinical staff as vital if the performance of the NHS is to improve. Other authors also share the view of the positive association between effective clinical leadership and improved patient care (Ham, 2003; Shortell, 1998; Spurgeon, 2001).

Inter-organisational clinical leadership and engagement

A fundamental issue in healthcare is the co-ordination of care across the whole pathway (Gittell *et al.* 2005), which is viewed as a concern by clinicians, patients and their carers and families. Kenagy *et al.* (1999) reveal how patients experience their medical journey from pre-diagnosis to treatment. Many highlight the existence of fragmented, loosely connected and poorly communicating providers offering uncoordinated elements of care. The Institute of Medicine published a report in 2003 clearly identifying poor co-ordination of healthcare as a weakness of healthcare systems. Audet *et al.* (2005) also

emphasise that the issues most frequently reported by clinicians as reducing the effectiveness of care are those that arise from problems with co-ordination.

However, clinicians are normally employed by a single organisation and therefore accountable and show clinical leadership to and within that organisation. This causes an inherent tension as the patients' focus is the journey they take, whereas the clinicians' focus is on their particular service or department located within one organisation, making up just a small element of the totality of the patients' journey.

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

User involvement, engagement and empowerment

Since the 1990s, there have been numerous policies placing an increased emphasis on involving patients (Care Services Improvement Partnership, 2006). Despite this emphasis, clinicians are frequently nervous and sceptical about asking service users for feedback, let alone involving and engaging them as evidenced by Fletcher and Bradburn (2001).

There is clear evidence of the value of patient centredness in promoting effective team outcomes (Shortell *et al.,* 2004). There is, however, a diversity of thinking about how to enact such patient centredness. The latest thinking suggests that a dynamic model of user involvement should be used, dependent on the patient group, setting, etc (Care Services Improvement Partnership, 2006). This supports the approach of this study, comparing two change teams working in different settings, with different patient groups and policy drivers.

There is significant evidence highlighting the difficulties of involving clinicians in patient engagement (Fletcher & Bradburn, 2001). However, there is also strong evidence

that achieving patient empowerment is critical to realising the true benefits of involving patients (NCCSDO, 2002).

Boundary of the research

The study was located within the locality of southeast London and encompassed four NHS organisations covering the private and voluntary sectors. The principal researcher was an "insider" and had the role of director, accountable to the Chief Executives of the four NHS organisations. Two of these organisations were acute care hospitals, providing secondary and tertiary healthcare. The other two were Primary Care Trusts, who commissioned all services on behalf of their local population, and provided primary, community and social care services. The vision for the change project was to realise profound change in three services (Renal, Stroke and Sexual Health). This was to be achieved by radically redesigning services across the whole patient pathway (across organisational boundaries), from prevention of the relevant disease process, throughout the whole patient journey to ensuring high quality end of life care where required. Achieving profound change in these services within the complex social and organisational environment in which they operated required considerable creativity and flexibility of the service teams involved and of their relationships with the wider health system. As suggested by the DoH (2005), service users, patients and carers are fundamental to the process of redesigning the patient pathway across services. Clinical engagement and leadership is also essential to gain the full commitment of all partners and the collaboration of non-statutory providers (such as the private and voluntary sectors) and to ensure sustainability of the changes (Ham, 2003).

Traditionally, health and social care has been delivered in functional silos related to specific organisations, or even departments or services within an organisation. In some degree, this is due to the regulation of professionals, services and organisations, as well as how care has historically been delivered. Improvements or changes tend to focus on a small element of the patient pathway. This is meaningless if a patient with a health problem has multiple, complex, interrelated health and psychological needs crossing service and organisational boundaries. Patients access their care either through elements of the

pathway or across the whole pathway, and want to travel seamlessly and systematically through the process. Patients' journeys and thus their experiences are rarely of single services, departments or organisations. Patients require integrated care across healthcare boundaries (DoH, 2004).

Over the three years of the research, the extensive service user feedback that the change project obtained identified that problems arise in relation to the linkages between the services or organisations (Holmes, 2006). This specifically relates to patients attempting to move across the pathway or those requiring referral to another or several services. In these cases, patients frequently experienced poor communication, became lost in the system and received conflicting clinical advice and information, which all combined to create a poor experience. This study considered how clinicians (specifically doctors) working effectively across organisational boundaries could enhance patient experience. The focus within this study was on doctors as clinical leaders. Whilst it is acknowledged that there is a growing professionalism in all healthcare professions, doctors are still highly regarded and powerful (Armstrong, 2002; Kenny & Adamson, 1992). To afford the change project the best chance of success, a significant focus was made on doctors as the main clinical leaders. For the purposes of this study, therefore the term clinician largely relates to doctors.

The study was set in a real healthcare setting, which brought many complexities and ambiguities. Cultural differences were frequently experienced, as the study crossed four NHS organisations including the voluntary and private sectors. Different and diverse discourses and power bases existed between the different professional groups, organisations and patients. Changing services and behaviours takes significant time and energy, and is complex to embed. Additionally, gaining meaningful patient involvement required creativity and flexibility.

Research aims and methodological context

This study reviewed the working practices and impact of thirty doctors working within a large cross-organisational healthcare change project. The change project was focussed on improving the whole patient journey. The project was organic in nature, using

formative feedback to learn from effective changes, whilst incorporating the insights created from mistakes. Within each of the projects, doctors discovered innovative ways of working outside their traditional organisational boundaries and accountabilities.
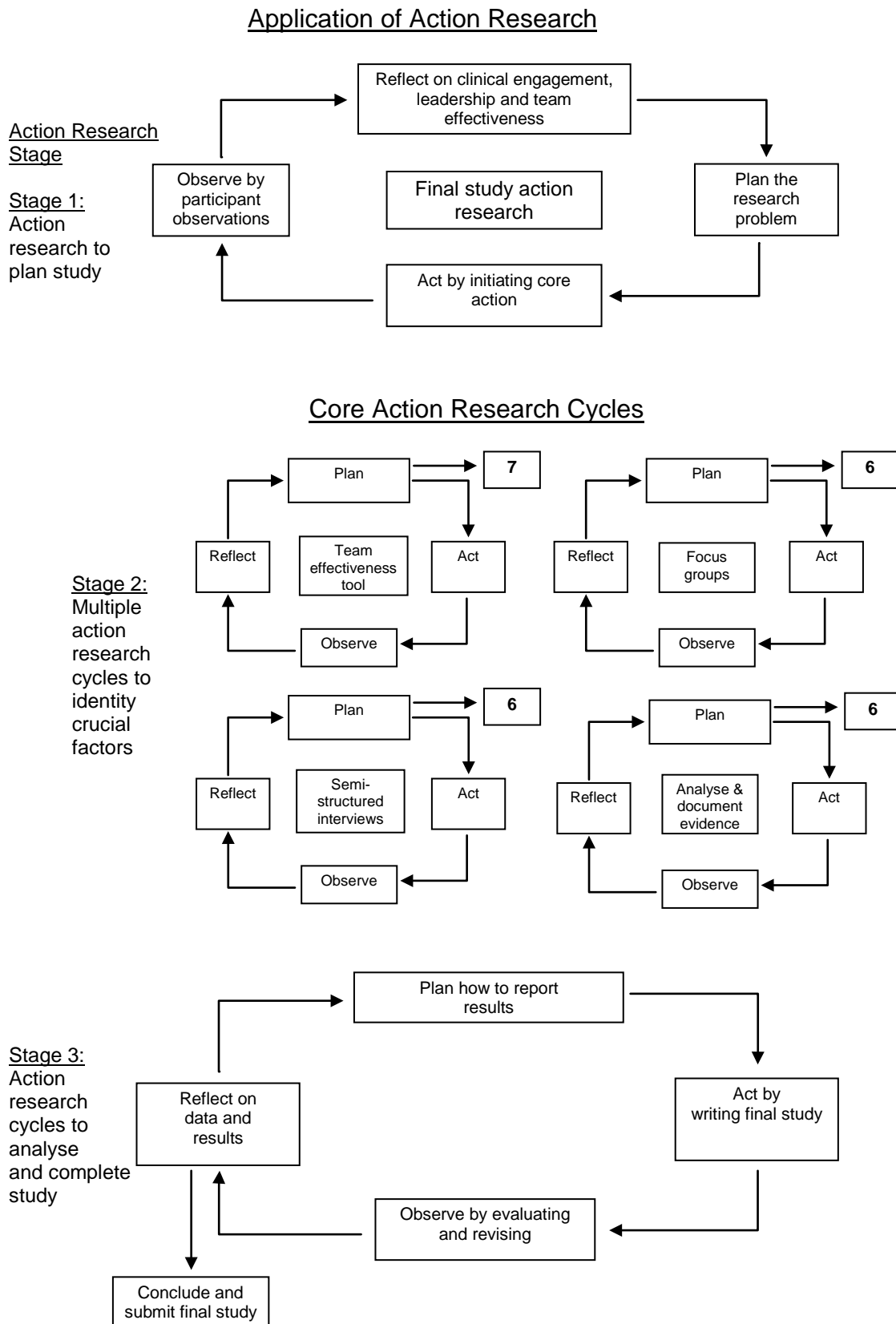
The aims of the study were to identify the characteristics and impact of effective clinical leadership and engagement when working across organisational and professional boundaries, and to contribute to the knowledge and understanding about inter-organisational leadership and engagement. The study had a focus on patient pathways and journeys.

The research question was; what are the identifiable characteristics and impact of effective clinical leadership, clinical engagement and team effectiveness when working across organisational and professional boundaries?

This study was located in the real world, which is complex, messy, political, and constantly changing, for example NHS re-structures, new policy targets, and multiple differing organisational cultures. Consequently, the research intentions and design had to reflect this epistemological stance. To take account of the inherent complexity of the study, a pragmatic approach was used, incorporating an action research approach, using a single case study design. This methodological approach acknowledged the multifaceted nature of the research area, and the flexible design allowed a multi-method approach to data collection and analysis. Data triangulation was used to enhance the rigour of the research (Meyer & Spilsbury, 2000). The study was on human activity, and included quantitative and qualitative research methods. A quantitative method was used to compare the effectiveness of two teams allowing new understanding to be gained via testable and verifiable data collection. A team effectiveness questionnaire was used with two of the change teams, including the key doctors driving the changes. This allowed an analysis of the relative effectiveness of the teams.

Study approach and design

The action research framework below (Figure 1) identifies the intended different stages of the study through the application of action research. The first action research stage occurring between January and December 2005 was planning the study. The second stage, which occurred between January and September 2006, entailed multiple action research cycles to identify crucial factors. The final stage incorporated the final analysis, writing and completion of the study, and took place between July 2006 and July 2007.

Application of Action Research

Action Research
Stage

Stage 1:
Action
research to
plan study

```
                    ┌────────────────────────────┐
                    │ Reflect on clinical         │
                    │ engagement, leadership and  │
                    │ team effectiveness          │
                    └────────────────────────────┘

┌──────────────┐    ┌──────────────────┐    ┌──────────────┐
│ Observe by   │    │ Final study      │    │ Plan the     │
│ participant  │    │ action           │    │ research     │
│ observations │    │ research         │    │ problem      │
└──────────────┘    └──────────────────┘    └──────────────┘

                    ┌──────────────────┐
                    │ Act by initiating│
                    │ core action      │
                    └──────────────────┘
```

Core Action Research Cycles

Stage 2:
Multiple
action
research
cycles to
identity
crucial
factors

```
   Plan → 7                      Plan → 6
Reflect  Team          Act    Reflect  Focus         Act
         effectiveness                  groups
         tool
         Observe                        Observe

   Plan → 6                      Plan → 6
Reflect  Semi-         Act    Reflect  Analyse &     Act
         structured                    document
         interviews                    evidence
         Observe                        Observe
```

Stage 3:
Action
research
cycles to
analyse
and complete
study

```
              ┌──────────────────┐
              │ Plan how to      │
              │ report results   │
              └──────────────────┘

┌──────────────┐                   ┌──────────────┐
│ Reflect on   │                   │ Act by       │
│ data and     │                   │ writing final│
│ results      │                   │ study        │
└──────────────┘                   └──────────────┘

              ┌──────────────────┐
              │ Observe by       │
              │ evaluating and   │
              │ revising         │
              └──────────────────┘

┌──────────────┐
│ Conclude and │
│ submit final │
│ study        │
└──────────────┘
```

Figure 1: Action Research Framework: Overview of Intended Stages

Action research approach

Action research involves a cyclical iterative process of collecting, feeding back and reflecting on data to effect change (Coghlan & Brannick, 2001). The stages comprise planning, acting, observing and reflecting. Within each stage of the study and the phases of data collection, many iterative action research cycles were undertaken from investigation and scoping, through piloting, adapting, designing and development. The reflections and learning from each stage influenced the next (Figure 1). For example, the design, analysis and building understanding stages of the team effectiveness tool, influenced the design and development of the focus groups and semi-structured interviews. The focus groups similarly influenced the semi-structured interview design and development. The whole process was iterative and sequential, as each stage relied on data collection and analysis from the previous stages (a detailed review of each of the iterative cycles undertaken for the team effectiveness tool is presented in Table 1). In addition, the knowledge and learning influenced the project as each cycle was undertaken. For example, the use of plain and clear English (DoH, 2003) became policy for all documents the change project produced, and the management groups created a new system of allocating and monitoring agreed actions within a clear timeframe, thus enhancing delivery.

Case study design and data collection

Yin (2003: 4) states;

"the case study is the method of choice when the phenomenon under study is not readily distinguishable from its context".

In this respect, the lead doctors who were actually working within the change projects were the focus of study. An examination of two change projects explored the characteristics and impact of good clinical leadership and engagement across organisations. This design allowed the utilisation of multiple sources of data collection in real time. It also allowed for an emergent process, which aligns with the study approach and the continuous quality improvement methodology used within the whole change project.

It is important to acknowledge that one argument for the use of the single case study is largely dependent on the assumption that understanding one case will add to the understanding of a different case and may ultimately produce transferable learning. The argument is not just that a case study has value within its own right; with an additionally adequately / richly described environmental setting, contextual learning is possible. (Keen & Packwood, 2000).

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

A purposive sampling method was selected which suited the flexible multi-method approach chosen. This allowed the study to focus on a sample, which could answer the research question in a meaningful way through real world experience. Two change project teams were included in the study. In terms of transferable learning the relatively small sample size was validated through an in-depth analysis of all three data sources undertaken by data triangulation.

Discussion of the research phases

Phase 1 - Team effectiveness tool

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

project's work. By influencing and leading the group, they could potentially demonstrate the characteristics of successful working across organisational boundaries.

Development process and selection

The phenomenon measured was the individuals within the management groups' perception of their own management group. The project management group comprised doctors, managers, service users and project management staff. The role of the management group was to design the strategy of the change projects, lead and deliver specific work streams and be accountable for the whole project.

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

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

A systematic cyclical approach was taken in choosing this tool by reviewing the study's research questions and aims, and considering several tools (Oppenheim, 1992). It was concluded that this tool was the most appropriate because it measured all the required parameters by answering the key questions about the effectiveness of a change

management board, which was set up for a limited time and had diverse stakeholders. It also had resonance with the creativity approach to change management taken by each management group (NHS Modernisation Agency, 2005).

Strengths and weaknesses

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

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

The question arises as to whether a management group, which was so diverse and time limited, could be considered a team, or was more akin to a loose network (Gittell *et al.* 2005). Whilst the teams undoubtedly differed in both composition and operational duration from the conventional intra-organisation team, the reasons justifying these differences were established. The differences themselves do not contradict the definitions of "team" offered in the literature review (Wheelan, 1999).

It must also be recognised that each of the management groups worked and were run slightly differently (despite the nature and scope of the work being the same), which potentially affected the perceived team effectiveness.

Phase 2 - Focus groups

Robson (2002) defines a focus group as a group interview focussed on a particular subject area. In this study, the subject was clinical engagement and leadership, with the focus on doctors leading inter-organisational change. Two focus groups were undertaken with six doctors in each. The insights and analysis of the team effectiveness tool influenced the focus group development, for example influencing the inclusion of a question regarding accountability and responsibility. This was appropriate as the doctors involved in the focus groups already provided extra commitment to the change project. Group processes and dynamics between the participants provided some check as to what was acceptable, such that they could challenge extreme views.

The doctors were interested in successful cross-organisational working so it was hoped that the group dynamics would ensure the group concentrated on important issues. Open debate and the presence of several perspectives in one room, ensured consistent and agreed views were gained (Senge, 2000). As discussed by Morgan and Krenger (1998), it was necessary for the questions and debate to interest the participants and empower them to contribute fully, thus stimulating areas of discussion, creating insights and revealing hidden meanings which would not have emerged in an individual exercise (Kitzinger,1999). Furthermore, the raising of taboo and difficult areas could be encouraged by the perceived safety of the group.

The homogeneity of the group allowed capitalisation on the doctors' collective shared experiences, an important issue for this study. The process additionally revealed relevant cultural values or group norms. Finally, as an experienced group facilitator, the author was able to bring skills and expertise to the process (Oppenheim, 1992).

Despite the significant advantages of using focus groups, there were also significant disadvantages, which were important to consider. The significant disadvantage, as described by Oppenheim (1992), were that the time available was limited thus restricting the number of questions raised.

Phase 3 - Semi-structured interviews

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

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

There are disadvantages in using this method. The interviews can be time consuming and the volume of data collected immense. The interviewer must possess a sufficient level of skill to facilitate the production of useful, good quality output from a semi-structured interview (Oppenheim, 1992). These disadvantages were addressed during the analysis of the interviews, and throughout the study.

Data triangulation

Reliability and validity were important concerns within this action research single site case study. However, the site was highly complex, comprising four statutory NHS organisations and numerous voluntary and private sector providers. Multiple data sources were triangulated in order to address the limitations of the design and to enhance the rigour of the research (Meyer & Spilsbury, 2000). Gill and Johnson (1997) suggest triangulation as a way of combining qualitative and quantitative data to help to promote the

validity of a study by helping to reduce reactivity, respondent and researcher bias. Data triangulation compares results from multiple data sources to look for patterns of convergence or contrast to develop the overall interpretation (Whitmore & McKee, 2001).

Ethical, moral and legal issues

Ethical approval for this study was achieved via a 'Notice of Substantial Amendment' to the evaluation of the change project. Ethical approval for the research was granted by the local NHS research ethics committee. Each of the three data collection methods used offered different ethical challenges. With the team effectiveness tool, meeting all the wider stakeholder group's needs was required, for example service users. This involved the use of appropriate clear and plain English as recommended in a "Tool-kit for Producing Patient Information" (DoH, 2003), the provision of support in filling in the tool, and postal as well as electronic distribution. With both the focus groups and the semi-structured interviews, there was a need to consider the timing so as not to disadvantage or inconvenience people. All participants were monitored and encouraged to contribute their views. The environment and atmosphere were observed and interventions would have been considered if difficulties had arisen. Throughout the whole study consideration was given to ensuring that the two teams did not see any stage of the process as raising any undue concerns, causing competition between them, or creating any other disruption.

Study activity

The design of the study was complicated due to the complexity of the study focus and setting. Moreover, the multiple action research cycles undertaken were interrelated, reflecting the complexity of this real world research.

Figure 2 demonstrates how each action research cycle informed the next stage of the study activity. Each phase of data collection involved several iterative action research cycles (Coghlan & Brannick, 2001) for example: investigation and scoping; design and development; analysis; and, the creation of new understanding and insights that created modifications of the change project during the research study (as was presented Figure 1).

The study influenced the activity to disseminate the practical recommendations produced from the overall findings (Woodard, 2007). Two of the three change project teams were used, the sexual health and kidney management teams, since they were identified as offering potential learning.
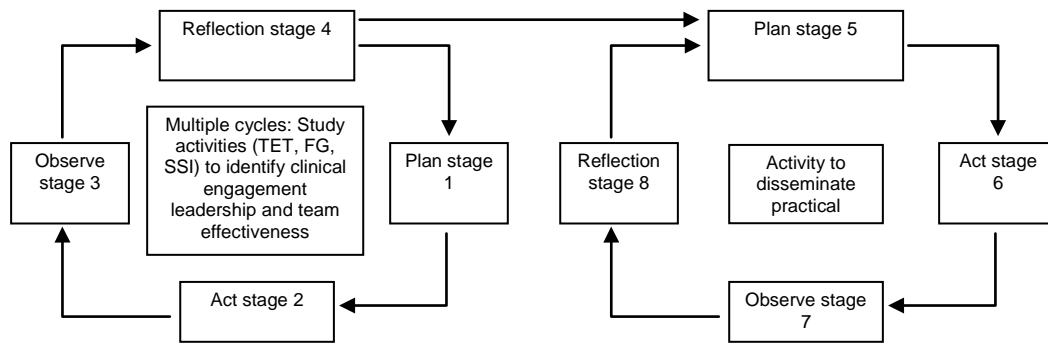
Figure 2: Study Activity

Table 1 below illustrates in detail the team effectiveness tool, action research cycles. The table includes the cycles, the building of further understanding and the influence the process had on the focus groups and the semi-structured interviews. In addition, it shows changes, which occurred within the change project because of the study activity.

Table 1: Team Effectiveness Tool (TET) Iterative Action Research Cycles

Method	Plan	Act	Evaluate	Reflection
TET	Investigation and scope - use of a quantitative tool	Literature review and discussion with experts	Options - types of tool	On my tacit knowledge and experience in relation to potential different tools
TET	Tool chosen - considered adaptations required	Made adaptations	Effect of adaptations	On any further adaptations required
TET	Adaptations and pilot stage	Made adaptations and piloted tool	Impact and issues arising from pilot	On adaptations and pilot for TET and learning for FG and SSI
TET	Final adaptations and implementation	Final adaptations made, sent out TET and follow up reminders	Response rates and implementation process	On process and learning for FG and SSI
TET	Analysis	Framework analysis – (further cyclical process throughout analysis)	Themes, understanding, insights and changes	On themes, understanding, insights and changes
TET	Reviewed implications, learning and influence on FG and SSI	Process learning and analysis of TET fed into investigation, scoping, design and development of FG	Thematic review of analysis of TET, FG and SSI via data triangulation	On analysis and learning from data collection methods – what changes have been or need to be

Method	Plan	Act	Evaluate	Reflection
		and SSI		made in change project
TET	Reviewed implications, learning and influence on change project	Made specific changes, e.g. policy for use of clear and plain English, increased accountability within management groups for actions, influencing future national medical training, etc.	Impact of changes made	On impact of changes made and on future research activity and projects

Phase 1 – Team effectiveness tool

The instrument of measurement for Phase 1 of the study activity was a team effectiveness tool, which was an attitudinal scale measuring individuals' perceptions of the effectiveness of their management group. The tool was a 4-point Likert scale (Barnett, 1991) with all questions positively directed with responses varying from good, satisfactory, need to improve to poor. A 4-point scale was used because scales with an even number of points allow some variation, but force a choice and avoid clustering around a mid-point (Oppenheim, 1992). Further adaptation and piloting was required to make it appropriate and fit for the purpose of this study.

Adaptation and piloting

In order to determine the perceived effectiveness of the management groups, the tool required adaptations to ensure its complete applicability to this research study. The adaptations were driven by reviewing the question design literature (Oppenheim, 1992;

Walliman, 2001), considering issues such as what variables needed to be measured, the use of clear unambiguous language, simplicity to enhance the response rate and layout for processing of the information. The adaptations included the addition of questions, which allowed identification of which management group the participants came from. The instructions and some of the questions were simplified as the management groups included service users. The standards of plain and simple language (DoH, 2003) were applied and the tool was reformatted so it could be circulated electronically or by post. This met the needs of all of the research participants. The tool was piloted with two members of each project management group to ensure ease of use and to review any issues arising and modified accordingly.

Population

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

The sexual health population comprised four men and twelve women. Their roles and healthcare setting are summarised in Table 2 below.

Table 2: Sexual Health Management Team Population (n = 16)

Job Role / Remit	Total	Acute Hospital	Primary Care	Voluntary or Independent	Cross-organisational

		Setting	Setting	Sector	Role
Hospital Consultant	2	2			
General Practitioner / Community Doctor	4		4		
Manager	7	1	4	2	
Change Agent / Improvement Facilitator	3				3
Patient / Service User	0				

The kidney management team population comprised nine men and five women. Their roles and healthcare setting are summarised in Table 3 below.

Table 3: Kidney Management Team Population (n = 14)

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

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

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

Activity

The team effectiveness tool was circulated to all members of both teams. The information sent out included a covering letter with clear instructions on how to complete the tool. All NHS staff requested the tool to be circulated by email, whilst two of the four patients requested the postal method. Support in completing the tool was offered, but none was requested.

Non-response can be an issue with questionnaires sent out via email and post and can potentially bias the result. Non-response was reduced by clear communication, using a simple, quick and easy questionnaire, providing adequate time for people to return the questionnaire, and undertaking two follow-up mail-outs (Oppenheim, 1992). On reflection, circulating the tool during the August summer holiday period resulted in the need to undertake two follow-up reminders.

Analysis

All responses were entered on an Access database using a bespoke Access form. Anonymity was assured by a data analyst saving all of the questionnaires on the database with no link to source. Due to the small sample size (n=26) it would not have been statistically valid to generate confidence intervals around the results and therefore descriptive statistics have been used to compare the returns from the two study groups (Robson, 2002). The trends and totals are evident in the number of responses and the use of percentages.

Phase 2 - Focus groups

Two focus groups were undertaken and the learning from the team effectiveness tool influenced the design and development.

The resources employed in the creation of a topic guide for the focus groups were the literature regarding focus groups (Oppenheim, 1992), and the reading and literature used in the literature review. Learning from the research process, analysis and the new insights and understanding were also instrumental. For instance, in one action research cycle, the team effectiveness tool analysis and findings were presented to each of the management teams individually and discussed with the evaluation team (which worked with the change project). For example, the debate with the management group highlighted the need to ensure the focus groups and semi-structured interviews focussed specifically on patient involvement as a key topic area as, on reflection, the team effectiveness tool had not offered any illuminations in this area. In addition, accountability was debated as both an inhibitor and enhancer. This resulted in a specific question on accountability being included within the topic guides.

Sample

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

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

Activity

All twelve doctors invited from both management teams participated. A mutually convenient time and location at a neutral venue away from the workplace was arranged. The two management team focus groups were held separately so any differences in opinions and mind-sets between the two groups of doctors could be identified. No difficulties requiring intervention arose. In addition to the researcher (Fran Woodard), an independent observer was employed to document the interactions between participants and the non-verbal behaviours of the group. (Kitzinger,1999).

The focus groups ran for one and a half hours, in comfortable, quiet neutral settings. Consent for the recording and transcription of tapes was obtained. However, the non-verbal behaviour noted and observed by the facilitator and observer added to the quality and reliability of the data (Walliman, 2001).

Phase 3 - Semi-structured interviews

Phase 3 of the study consisted of three semi-structured interviews with two doctors and one service user. The learning from the team effectiveness tool and the focus groups influenced the design and development. The final topic guide was created by using open-ended questions (Oppenheim, 1992) providing a loose structure to define the areas to be covered. An inductive process was adopted to define the areas to be explored.

The use of an independent observer for the focus groups was noted to be advantageous and was therefore used for the semi-structured interviews. This illustrates the cyclical action research approach, allowing for data collected from one method or source to inform the next stage. In order to promote validity and reliability, the questions were checked through debate and discussion with relevant experts.

Sample and activity

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

Analysis – Focus groups and semi-structured interviews

A transparent process was used for the data collection and analysis stages. The focus group and semi-structured interview data was analysed using Ritchie and Spencer's (1993) Framework Analysis. The stages were iterative and are represented in Table 4 below. The sexual health and kidney management teams' focus group data was analysed together. The original idea was to analyse the data separately to gain comparisons. In reality, whilst undertaking the analysis no difference was seen so the data was analysed co-jointly. The three semi-structured interviews were also analysed simultaneously.

Table 4: Framework analysis

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

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

The indexing stage involved applying the framework systematically to all the raw data using numerical codes. The charting stage required assigning the data to the appropriate part of the framework, and then forming charts. This allowed the whole dataset

to be easily read across its breadth. The charts were themed on each key subject area, drawing together all themes across the whole dataset and highlighting single and repeating themes. The final stage was mapping and interpretation, using the charts to define concepts (for example leadership), mapping the range and nature of patterns and trends, finding associations between themes (such as patient involvement), explaining the findings and developing strategies.

Findings

Team effectiveness tool

Out of a total population of thirty, n=26 answered the questionnaire tool giving an overall response rate of 86.67%. The findings suggest that both teams were open and accepting of other views both inside and outside the teams, able to communicate openly and honestly, and work creatively with problems. However, in contrast less effective handling of problems was a recurrent theme across both teams.

Focus groups

Table 5 summarises the nine core thematic areas elicited from the analysis of the focus groups. These themes are diverse in nature and cover: environmental conditions; contextual factors; personal skills and behaviours; patient involvement; and, methodological approaches. No differences in findings were evident between the sexual health and kidney clinicians. The power of the patient voice, involvement and leadership was a very strong theme with clinicians stating this was one of the most important drivers to cross-organisational working.

Table 5: Focus group analysis summary

Focus Group themes
▪ The need for a forum or focus to initiate inter-organisational working
▪ Clinical leadership, engagement and team effectiveness

Focus Group themes
▪ The power of the patient's voice, involvement and leadership
▪ Barriers and risks to inter-organisational working
▪ The use of incentives
▪ Accountability…to what and to whom?
▪ Service improvement approaches versus randomised controlled trials
▪ Personal risk of inter-organisational working
▪ Time out and the space to undertake service improvement work

Semi-structured interview analysis

Table 6 summarises the seven core thematic areas arising from the analysis of the semi-structured interviews. Many of these themes built on the focus groups' findings, with new themes also arising. The power of the patient's voice, involvement and leadership was a strikingly strong theme, as were the behaviours and skills clinicians require to lead inter-organisational projects.

Table 6: Semi-structured interview analysis summary

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

Overall summary of all of the findings:

1. The need for a focus or forum for clinicians to have the time and space to initiate inter-organisational working;

2. The power of the patient's voice, involvement and leadership in delivering impactful change;

3. The need to understand organisational and personal barriers and risks to inter-organisational working;

4. The requirement to align incentives and accountability;

5. The need for the NHS to value service improvement approaches as well as randomised controlled trials;

6. The necessity for clinicians to have managerial and leadership skills to effectively run inter-organisational projects;

7. The necessity for senior management and corporate engagement.

Discussion; putting the findings into practice

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

A prerequisite to gaining effective cross-boundary working, as recognised and acknowledged by the study participants, was the need to make significant changes to current medical training to enhance the development of new skills. These new competencies and skills will equip clinicians to participate effectively in inter-organisational working. The new competencies highlighted as essential were enhanced leadership alongside relevant managerial and service improvement skills. Whilst there are some national stakeholders who are working on this agenda, the changes to training however are yet to be realised. This creates an inherent tension. The Department of Health and other national bodies promote the importance of cross-boundary working and commissioning to improve the quality of care provision. In addition, clinicians and patients within this study and other studies (Institute of Medicine, 2003) clearly believe the benefit of such working practices. None the less, there is a distinct / theory practice gap, as these new skills are deemed imperative to actually deliver the resultant higher quality care from cross-boundary

working. This study demonstrates when creating new policy and directives, there is a need to rapidly provide the development and support to enable effective delivery.

The power of the patients' voice and patient empowerment has been seen to be growing throughout policy and the literature (Institute of Medicine, 2003; Shortell *et al.* 2004), but with little focus on how this affects patients' quality of life. The focus has largely been on how to involve patients in NHS processes and structures (Care Services Improvement Partnership, 2006). This study has highlighted the necessity for change projects to aspire to a high degree of patient centredness, as well as the fundamental need to ensure that a key focus of patient involvement is on improving the patients' quality of life and not just on service improvements or redesign. In fact, the findings suggest that patients believe that patient centeredness is fundamentally based on how their quality of life can be improved, rather than the process of being involved in changes to services or re-design projects. It is within this novel frame that significant benefits for patients can be realised. The transferable learning from this study is that patient / service user involvement is complex and can be difficult to achieve as seen with the sexual health agenda, but is extremely worthwhile (Greenhalgh *et al.,* 2010). Future studies would benefit from further inclusion of service users, to gain a better understanding of the relationship between patient involvement and a resultant improvement in quality of life.

This study was consistent with the literature (Collins, 1991; Ham, 2003; Spurgeon, 2001; Graham & Steele, 2001) by highlighting the issues of incentives. It suggests there is an urgent need to achieve alignment of the drivers and incentives for inter-organisational working. Study participants viewed incentives, across the healthcare system, as vital to achieving and sustaining change. Improvement in the quality and safety of patient care was highlighted as a clear incentive for clinicians. However, the day-to-day complexities of actually attempting to work across organisational boundaries can diminish clinicians' motivation. The NHS is enduring an acute tension between the push towards cross-organisational working to deliver high quality effective care (with a clinical focus), and the financial pressures and competition between individual NHS organisations (policy and organisational focus). There is a necessity to find the balance between or a solution to these opposing forces, and thus realise the benefits for patients. This study shows how some

policies can in reality result in significant disincentives across the healthcare system (Fitzgerald *et al.* 2007).

Whilst literature exists describing the nature of accountability (Connors & Smith, 1999; Connors *et al.* 2004), this study highlights that accountability is currently an inhibitor of effective cross-boundary working. For example, being employed by different organisations and the resultant spilt loyalties was seen as a barrier to effective inter-organisational working. This study suggests that for successful inter-organisational working to occur, a change in this culture is fundamental. New innovative accountability mechanisms need to be sought for the successful delivery of this way of working. This study demonstrates that to successfully implement new policy direction, innovative human resource practice is also required. This could help to create new accountability mechanisms, new roles, and reduce bureaucracy, but still ensure all legal and statutory requirements are fulfilled. This would allow the flexible, agile working practices required to effectively deliver the high quality of care that inter-organisational working promises.

This study supports the findings that leadership by doctors is important to improving the NHS (Ham, 2003), and that effective leadership promotes improved patient care (Ham, 2003; Shortell, 1998; Spurgeon, 2001). The study did not offer further insight into the definition of clinical leadership (Cook & Leathard, 2004; James, 2007), but supports the idea that context is significantly relevant to leadership - in this case working across organisational boundaries (Edmonstone, 2005, Pettigrew *et al.,* 1991).

Practical Recommendations developed by drawing on the key findings and learning from this study have been disseminated widely across the UK healthcare system (Woodard, 2007).

Recommendations

The tension between the evidence, the clear policy directives and the patients' voice supporting a pathway focus (and thus inter-organisational working) and the current financially stretched and competitive environment of the NHS requires further debate and

consideration by policy makers, NHS lobbyists and professional bodies. There is a need to gain agreement of the level at which NHS organisations can support inter-organisational working, and thus create the right environment for it to flourish. Within this debate, due consideration must be given to aligning appropriate incentives, creating novel innovative accountability lines and maximising the productivity gains this affords. Further studies with a health economic focus would be beneficial in identifying robust managerial and financial evidence for the effectiveness of and gains from inter-organisational working, thereby demonstrating its value for money.

Current training for doctors and other clinicians requires reviewing and updating to ensure that in the future it equips them for effective participation in inter-organisational working. Revised training must be designed to build the fundamental skills and culture change required to enable effective clinical leadership and engagement across organisational boundaries. Additionally, consideration should be given to revising incentives and accountability to facilitate this change.

Finally, this study has shown that the patients' voice is at its most powerful when it is facilitating the focussing of improvements on enhancing quality of life. This area is ripe for further exploration, especially in light of the current fiscal challenges the state is experiencing.

References

Alimo-Metcalfe, B. (2004). Spotlight. Interview with Beverley Alimo-Metcalfe. *Journal of Health Organisation and Management*, 18 (6), 393-398.

Armstrong, D. (2002). 'Clinical Autonomy, Individual and Collective: The Problem of Changing Doctors' Behaviour'. *Social Science and Medicine,* 55, 1771-1777.

Audet, A., Doty, M., Shamasdin, J., & Schoenbaum, S. (2005). *Physicians' Views on Quality of Care Findings*. Commonwealth Fund National Survey of Physicians and Quality of Care. New York: The Commonwealth Fund.

Barnett, V. (1991). *Sample Survey Principles and Methods*. London: Hodder.

Beech, M. (2002). 'Leaders or Managers: the Drive for Effective Leadership'. *Nursing Standard*. 16 (30), 35-36.

Bolster, L. (2006). *What Mechanisms Need to be in Place to Develop an Effective Team Culture?* MA thesis. York St John.

Britten, N. (1995). 'Qualitative Research: Qualitative interviews in Medical Research'. BMJ, 311: 215-253.

Buchanan, D. A., Addicott, R., Fitzgerald, L., Ferlie, E., & Baeza, J.I. (2007). 'Nobody in Charge: Distributed Change Agency in Healthcare', *Human Relations,* 60 (7), 1065-1090.

Care Services Improvement Partnership. (2006). *Strengthening Service User and Carer Involvement: A Guide for Partnership. A Discussion Paper*. London: Stationery Office.

Coghlan, D., & Brannick, T. (2001). *Doing Action Research in Your Own Organization.* London: Sage Publications.

Collins, M. (1991). *Human Resource Management Audit.* Birmingham: North Western and West Midlands Regional Health Authorities.

Connors, R., & Smith, T. (1999). *Journey to the Emerald City.* New York: Prentice Hall Press.

Connors, R., Smith, T., & Hickman, C (2004). *The Oz Principle*. New York: Penguin Group.

Cook, M.J. (1999). 'Improving Care Requires Leadership in Nursing'. *Nursing Education Today,* 19, 306-312.

Cook, M.J., & Leathard, H.L. (2004). 'Learning for Clinical Leadership'. *Journal of Nursing Management,* 12, 436-444.

DoH. (Department of Health). (2003). *Tool-kit for Producing Patient Information.* London: Stationery Office.

DoH. (Department of Health). (2004). *Improving Chronic Disease Management.* London: Stationery Office.

DoH. (Department of Health). (2005).*Health Reform in England: Update and Next Steps.* London: Stationery Office.

DoH. (Department of Health). (2010). *Equity and excellence: Liberating the NHS.* HMSO.

Dopson, S., Locock, L., Gabbay, J., Ferlie, E. & Fitzgerald, L. (2003). 'Evidence-based Medicine and the Implementation Gap'. *An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine,* 7 (3), 311-330.

Dopson, S., Fitzgerald, L., Ferlie, E., Gabbay, J., & Locock, L. (2002). 'No Magic Targets! Changing Clinical Practice to become more Evidence Based'. *Health care Management Review*, 27 (3), 35-47.

Edmonstone, J. (2005). 'What is Clinical Leadership?' in, Edmonstone, J. (ed). *Clinical Leadership Development. A Book of Readings.* Chichester (UK): Kingsham.

Fitzgerald, L., Ferlie, E., Wood, M., & Hawkins, C. (2002). 'Interlocking Interactions, the Diffusion of Innovations in Healthcare'. *Human Relations,* 55 (12), 1429-1449.

Fitzgerald, L., Ferlie, E., Addicott, R., Baeza, J., Buchanan, D., & McGivern, G. (2007). 'Service Improvement in Healthcare: Understanding Change Capacity and Change Context'. *Clinician in Management,* 15, 61-74.

Fletcher, G., & Bradburn, L. (2001). *Voices in Action Resource Book. Training and Support for User Representatives in the Health Service.* London: College of Health.

Gill, J., & Johnson, P. (1997). *Research Methods for Managers.* (2nd ed). London: Paul Chapman Publishing Ltd.

Gittell, J., Weiss, L., & Wimbush, J. (2005). *Linking Co-ordination Networks and Organizational Design to Improve the Coordination of Work.* In Press.

Govier, I. (2004). 'Advancing Excellence in Leadership'. *Nursing Management,* 10 (9), 13-15.

Graham, A., & Steele, J. (2001). *Optimising Value.* London: Public Management Foundation.

Greenhalgh, T., Humphrey, C., & Woodard F. (2010). *User Involvement in Healthcare.* Oxford. Wiley-Blackwell BMJ Books.

Guba, E., & Lincoln, Y. (1989). *Fourth Generation Evaluation.* Newbury Park, CA: Sage.

Ham, C. (2003). 'Improving the Performance of Health Services: The Role of Clinical Leadership'. Lancet 25th March 2003. Available at: http://image.thelancet.com/extras/02art8342wed.pdf [Accessed May 3rd 2005].

Holmes, J. (2006). 'Sexual Health on the High Street – Redesigning Sexual Health Services'. Snakes and Ladders. Poster Abstract at the Institute of Health Improvement. European conference, Prague. Available at: http://www.southwarkpct.nhs.uk/documents/2681.pdf [Accessed December 02 2010].

Institute of Medicine. (2003). *Crossing the Quality Chasm: A New Healthcare System for the 21st Century.* National Academies Press: Washington DC.

James, L. (Updated by Booth, A. and Mead, T.) (2007). *Clinical Leadership*. Department of Health. January. Available from: http://www.library.nhs.uk/healthmanagement/ViewResource.aspx?resID=64789 [Accessed December 22nd 2007].

Keen, J., & Packwood, T. (2000). 'Using Case Studies in Health Services and Policy Research' in, Pope, C., & Mays, N. (eds). *Qualitative Research in Health Care.* London: BMJ Books.

Kenagy, J., Berwick, D., & Shore, M. (1999). 'Service Quality in Health Care'. *Journal of the American Medical Association.* 281, 661-665.

Kenny, D., & Adamson, B. (1992). 'Medicine and the Health Professions: Issues of Dominance, Autonomy and Authority'. *Australian Health Review*, 15 (3), 319-334.

Kitzinger, J. (1999). 'Focus Groups with Users and Providers of Health Care' in, Pope, C., & Mays, N. (eds). London: BMJ Books, p20-29.

Kotter, J. (1999). 'What Leaders Really Do?'. Harvard Business Review Book. Boston: Harvard Press.

Meyer, J., & Spilsbury, K. (2000). 'Comparison of Findings from a Single Case in Relation to those from a Systematic Review of Action Research'. *Nurse Researcher,* 7 (2), 37-53.

Morgan, D., & Krenger, R.A. (1998). *The Focus Group Toolkit.* London: Sage Publications.

NCCSDO. (2002). *User and Carer Involvement in Change Management in a Mental Health Context: Review of the Literature.* London: NCCSDO.

NHS Modernisation Agency. (2005). *Improvement Leaders' Guide: Building and Nurturing an Improvement Culture.* London: Department of Health Stationery Office.

Oppenheim, A. (1992). *Questionnaire Design, Interviewing and Attitude Measurement.* London: Continuum.

Oshagbemi, T., & Gill, R. (2004). 'Differences in Leadership Styles and Behaviour across Hierarchical Levels in UK Organisations'. *Leadership and Organisation Development Journal*, 25 (1), 93-106.

Pettigrew, A., Ferlie, E., Fitzgerald, L., & Wensley. R. (1991). 'The Leadership Role of the New Health Authorities: An Agenda for Research and Development'. *Public Money and Management.* Spring, 39-43.

Pope, C., & Mays, N. (1995). 'Qualitative Research: Rigour and Qualitative Research'. *BMJ.* July 8th, 311, 109-112.

Rippon, S., & Monaghan, A. (2001). 'Clinical Leadership; Embracing a Bold New Agenda'. *Nursing Management*, 8 (6), p6-9.

Ritchie, J., & Spencer, L. (1993). 'Qualitative Data Analysis for Applied Policy Research' in, Bryman, A. & Burgess, R. (eds). *Analysing Qualitative Data.* London: Routledge, p173-194.

Robson, C. (2002). *Real World Research.* (2nd Ed). Oxford: Blackwell.

Schein, E. (1997). *Organisational Culture and Leadership*. Oxford: Jossey-Bass.

Senge, P. (2000). *The Dance of Change: Sustaining Momentum in a Learning Organisation.* London: Nicholas Brearley Publishing.

Shortell, S. (1998). 'Assessing the Impact of Continuous Quality Improvement on Clinical Practice: What Will it Take to Accelerate Progress?' *Millbank Quarterly,* 76 (4), 593-624.

Shortell, M., Marsteller, J., Lin, M., Pearson, M., Wu, S., Mendel, P., Cretin, S., & Rosen, M. (2004). 'The Role of Perceived Team Effectiveness in Improving Chronic Illness Care'. Medical Care, 42 (11), 1040-1048.

Siriwardena, A., & Niroshan, B. (2006). 'Releasing the Potential of Health Services: Translating Clinical Leadership into Healthcare Quality Improvement'. *Quality in Primary Care.* 14, 125-128.

Spurgeon, P. (2001). 'Involving Clinicians in Management: A Challenge of Perspective'. [On-line]. *Healthcare Care Informatics Review.* 5 (4). Available from: http://hcro.enigma.co.nz [Accessed August 27th 2005].

Vengen, S., & Huxham. C. (2003). 'Enacting Leadership for Collaborative Advantage: Dilemmas of Ideology and Pragmatism in the Activities of Partnership Managers'. *The British Journal of Management*, 14, 61-76.

Walliman, N. (2001). *Your Research Project: A Step-by-Step Guide for the first time Researcher.* London: Sage Publications.

Weber, M. (1947). *Max Weber: The Theory of Social and Economic Organization.* Translated by A. M. Henderson and Talcott Parsons. NY: The Free Press.

Wheelan, S. (1999). *Creating Effective Teams: A Guide for Members and Leaders.* London: Sage Publications.

Whitmore, E. McKee, C. (2001). 'Six Street Youth Who Could' in, Reason, P. & Bradbury, H. (eds). *Handbook of Action Research.* London: Sage, p396-402.

Woodard, F. (2007). *How to Achieve Effective Clinical Engagement and Leadership when Working Across Organisational Boundaries - Practical Recommendations.* Guy's and St Thomas' Charity available at:

http://www.gsttcharity.org.uk/pdfs/mipracticalrecommendations.pdf [accessed 22nd November 2010]

Yin, R. (2003). *Applications of Case Study Research.* (2nd ed). London: Sage

Author Biographies

Fran Woodard is currently the Director of Transformation and Cancer Programme for King's Health Partners, SE London. Her role is to lead transformational change and cost improvements as well as the delivery of an internationally distinctive Comprehensive Cancer Centre. These are large-scale multi-organisational transformational programmes incorporating the enhancement of clinical service delivery, integrating research and clinical practice to reduce the research pipeline and increase translational research, capital and information technology solutions, income diversification strategies and the delivery of patient centred care.

Fran Woodard is an experienced senior manager with extensive skills in directing, leading and delivering radical large-scale improvements, developing and evaluating complex services and aligning business objectives with improving quality, efficiency and productivity. She has a doctorate in 'Leading Inter-organisational Change', which focussed on the relationship between leadership and change when transforming services across organisational and professional boundaries.

Gordon Weller is programme leader for the doctorate in professional studies in health within the school of Health & Social Sciences at Middlesex University. He has a background in research and teaching in human resource management, leadership and professional development. He has been involved in research studies focusing on the health professional as an insider researcher. He has worked in his current role since 2007 and

previously led initiatives in work based learning and research over fifteen years within the higher education sector.