brighton and sussex
medical school

University of Brighton

Exploring Change in Leadership and Commissioning of Health and Social Care:
A Digest of Masters Dissertations
September 2011 - February 2015

Division of Medical Education
Brighton and Sussex Medical School

Exploring Change in Leadership and Commissioning of Health and Social Care: A Digest of Masters Dissertations September 2011 - February 2015

Foreword

The Division of Medical Education of the Brighton and Sussex Medical School is delighted to publish this digest of Masters dissertations from our Leadership and Commissioning course.

The majority of our postgraduate students' dissertations from 2011 to the present are summarised in the digest. The subjects covered within the dissertations are diverse but what links them all is the backdrop of change the authors are operating under and their concern to contribute to improvement within health and/or social care.

Whilst each dissertation is the result of unique academic study by individuals near the end of their Masters programme, the digest shows the overall wealth, breadth and depth of studies undertaken by our postgraduate students in the complex fields of leadership and commissioning in health and social care.

The Division is proud of the academic support we offer all our postgraduate students on these programmes. This support includes help to develop the study proposal and regular individual academic supervision for its duration.

We welcome any further interest in our postgraduate students' dissertations. For further information about any of the individual studies featured in this digest, please contact Caroline Hopper or Breda Flaherty at the Division of Medical Education, Brighton and Sussex Medical School.

Congratulations to all our Masters graduates and I commend this digest to you.

Professor Gordon Ferns

Head of the Division of Medical Education

Brighton and Sussex Medical School

May 2015

Contents

Frontispiece and Course Supervisors' Biographies

This digest contains summaries of Masters dissertations on leadership and commissioning of health and social care from the Division of Medical Education at the Brighton and Sussex Medical School. The dissertations, produced between September 2011 and February 2015, are a culmination of Masters students' work as awarded by the University of Brighton.

Our Leadership and Commissioning postgraduate course prides itself on being topical, theoretical and applied. The dissertations are academically rigorous and also relevant to the contemporary settings of health and social care.

The papers explore change within the field of leadership and commissioning in health and social care in the UK. All the projects evaluated were seeking to improve services and ways of working within the systems they were operating in. Whilst their findings were applicable to their particular context, they have a wider interest and application. The digest follows the academic convention of citing the dissertation supervisor as co-author.

The papers demonstrate the significant difference that can be made to improve practice and services within organisations and the impact on their wider stakeholders.

For further information about the course please contact: Breda Flaherty - b.flaherty2@brighton.ac.uk - or Caroline Hopper - c.m.hopper@brighton.ac.uk - or pgm@bsms.ac.uk or visit www.bsms.ac.uk/postgraduate

Breda Flaherty

MA; Postgraduate Diploma Training and Organisation Development; Postgraduate Diploma Management Studies

Course Leader, MSc Leadership and Commissioning

Breda Flaherty is Course Leader for the Brighton and Sussex Medical School (BSMS) multidisciplinary MSc in Leadership and Commissioning. She holds Associateships at the NHS Leadership Academy and The King's Fund. Breda has led her independent consultancy since 1992, where her focus is on developing leaders in changing organisations, and through which she leads service improvement initiatives, by invitation, across health and social care services. Her BSMS 'Clinical Commissioning' module was recently showcased as one of the top five clinical commissioning group development programmes nationally.

Breda is particularly interested in improving dementia care, developing community models of care for heart failure and respiratory disease, and in specialist service provision for HIV care. She specialises in bringing engagement with patients and service users to the heart of professional decision-making.

Caroline Hopper

BA; Postgraduate Diploma Social Policy; MBA; Certificate in work place counselling

Dissertation Coordinator, MSc Leadership and Commissioning

Following a career in universities, local government and the voluntary sector; Caroline joined the NHS in London and was then an Executive Director in health authorities and primary care trusts in Surrey and Sussex for over 12 years. She held a wide range of general management roles on NHS Boards including director of: commissioning; strategic and service development; public engagement and human resources and organisational development.

Caroline's particular interests at the university span service improvement, leadership, quality, knowledge management and individual student academic and professional development.

Caroline also works on a consultancy basis with the health, social care and education sectors and is particularly interested in strategic, professional and organisational development

Resistance to commissioning change – a case study

Matthew White and Breda Flaherty

September 2013

Key points about the background and case study

At the time of writing this dissertation, the author was in a 'community of practice' involved in a change to integrate community health and social care for older people in a local health economy. As the change was the primary focus of investigation for this case study, he was an insider researcher, a role discussed in the study.

A stakeholder analysis formed Part 2 of the study.

The author's starting point was the challenge facing the NHS – the need to make significant savings (identified as £20 billion by 2015) while completing reforms to put GPs at the heart of commissioning in the form of clinical commissioning groups (CCGs), managing increased demand for services, and improving service quality/patient safety.

The premise of a shared understanding of the need for change was contrasted with the 'poor record' of the NHS of delivering change, often due to 'resistance from stakeholders including the public and politicians and within the service itself'.

The study explored this dichotomy between a desire for change and the difficulty in making it happen, specifically from a commissioning perspective. The aim was to understand more about resistance to commissioning change and for the findings to inform the development of CCGs and their commissioning approach.

A case study from a local health economy – a complex change to integrate community health and social care for older people – was the primary focus for investigation.

With one of the oldest populations (over 65s) in England, services in the health economy were considered poorly configured to meet needs and not offering the right quality.

The commissioning intentions were to develop community multi-disciplinary health and social care teams around primary care hubs, a single point of access for health and social care, and more support for patients to self-care. The aim was to reduce emergency admissions of the over 65s by 30% with a subsequent reduction in average length of stay of 30% alongside a reduction in the number of long term residential placements.

High level outcomes sought included a single delivery system, high quality pathways to maintain and maximise independence, a sustainable and cost effective system across health and social care, and transformed services through a seamless and integrated approach.

Strategy was set by a system-wide group of senior executives. Commissioners hosted a collaborative design and delivery team reporting to a programme board. Front line staff were involved with and engaged through workshops and larger scale events.

The change was developed and instigated in 2011; 13 sites were planned to cover the whole geographic area of which four were live by May 2013 but not operating to the full specification, ambition or infrastructure. Key staff, such as team leaders and care co-ordinators, were not in place and staff who were in post appeared to have two roles – their new and previous roles.

Summary of the literature review and methodology

- The review was discussed with particular reference to key change and leadership concepts and relevant literature on commissioning, integration and change in healthcare.

- A range of transformational models relating to organisations, culture, leadership and change were identified and discussed with particular reference to resistance to change and the concepts and practicalities of integration.

- While written from different perspectives and with different motives, many commonalities emerged, primarily:

- change requires a clear vision, one that is built from experience as well as exposure to new things and new ideas
- leadership is a social process that should empower others to act on the vision
- change takes learning and time, must be approached rigorously and its nature understood because 'culture eats strategy for breakfast'.
- The study was qualitative with an interpretative phenomenological approach taken to data obtained from 6 semi-structured and in-depth interviews, case materials and documents; purposive sampling was used to select a cross-section of public officers with the most active participation in the change.

Summary of the analysis, key findings and discussion

Analysis of the interviews identified seven overarching themes. Findings were reported under each of the themes and discussed with reference to relevant literature. Participants' comments were included, and the insider researcher role discussed.

Taking on the culture: Participants had a strong awareness of the cultural challenge to deliver the change. They described the change not as a service but in terms of a philosophy for how health and social care approached patient need. This realisation was firmly rooted in the knowledge that professional boundaries and 'power structures' would need to be drastically different – and the transition difficult for many staff.

Change management: This theme emerged throughout and it was apparent participants believed the change management process was underdeveloped. While they had strategies in mind to improve the approach, these were not being deployed, raising further questions about this change environment.

Organisational commitment: Commitment and willingness to change and being prepared to share sovereignty were identified in the literature as being crucial when trying to integrate services yet most participants questioned whether that had happened and all organisations were truly behind the vision for the change. Others felt pressures, including the commissioning reforms, had led to inconsistencies between agreements and action and a focus on one's own organisation while some stated the same pressures were drivers for change, a view supported in the literature. However, the overwhelming feeling was that many (predominately provider) organisations were displaying a lack of commitment towards the vision.

The leadership model: While case materials suggested an intention for 'shared and distributed leadership', participants' comments suggested this did not take hold as senior leaders 'feared losing control' and remained ultimate decision makers, which left those who would have shared leadership feeling disempowered and not taking decisions; this resistance was a product of the leadership model itself, the very thing the literature showed should drive change.

The commissioning model: As this was influenced by the leadership model, the collaborative approach adopted between commissioners and providers favoured using the vision to guide an emergent process over more specification-led commissioning. Most participants agreed it was the right approach but referred to difficulties in understanding how to make collaboration work. Two topics emerged:

- the lack of ownership of the vision; despite most recognising the definition offered during interview, all acknowledged the change would mean different things to different people in different situations and there was a need for a universal vision to be agreed and communicated regularly as recommended in the literature
- lack of clarity of roles and responsibilities (specifically for commissioners); this was significant as the commissioning organisation hosted the collaborative team.

Overall there was a sense collaborative commissioning was the right model but without a clear framework and effective governance it had a price.

The pace of change: All commented on this with most stating it had been slower than expected and favouring acceleration of delivery. They aired concerns that, without tangible results, momentum would dissipate causing negative behaviours and apathy to take hold; some were concerned that was already the case.

The complexity of change: Although the change process had been separated into 'manageable' steps as the literature recommended, it appeared this approach had not simplified it enough to ensure a smooth path with one participant describing it as 'organised chaos'. Another described the challenge of overcoming resistance where there was 'scarcity of evidence'. The findings led the author to question how the system and its change leaders respond when uncertainty leads to resistance or a state of chaos. 'Do they revert back to old ways of working or persist, showing courage and conviction?'

Summary of the conclusion of the case study and recommendations

Emerging themes and findings included: a lack of belief that the deep rooted cultures and professional boundaries could be overcome; an underdeveloped approach to change management; a lack of system-wide commitment to the change; and weaknesses in the leadership and commissioning models used.

A number of improvements were recommended including: CCGs adopting and consistently employing a change methodology; robust management processes and governance arrangements to secure accountability and delivery; consistent communication of a single vision; educate for change; and monitor and evaluate on-going change, creating a robust evidence base for what works locally.

Summary of the stakeholder analysis

Part 2 of the study explored the position of senior leaders involved in the change and the wider professional body, from needs assessment and prioritisation into design and delivery, with specific regard to involvement in decision making.

The statutory requirements of NHS commissioners to engage with and listen to the views of stakeholders were discussed together with key concepts to identify stakeholders in change management.

The needs assessment process was simple and succinct – an aging population and an inability to meet their needs - and there was little challenge from stakeholders towards the commissioner prioritising the change due to the evidence base and national policy direction to integrate health and social care and better community support for the elderly and frail.

Senior leaders of commissioners of health and social care and local providers discussed, planned and designed the change and its objectives. They agreed the commissioning model was to be emergent, evolutionary, and collaborative and led by a programme board of representatives from all partner organisations, chaired by commissioners. Events were held to engage a wider group of professionals but, after some initial enthusiasm, very few attempted to become more involved.

Although the decision to share responsibility and distribute leadership across all partners appeared reasonable given the nature of the cultural change and implications, the application was less straightforward. The study findings suggested true ownership of the change remained unclear. Participants described a process of 'design by committee' which slowed the pace of change. Stakeholders started to disengage and air frustration with even those attempting to drive the change finding it difficult to maintain enthusiasm.

At a later stage, leadership and decision making became more centralised which caused further frustration to some stakeholders due to perceived disempowerment.

Summary of the conclusion of the analysis of stakeholder perspectives

An improved and continuous approach to stakeholder management and engagement could go some way to addressing some of the difficulties observed in this analysis. A more fundamental shift in the cultural beliefs and norms about change may be needed to create the kind of system-wide commitment that would truly deliver transformational change.

The impact of a quality improvement initiative in a sexual health clinic: clinical engagement and motivation

Dr Charlotte Hopkins MBBS, FRCP, and Caroline Hopper

September 2014

Key points about the background and case study

At the time of writing this dissertation, the author was a consultant physician in sexual health and HIV medicine at a London NHS trust and the service transformation lead.

A series of quality improvement initiatives were proposed and implemented at the busy sexual health clinic to improve the quality of the service and patients' experiences.

The purpose of the study was to determine the enablers for frontline clinicians to motivate and engage with a quality improvement initiative and the impact on the quality of the service in a 'clinical microsystem' – the sexual health clinic.

As the NHS quality agenda continues to grow, the author wanted to address how quality improvement (QI) played out at the frontline in a sexual health clinic setting. The definition of QI was taken from The Health Foundation – 'better patient experience and outcomes achieved through changing provider behaviour and organisation through using systematic change methods and strategies'.

The study had an explicit aim to draw out the individual and team learning as well as the staff perceptions around their motivation to engage with specific changes introduced as QI initiatives.

It followed the implementation of QI initiatives to address concerns about the length of time patients were waiting to be seen as well as the risk to the clinic's reputation.

A 'slot system' was introduced for patients attending the walk in clinic with the aims of: offering patients an estimated time when they would be seen; easing the flow of patients; reducing complaints and interruptions for reception staff; finishing clinics on time; and motivating the clinical team.

In addition, new tests utilising the latest technology for detecting sexually transmitted infections were introduced together with a new governance structure to ensure results were communicated and delivered in a timely manner to patients via a text message.

Summary of the literature review and methodology

- A broad-based literature review was undertaken; it centred on establishing existing knowledge and considered: the context of QI and its importance to the NHS; QI at different levels within a complex healthcare system; individual factors which contribute to QI; successful service improvement (motivation, leadership and learning); and relevant theories to shape subsequent research and data collection.

- A qualitative study which used purposeful sampling and 6 semi-structured interviews with staff of the sexual health multidisciplinary team (MDT) following the QI initiative at the clinic. An interpretive phenomenology approach was applied and thematic analysis was used to describe the emerging themes.

- The study focused on how the individual and group/team levels fit into the bigger system for QI. The author posed the question: 'We know it is important so what is missing to ensure engagement and success from the current published literature?'

- The question was explored and discussed under the following headings:

  - motivation

  - leadership and quality improvement

  - learning and quality improvement

  - engagement, barriers and enablers to quality improvement.

- The summary of the literature review noted the literature showed engagement with change and QI was multifactorial and papers published on enablers for successful QI were sparse.

However those critical success factors described were: direct patient benefit; successful organisational track record; local credible champions; and dedicated time. Numerous challenges and barriers were also described – lack of time, resources, training, structured programmes and poor leadership.

Most research also focused on discrete sets of clinician engagement while the study was interested in the multi-disciplinary perspective.

The majority of current published literature relate to larger national or regional initiatives such as the 'safer patient' initiative. Although many lessons and themes are likely to be transferrable, it did highlight a gap in knowledge regarding engagement at the microsystem level where frontline clinicians are trying to improve the quality of care for patients.

- The study question was: *What are the factors and conditions that need to be created and met to satisfy staff to ensure effective motivation to engage with quality improvement work at the microsystem clinic level within the English NHS healthcare setting?*

- Further objectives identified were:

  - to develop an understanding how the multi-disciplinary team perceived their motivation for change

  - to determine what impact a service development initiative in a sexual health clinic had on a genitourinary MDT and its wider service provided

  - to discover what the MDT's perceptions were regarding the quality of the service provided and draw out learning from the team.

- In the methodology section, the author addressed the insider researcher role, and in the study design section, explained why a qualitative method was chosen.

- 6 of the 10 members of the clinic's multi-disciplinary team volunteered to be interviewed – 3 nurses (of varying bands), 1 receptionist, 1 consultant and 1 trust grade doctor.

Summary of the analysis and key findings

Thematic analysis using coding and categorising was used to look for emerging themes and checked by the MSc supervisor for verification. Three types of comparison were used. The findings were cross-referenced with other research findings. Respondents' comments under each of the themes were included.

The main themes were:

Communication

- This was a consistent theme throughout each participant's interview with similar experiences emerging.

- Communication concerning the team had several layers – themes relating to the team and those directly related to communication with patients.

- The importance of initial communication from the project lead with the MDT was strongly emphasised; this can create the right environment to generate 'buy in' and sustainable success for the change proposed.

- Improved communication across the MDT was a perceived benefit as a direct result from the changes introduced.

- The importance of regular feedback to the team, sharing ideas and creating a platform for their voices to be heard.

- As one type of communication became enhanced, negative comments and interactions with patients decreased.

Motivation for change

- If a clear benefit for patients, team or department are explained at the very beginning, this can be a motivating factor for the MDT to have 'buy in' for the proposed change. This was especially true if they can see patient benefit. Ideally it must also demonstrate effectiveness with evidence.

- Although benefits to the individual are important, there was a sense of interviewees having a broader view - it is important to consider any new changes within the wider context of NHS financial issues. Cost effectiveness was a consideration for some participants.

Quality of service provided (teams and patient benefits)

- It was felt the quality of the service offered had greatly improved in terms of better patient experience and care.

- The 'slot system' led to increased efficiency and productivity with clinicians able to see more patients in a timely manner which in turn led to fewer complaints and better working conditions in the clinic.

- Further suggestions to improve or recommendations for what could have been done differently were given; for example, no measures were taken to inform whether the change had led to an improvement.

Learning

- The results showed that, even if something had failed in the past, if it is still a good idea it's worth trying later

because conditions may have changed.

- Some participants felt they had discovered ideas that work which they could use in the future in other settings.

- None of the participants mentioned any new skills they had personally developed. The author acknowledged this reflected a weakness in how the changes were implemented and a poorly asked/answered question. This was discussed in further detail in the 'strengths and limitations' section.

Leadership

- Strong leadership and its importance for change came through as an emerging theme and it was viewed consistently as a critical success factor.

Conclusion

This study described critical success factors which can contribute to the successful implementation of a local frontline quality improvement project within the NHS healthcare setting and added value to current knowledge in this subject area.

These factors include: leadership; communication; clear benefit to patients and staff; and measures to demonstrate how the changes led to the intended improvements.

Quality improvement initiatives are an effective strategy to deliver the overarching quality agenda within healthcare. They can improve both the quality of care and patient experience simultaneously and, with engaged participants, this can lead to improved team success.

A study of managers' and consultants' perceptions of engagement, behaviours and traits and how these might affect medical engagement in a specialist surgical trust

Kate Saunders and Caroline Hopper

November 2013

Key points about the background and study

At the time of writing this dissertation the author was employed by the specialist surgical trust and as such was an insider researcher, a role discussed in the study. Her experience suggested that within the trust there were varying degrees of medical engagement ranging from extremely engaged to not overly interested, depending on the topic in question. Ethical approval was obtained from the research ethics committee of the organisation.

The author's starting point was the priority of medical engagement within the NHS in the belief the more doctors engage in leadership, the greater the degree of organisational performance, productivity and empowerment for team working in actively pursuing quality initiatives will be seen.

A climate of austerity also demanded high quality, safe, effective and efficient care was delivered to all patients, with success dependent on an engaged workforce.

In particular, the relationship between doctors and managers was considered to be either a key enabler or disabler to engagement, depending on how good that relationship was perceived to be, and critical to overall organisational success.

The trust in the study was identified as 'high performing' as defined by high Monitor scores, high ratings by the Care Quality Commission and excellent patient feedback via the annual patient survey. However, her experience suggested there were varying degrees of medical engagement within the organisation.

The aim of the study was to explore how medical engagement was perceived within the organisation – a specialist tertiary trust – by both consultants and senior managers and to try to identify any traits or behaviours that either positively or negatively affected clinicians' willingness to engage with the quality, innovation, productivity and prevention (QIPP) challenge. The study would increase understanding within the trust of:

- which behaviours and traits, if any, either adversely or positively affect medical engagement

- which other inhibitors, if any, affect medical engagement.

Summary of the literature review and methodology

- A review of literature researching medical engagement was undertaken to summarise and synthesise evidence on both inhibitors and enablers, while considering the direct relational consequences of management and leadership behaviours on medical engagement and the effect on organisational performance and the QIPP challenge.

- Five key themes were identified from an analysis of the literature data on medical engagement within a specialist tertiary trust. These were: leadership; culture; engagement; behaviours; and traits.

- The findings of previous studies/research were discussed under each of these headings, including:

  - the importance of good leadership, different leadership theories and the debate over whether a particular model or theory works better than another in the complex field of health care

  - the differences in the cultures of high and low performing trusts, and how failures in health care,

such as in Mid Staffordshire, highlighted concerns over the effect the culture of organisations have on the quality of care, and the importance of medical engagement

- aspects of medical culture that might inhibit or enable medical engagement, and national projects to improve clinical engagement

- links between leadership behaviour and quality improvement, and characteristics of 'destructive' leaders and those considered successful

- individual and collective traits in relation to leadership abilities.

- The study was qualitative using interpretative phenomenology; the reasons for this were discussed.

- Semi-structured, in-depth interviewing was the sole method of data collection.

- A purposive sample of 5 hospital consultants and 4 senior managers from a range of specialities was recruited to ensure a broad coverage of the main working areas within the trust.

- Although all 9 were interviewed, the last interview took place two months after the others and the author decided not to include data from this interview in the analysis as comments would 'reflect a different moment in time within the organisation and as a result could unduly affect the results'.

- Thematic analysis was used to interpret the data collected from 8 interviews with 4 consultants and 4 senior managers.

- The author's role as an insider researcher was discussed.

Summary of the analysis, key findings and discussion

Key findings

Initial findings were grouped into three main themes covering response to change, relationships within the trust, and accountability and responsibility. Subsequently five sub themes were identified – behaviours, culture, engagement, leadership and traits.

The hospital consultants and senior managers produced diverse responses with frequent paradoxes. To capture this diversity, where possible a comparison between the two was presented. A wide range of participants' comments was quoted.

All responses were considered relational to a high performing trust, at a time of austerity and following a period of 'significant change'.

The findings suggested:

- Hospital consultants' and senior managers' perception of medical engagement have different foci.

- Hospital consultants focused on transparency in decision making, consistency, respect, reward (either monetary or professional) and autonomy when considering medical engagement, with lack of consistency, lack of transparency and excessive control being identified as key inhibitors to engagement.

- Comparatively senior managers focused on trust, transparency, training and time, while considering empowerment, consistency and control to be key enablers.

- Both groups felt lack of clarity around objectives, strategy and structure confused the lines of accountability and responsibility.

Discussion

The main interview findings were analysed in relation to the findings from the literature search on medical engagement and in the context of the trust as a high performing organisation in a time of austerity and following a significant period of change.

As the literature supported the concept that high performing organisations had higher levels of medical engagement than low performing organisations, the study explored this perception.

The study identified that perceptions of medical engagement varied greatly between clinicians and senior managers, producing several paradoxes. With potentially large numbers of clinicians not engaged in the trust's business, the study provided an opportunity to consider factors that may be preventing this cohort of staff from being fully engaged.

However, as the literature search had shown no 'universally accepted definition of medical engagement', measuring how engaged the clinicians were in the trust's business was not possible.

Discussions of the findings were presented according to the five sub-themes identified during the analysis of the data:

- behaviours within the organisation

- culture within the organisation

- engagement within the organisation

- leadership within the organisation

- traits within the organisation.

These themes were discussed with reference to the findings of relevant studies. Key points were:

- Behaviours of staff such as having a positive attitude towards the organisation and working with colleagues to improve performance strongly correlate to individual engagement levels; within the study, both individual and corporate behaviours were identified as playing a significant role in medical management, with honesty, openness and transparency seen as key enablers.

- The cultural divide between managers and doctors is well documented with little consensus over the best way to narrow the gap; themes from the study emphasised both differences and similarities between the varying professional groups, suggesting that professional identities can affect individuals' perceptions of engagement as the professional subculture predominates.

- The literature strongly linked trust to both medical engagement and follow-up but also inextricably to professional bureaucracies and the need for clinicians to trust their information source; within the study, senior managers aligned engagement to trust, transparency, training and time compared to the consultants' focus on needing to feel valued, sufficient reward (either monetary or professional respect), increased autonomy around management decisions and transparency in decision making.

- The British Medical Association (2011) study of doctors' perspectives of clinical leadership identified more barriers (such as lack of time, the difficulty of leading autonomous practitioners and limited leadership opportunities) than enablers to engaging in the leadership agenda; similar views were expressed within the study suggesting deeply embedded views are challenging to many NHS organisations and did not relate solely to the trust in the study. Comparatively, all the senior managers considered leadership a core role with empowerment, control, training and consistency being the main themes identified.

- Despite the study aiming to include traits as either inhibitors or enablers of medical engagement, little reference was made beyond the fact the trust was small and therefore no discussion or conclusion could be inferred.

- The insider researcher role was further considered together with the strengths and limitations of the study.

Summary of the conclusion

The findings suggested that hospital consultants' and senior managers' perception of medical engagement have different foci, with consultants concentrating on transparency in decision making, consistency, respect, reward (either monetary or professional) and autonomy when considering medical engagement, with lack of consistency, poor transparency and excessive control being identified as key inhibitors to engagement. Comparatively managers focused on trust, transparency, training and time, while considering empowerment, consistency and control to be key enablers.

The study proposed that lack of clarity around objectives, strategy and structure confused the lines of accountability and responsibility. The findings added to the growing database of evidence in relation to medical engagement and proposed new concepts in relation to high performing trusts being successful regardless of levels of medical engagement.

Despite being a highly successful trust many of the issues raised were the same as those experienced in less successful organisations. A lack of any universally accepted definition of medical engagement meant there was no bar from which to gauge how engaged the medical staff were, and it was therefore possible the bar was set much higher than previous studies.

What factors influence the effectiveness of interventions to reduce preventable hospital admissions? An exploration of commissioners' perspectives of planning and implementing initiatives to reduce preventable hospital admissions in older people

Sally Reed and Caroline Hopper

February 2015

Key points about the background and study

At the time of writing this dissertation the author was a commissioner involved in local health and social care initiatives to reduce preventable hospital admissions.

With increasing economic and demographic challenges facing local health and social care economies, much emphasis is targeted towards community-based interventions to reduce preventable hospital admissions, particularly for older people with long term conditions. To achieve local reductions a range of evidence-based initiatives have been introduced with varying levels of effectiveness.

The purpose of the study was to explore the factors that influence the effectiveness of such interventions. The study specifically considered the views of commissioners and sought to answer two key questions:

With increasing focus on reducing unplanned admissions, why does this continue to be such a complex issue to resolve?

What are the key factors commissioners and health care leaders need to consider when planning and implementing future projects and initiatives?

Part 2 of the study was a critical analysis of stakeholder perspectives on reducing preventable hospital admissions.

Summary of the literature review and methodology

- The literature review focused on three key areas:
  - hospital admission avoidance studies and reviews
  - theory underpinning the study
  - approaches to change in health and social care.
- Policy literature related to the subject provided the core foundation for the study and identified five key factors to the considered:
  - the need for a whole systems approach
  - workforce factors
  - leadership
  - stakeholder management
  - evidence base to support change.
- An interpretative phenomenological approach was used with a focus group of 6 commissioning managers to elicit their experiences of commissioning and redesigning services aimed at reducing preventable hospital admissions, primarily for older people.
- Qualitative data analysis, using a thematic approach, was undertaken.
- The insider researcher role was discussed.

Summary of the analysis, key findings and discussion

The qualitative data analysis revealed seven overarching themes:

- public perceptions
- professional perceptions
- additional complexity
- awareness of services
- accessing services
- staffing and workforce
- socio-demography.

The findings were reported under these themes and a range of participants' comments included.

Public perceptions: Participants agreed the way people access and use services were key factors in how effective admission avoidance initiatives were and all recognised rising patient expectations. Why people choose to go to A&E over their GP practice and the importance of fully engaging with local communities in order to make any change or shift in local systems were considered. People's familiarity with and trust in their local hospital were discussed together with concern that patients had little information or understanding of community services as an alternative. Patients' feelings of safety in hospital were considered, particularly in relation to those nearing the end of their life. Participants agreed that rather than trying to change behaviours, current patterns should be incorporated into planning.

Professional perceptions: The engagement and motivation of healthcare professionals in reducing hospital admissions were identified as key factors. Some participants felt commitment was not always evident and possible reasons for this were discussed including: the level of risk involved with diverting patients who would routinely be admitted to hospital; lack of confidence in or knowledge of community services; lack of robust evidence that an initiative could deliver a safe and appropriate alternative to hospital admission; and an acknowledgement that much of evidence was based small or specific cohorts as opposed to fully researched new therapeutic interventions and this was a barrier when engaging clinicians in service redesign. Evidence of local effectiveness was considered the key way to influence professionals to use new services as alternatives to traditional pathways.

Additional complexity: The increasing complexity of services as they have developed and the issues this presented for patients and professionals were explored. Participants were concerned insufficient consideration was given to understanding how new services fit into current systems and existing services. A specific example was the growing complexity of urgent care systems with the introduction of walk-in centres and minor injury units. It was felt national policy risked adding to the complexity where policies may give rise to further conflict in systems; examples identified included payment mechanisms and short-term funding opportunities. The short term nature of some leadership posts was noted with the need to deliver immediate benefits as opposed to longer term changes. The need for improved planning at all levels, including mapping existing processes to determine which elements of existing practice would add value before making changes, was discussed.

Awareness of services: While linked to the complexity of systems, the lack of awareness among professionals and patients of services and what they offer, resulting in low referral rates to new schemes, were discussed as specific factors. In addition, existing services have developed for specific cohorts and future services needed to be more co-ordinated and flexible to meet the needs of complex patient groups such as older people with multiple health conditions. There was recognition of increasing attempts to inform the public about alternatives to hospital but little evidence of these communications being heard.

Accessing services: Building on the two previous themes, barriers to accessing some of the alternative services were further explored. This included some GP referral processes with an acknowledgement GPs would prefer to telephone services direct rather than completing electronic referral forms.

Staffing and workforce: Recruitment issues were identified as a key workforce factor, including difficulties providers have recruiting staff with relevant skills and experience to new services, locum GPs unfamiliar with local services, and barriers to collaborative working. The need for closer links with universities to ensure training modules were linked to current and future requirements was identified. In the shorter term, it was felt the skills and knowledge of the existing workforce could be better harnessed by staff working in a collaborative model as opposed to what was often perceived as adversarial.

Socio-demography: The final theme referred to throughout the discussion was the background of the aging population with increasingly complex health needs.

The key themes were discussed in the context of the underpinning policy analysis and theoretical texts summarised within the literature review under three main headings - complex systems, workforce and stakeholder engagement.

Summary of the conclusion

The findings underpinned current policy advocating an integrated, collaborative approach to addressing complex issues such as reducing preventable hospital admissions for older people.

While the findings reflected the evidence drawn from the literature, exploration of commissioners' specific perspectives provided greater detail of the factors which need to be considered when planning and implementing change or redesign of services - and the impact these factors have when not fully addressed.

The importance of patients and local communities' perceptions and the influence of clinicians in deriving the desired outcomes reinforced the important role of robust stakeholder involvement with these groups.

It will be important for healthcare commissioners/ leaders to ensure sufficient time and resource is allocated to this critical area in order to realise the benefits for patients alongside those required for local health and social care systems.

Summary of the analysis of stakeholder perspectives in relation to planning and implementing interventions with a view to reduce preventable hospital admissions

After discussing statutory duties for NHS commissioners in relation to public and patient involvement and defining the terms 'stakeholder', 'stakeholder engagement', 'stakeholder analysis', and 'stakeholder management', the key local stakeholders were identified and their perspectives discussed.

The local Health and Wellbeing Board (HWB): The reduction of hospital admissions for people with long term health conditions was identified as a priority by the local HWB and included in its Health and Wellbeing Strategy 2013-16. A partnership between the local authority, NHS and local people, the board's membership includes GPs, county councillors, the local Healthwatch and senior local authority officers. It is supported by an assembly of representatives of local organisations from the public, private and third sector.

Public and patient perspectives: Despite a number of local mechanisms being in place to engage local people and patients, the focus group stressed the importance of fully engaging with local communities in order to make any change or shift in local systems.

Doctors' perspectives: The study supported the importance of engagement with clinicians in planning and implementing interventions to reduce hospital admissions. Key areas were: the importance of an agreed purpose, based on evidence; communicating effectively throughout the process; and ensuring the change minimises perceived additional complexity or bureaucracy.

Wider stakeholders: Robust strategies need to be in place to ensure all groups of stakeholders were engaged in an appropriate way. Wider stakeholders were identified as staff involved in delivering new or redesigned services, funding agencies, and national bodies, in particular policy makers.

Summary of the conclusion of the analysis of stakeholder perspectives

Planning and implementing interventions to reduce preventable hospital admissions for older people requires collaborative working across many organisational, sectorial and professional boundaries. Success is dependent on robust stakeholder engagement from the initial planning of any changes.

While a wide range of stakeholders need to be involved in planning and implementing, the findings from this study identified two crucial groups - patients/local communities and clinicians, primarily GPs. The latter has both high power and high levels of stakeholding in these changes. Although patients have less power to influence strategic decisions, their patterns of service usage based on their experience and expectations can have a significant impact on the effectiveness of changes or interventions in this area.

The procurement of children's residential and foster care placements: a service evaluation

Sue Boiling and Breda Flaherty

July 2012

Key points about the background and study

At the time of writing this dissertation, the author was the manager responsible for commissioning placements for looked after children (LAC) in a local authority (LA).

The purpose of the study was to evaluate the effectiveness of framework arrangements, advocated by central government, as a commissioning intervention to secure children's placements at optimum quality and price. The aim was to use the findings to inform and influence the LA's future commissioning and procurement practice. Part 2 explored the development of a partnership with young people to enable their views and needs to be considered at every stage of the commissioning cycle.

The LA introduced a framework for independent providers of children's residential and foster care services in 2008. A primary motivation was the need to make efficiency savings of £2.2m in the placement budget.

At the time of writing, the LA had an in-house fostering service and directly provided residential care to disabled children only; all other residential services were purchased from the independent sector - mainly from the 45 (17 residential and 28 fostering) providers on the framework. Providers are awarded preferred (the highest) or accredited status.

Placements were selected via an individual placement tendering (IPT) process, considered an innovative and flexible way of procuring placements. The ability of the provider to meet the individual children's needs, rather than short term cost, was the basis of the IPT evaluation process.

83% of LAC children were placed within 20 miles of the LA boundary. Placements outside the local area were considered appropriate for some children (for example to provide necessary safety).

Ofsted's 2011 inspection of the LA concluded the 'quality of placement provision is good and there are good interagency working relationships between the LA and independent providers'.

Summary of the literature review and methodology

- A literature review was undertaken to identify what was already known about the use of frameworks, including placement choice and value for money, to procure children's care placements. While the review highlighted the contextual importance of the relationship between commissioners and providers in developing effective children's services, it indicated a lack of empirical research into the efficiency of framework arrangements within children's social care.

- An exploration of stakeholders' (all 45 providers and 7 LA team managers) experiences of the framework using qualitative and quantitative methods.

  - Stage 1: Responses to an earlier survey (2011) of these stakeholders were reviewed and re-analysed.

  - Stage 2: Semi-structured individual interviews with 6 stakeholders who represented the range of views (positive and negative) expressed in the survey.

Quantitative date obtained from stage 1 was triangulated with the qualitative findings of stage 2.

Summary of the analysis and key findings

Consideration of whether the framework approach had assisted the LA to manage the market to: increase placement choice; promote value for money and make financial savings; and improve quality. A range of respondents' comments under each of these headings was included. The findings were cross-referenced with other research findings.

Relationships

- 94% of respondents agreed or strongly agreed the working relationships between the LA and providers had improved; a number of providers were keen to highlight that individuals' approach and commitment to relational commissioning, not the framework, had the biggest impact – and further improvements could be made.

Placement choice

- 71% of the LA officers agreed placement of choice had improved while 29% indicated it had made no difference. The framework had a greater impact on increasing registered independent fostering agency (IFA) placements than on residential services. 50% of residential providers and 62% of fostering providers agreed or strongly agreed the framework had assisted them to develop services to meet the needs of the LA.

Promoting value for money and making financial savings

- The number of LAC (excluding those who have regular respite care only) had increased by 35% since the framework was introduced. The number of children placed with independent providers had increased by 127% while the spend in the independent sector had increased by 32.5%.
- The unit costs of all placements procured in the independent sector (predominantly) via the framework had decreased; for the same period direct costs of in-house foster care had risen.
- Savings amounted to at least £2.64m (which rose to £4.3m if the impact of the 2% annual corporate allowance was included).
- 84% of provider respondents identified financial stability, in the context of maintaining cost efficiencies and high quality, as one of three main challenges facing their organisations over the next one to three years.

Quality

- 86% of social workers and independent reviewing officers (IROs), and 69% of providers agreed or strongly agreed that the framework had led to

improved matching.

- 86% of social workers and IROs and 48% of providers agreed or strongly agreed the framework led to improved stability; placement stability improvements were also shown by measurement of two key national performance indicators.
- 71% of social workers and IROs and 57% of providers agreed or strongly agreed the framework led to improvements in outcomes for individual children.
- 71% of social workers and IROs agreed or strongly agreed the overall quality of care had improved while 33% assessed it had made no difference.
- The quality of care placements (as indicated by Ofsted placement data) commissioned within the independent sector for LAC by the LA surpassed those commissioned by other LAs.
- Young people, via the LA's young assessor's project (described in Part 2) indicated all the independent children's homes they had visited met the needs of LAC; 81% of residential providers exceeded the assessment standards the young people themselves had devised. Fostering provider assessments were being piloted.

The key findings were explored further in the discussion section in the context of other research findings. Key additional points included:

- Anecdotal evidence from placement officers and social workers was that prior to the introduction of the framework only one option would offered for each child; on average three options were now considered.
- Only one new residential service had opened locally, two other children's homes had refocused their services to provide semi-independent residential care, four homes had closed due to falling placements and lack of financial viability.
- Providers were reluctant to develop any service which may be under-utilised and thus specialist services – for example for children with complex disabilities – were in short supply.
- A more effective way of measuring the progress made by and outcomes for LACs must be identified.
- The longer term impact of outcomes for children and thus the life-long costs was not robustly measured and a system to do so was urgently required.

The strengths and limitations of the study - primarily the positive aspects and challenges of insider research - were explored before the conclusion and recommendations.

Summary of the conclusion and recommendations of the evaluation study

- The study found substantial evidence that the introduction of the framework had assisted the LA to increase placement choice, make financial savings and improve placement stability. The quality of care, as measured by national inspection standards and children themselves, was high and a flourishing foster care market had developed.
- The need to promote placement choice, diversify the market (by having sufficient framework providers) and using LA and provider resources efficiently must be balanced in any future framework.
- Positive relationships existed between providers and the LA to identify innovative packages of care to meet the unique needs of individual children and support more children to remain in family based foster care. This led to fewer placements being made in children's homes.
- Although residential providers refocused their services to meet some gaps in need, minimal development had occurred in this segment of the market particularly for children with the most complex needs. The framework approach did not promote financial stability or assured business. This, together with the high costs of setting up a (specialist) residential service did not encourage investment by providers.
- Accordingly, this study did not support either of the (dichotomous) views arising from research that frameworks necessarily promote or discourage the development of positive partnerships and an associated high quality, cost effective, diverse placement service.
- A framework does not change the market; it is just one of the many market management tools available to commissioners. It is the development of positive partnerships and robust communication of need that makes the biggest difference.
- Further research should be carried out to determine: the longer term impact on outcomes of placing children with complex needs in family based care via a longitudinal case study method; the relative benefits of using other complementary procurement methods (for example block contracting, joint investment) to promote the development of local specialist residential services; and how outcomes for individual children can be more robustly monitored and used to inform commissioning practice and service development.

Summary of the analysis of stakeholder perspectives

Part 2 entitled 'Children as key stakeholders – how their needs were identified and prioritised' was a critical analysis, from the perspective of children and young people, of the development, during the duration of the framework, of a partnership to enable their views and needs to be communicated and considered.

Key concepts of stakeholder theory were explored before a review of the LA's project, set up jointly by the LA and voluntary agency advocacy and participation services, to recruit, train and support former LACs as assessors of children's homes.

The young assessors, with participation workers, devised the project plan, assessment process and criteria against which they would judge the quality of care provided. Young people undertake an annual visit, and meet children in private at individual homes. At the time of writing, a similar process for fostering providers was being piloted.

An amendment to the framework contract was issued stating all providers had to maintain a satisfactory rating from the young assessors to remain a framework provider.

Summary of the conclusion of the analysis of stakeholder perspectives

A service promoting the needs of LAC and maximising their life chances would assist them to make a longer term contribution to society and thus reduce long term costs.

When the LA's framework and tender process was originally designed, consultation but not collaboration took place. Over the duration of the framework a more collaborative partnership was established, enabling the views and needs of young people to be communicated and considered in every stage of the commissioning cycle.

A case study to explore the potential and limitations of commissioning to improve the management of patients with medically unexplained symptoms in primary care

Chloe Donald and Caroline Hopper

June 2014

Key points about the background and case study

At the time of writing this dissertation on a service evaluation project, the author was a commissioner employed by a clinical commissioning group (CCG) and one of the commissioners working on the project chosen for the study.

As such, she was an insider researcher and discussed this in detail, including how the study had a direct impact on the project; the CCG might have pulled out of the project completely if the author had not already started the study and needed to remain part of the project to complete it.

The case study explored the way in which the project went about changing the management of patients with medically unexplained symptoms (MUS). Stakeholder perspectives on the CCG's prioritisation of needs underpinning the MUS project were critically analysed in Part 2.

MUSs are those which cannot be explained by a physical cause. Patients with MUS account for 10%-20% of all new consultations in primary care and many have extensive investigations, possibly with referrals to hospital specialists and treatments, to little or no avail – an unsatisfactory experience for these patients and very costly for the NHS.

The government directive for improving access to psychological therapies (IAPT) together with the 2011 mental health strategy set out the policy priorities for this improved access for a wider range of people, specifically including those with long term conditions and/or MUS.

The largest body of evidence supported the investment in psychological services as part of the treatment for MUS with cognitive behavioural therapy (CBT) in

particular often cited as an effective way of managing symptoms and reducing the frequency of medical consultations, investigations and prescriptions. There was a general acceptance general practice should play a large part in the management of these patients – and more could be done in this setting.

As part of the IAPT programme, funding was awarded for a number of projects throughout the country, including the project in the case study.

Led by local mental health commissioners in the Joint Commissioning Unit (JCU) sitting in the local authority and supported by CCG commissioners, it was a six-month pilot (from December 2011 to June 2012) aimed at improving the management of patients with MUS in primary care throughout the locality.

It aimed to do this through identification of patients with MUS in primary care, GP education on consultation styles, ensuring continuity of care, and providing the option to refer patients for specifically tailored CBT. A small financial incentive was offered to encourage practices to undertake the pilot.

Specific objectives were to improve understanding of MUS in primary care, and reduce the frequency at which patients with MUS were attending the practice and the number of referrals to secondary care and diagnostics.

On the whole the project was deemed to be successful in its objectives for the practices in the pilot. But limited uptake by practices meant it was small scale; 19 practices signed up for the pilot with 12 completing it.

The study aimed to understand and analyse underlying themes and explain the project's successes and limitations. The study focused on the commissioning process, including the context in which the project was commissioned. The objectives were to:

- explore the issues and limitations of commissioning a

project of this kind

- explore the project's success from the viewpoint of current change literature

- identify other factors within the complex healthcare system which could have had an impact

- identify and make recommendations for possible areas of improvement for commissioners conducting similar change projects.

Summary of the literature review and methodology

- The purpose of the literature review was to ascertain what knowledge, research and models already existed in this area, the outcomes of these and if there were any gaps in the field.

- The literature on MUS outlined a clear case for change with a consensus that a more holistic approach was needed which took into account social and psychological factors.

- The review encompassed: the cost of MUS; MUS best practice; psychological interventions for patients with MUS; management of these patients in primary care; measuring improvements; needs analysis; influencing change in primary care; significant models of change; the importance of a 'joined up approach' to ensure holistic care; and the radical changes to commissioning introduced as part of the NHS reforms which occurred during the case study.

- An interpretative phenomenological approach was adopted using qualitative methodology, the benefit being that it took the impact of an insider researcher capturing and interpreting the data fully into account.

- Semi-structured recorded interviews were held with 7 participants selected from two groups involved in the pilot – 5 from the project group (commissioners, service managers and practitioners) and 2 from practices.

- The data was analysed, categorised into themes and verified.

Summary of the analysis, key findings and discussion

Four main themes/categories emerged from the interviews – communication, measuring improvement, change levers and structural change – with several sub themes. A range of participants' comments were quoted in the study.

Communication

- Participants recognised the importance of commissioner-GP communication with specific comments about the mode of communication used (email) and who delivered the message/information with comments about the potential for GPs to communicate most effectively with other GPs but also communication and commissioning direction still felt 'as top down' as when it had come from managers.

Measuring improvement

- One theme identified was the importance of being able to measure and demonstrate both an initial need for change and the extent to which any initiative achieved improvement.

- The 'practice' participants agreed there was a local need for the project. The project group participants were split with some identifying that without conducting a local needs assessment it was 'difficult to say' with one identifying the project came about through 'soft intelligence, national data and a government drive' as well as there being specific funding available.

- All participants identified issues around the measures used in the project, including lack of a robust baseline, questioning the reliability of the survey data from practices and whether the evaluation was biased, lack of a clear definition of MUS, lack of any measure of patient experience, and whether the six month timescale was too short to measure behavioural change.

- Benefit was identified in the qualitative results around GPs' experiences and changing practice.

Change levers

- The importance of appealing to GPs' interests to invoke change in practice was identified, including motivational factors, the potential levers commissioners had to influence behaviour, the barriers to change and the GPs' belief in their ability to change.

Structural change

- The case study coincided with the implementation of the NHS reforms. Participants identified such issues as loss of organisational memory, shifting priorities, loss of individual working relationships, uncertain future employment and unclear lines of reporting and leadership.

- There was uncertainty how mental health commissioning linked with the CCG and lack of clarity which organisation was taking the lead and to what extent the CCG would prioritise mental health related projects.

- At an individual level, there was lack of clarity around

leadership and individual roles. The practice group felt they no longer knew who their commissioning contacts were.

- The findings were analysed and discussed in relation to relevant literature around communication, measuring improvement, change levers with a focus on GPs, and structural change.

Summary of the conclusion of the service evaluation case study

While there did appear to be a potential for improvement in the way patients with MUS were managed, it was clear national drivers and top-down initiatives were not sufficient to implement transformational change across individual GP practices. The study provided insight into the barriers commissioners can expect to encounter, demonstrating that even with great potential, without proper management change projects will not be successful. The main findings were: the importance of taking into account the differing factors which influence individuals within a population; the need for clear communication; the importance of being able to measure any successes; and the detrimental impact large scale structural change can have on projects happening at the same time.

Summary of the analysis of stakeholder perspectives

The stakeholders in the MUS project were identified and the analysis of their perspectives on the CCG's prioritisation of needs underpinning the project detailed.

CCG commissioners: The initial driving force for the project did not come from an assessment of the local population. It was not part of the CCG's strategic commissioning plan and did not go through the usual sign off process. As it was led by mental health commissioners at the JCU, there was a divide between commissioning for physical and mental health. This might have meant the CCG no longer viewed it within its remit.

JCU mental health commissioners: Although a specific needs assessment was not done, it was felt national data and anecdotal local information indicated enough of a need for change which, coupled with external funding, made the project a commissioning priority. Without similar prioritisation by the CCG, it was difficult to develop an effective collaborative approach, and there was a lack of leadership in the early stages.

The Department of Health IAPT programme: The CCG did not employ a specific clinical lead for mental health. This leadership came from the Strategic Health

Authority. The IAPT clinical lead felt the CCG did not prioritise the project highly enough and this was difficult to influence from outside the CCG.

Mental health services provider: The provider supported the project and was responsible for the specifically tailored CBT programme for patients with MUS. It was felt some prioritisation was given to the project early on but this was lost due to personnel changes.

Primary care: Although one of the central principles of the NHS reforms was to put GPs are the centre of commissioning decisions, the study found the experience at practice level still felt 'top down' as before.

Summary of the conclusion of the analysis of stakeholder perspectives

Such projects have implications for many areas of the healthcare system; they require a collaborative approach, working across organisational boundaries to achieve a common goal. This can be difficult when organisations have different levels of prioritisation.

Strong leadership is needed to bring different organisations together and form a productive working group. There needs to be clarity around the roles of the stakeholders involved and organisational leadership. A robust, local, needs assessment is key for establishing a demonstrable need for change and it is used by commissioning organisations to inform strategic priorities.

Clinical Communities: GP motivations in their decision on whether to join a clinical social networking site

Nadine Idris and Breda Flaherty

September 2014

Key points about the background and case study

At the time of writing, the Clinical Communities pilot was at an early stage of development by an NHS organisation that runs GP practices and GP walk-in centres across London. The 7 GPs interviewed for the study were either GP partners or GP leads.

The author was an outsider to the project and organisation, a role discussed in the study. Stakeholder perspectives were analysed in Part 2 of the study.

The author's starting point was the changing role of GPs in the context of the need to further develop their skills and expertise to: manage increasingly complex patients with chronic medical conditions; take a greater role in the co-ordination of care, leading multi-disciplinary teams across primary, secondary, community and social care with the aim of improving integrated care for patients.

The wider context of the continual drive towards better outcomes for patients and increased efficiency in NHS service provision was outlined in relation to harnessing the power of information technology and the internet to drive innovation, in particular the use of social media in clinical practice, described as 'somewhat of a new frontier' with a growing body of research and literature but little in the way of quantifying its impact.

Clinical Communities was developed as a social networking platform to support GPs by enabling them to crowdsource clinical support from the online clinical community; once fully operational, this would consist of specialists in secondary care, other primary care professionals, and community health and social care professionals.

It aims to improve health outcomes by improving access to advice, facilitating learning, supporting integrated working and increasing efficiency, making the best use of NHS resources.

Exploring the question 'what motivates GPs in their decision on whether to join a clinical social network such as Clinical Communities?' the study's objectives were to find out:

- why GPs would want to use a clinical social networking site
- what impact they think it could potentially have in clinical practice
- whether they have any concerns over joining; and
- make recommendations on possible areas for future research.

Summary of the literature review and methodology

- The majority of material generated from searches was qualitative in nature, including many discussion papers and some systematic reviews.
- Social media and social networking sites were defined.
- It appeared healthcare related social media fell broadly into three categories:
  - patient peer support (patient to patient interactions)
  - patient and clinician interactions
  - those strictly for clinicians.
- As Clinical Communities is for clinicians only, the

literature review focused on literature regarding social media where it concerned its use by clinicians.

- A more detailed review was conducted for closed sites including for: rates of usage; the benefits of social media in clinical practice, including around reducing GP isolation; facilitating learning and continuous professional development (CPD); improving patient care; improved access to advice; the development of new relationships; concerns over the use of social media in clinical practice; and, in the context for general practice, clinical commissioning and the primary care transformational agenda. Factors for effective learning in clinical practice were also explored.

- The study methodology was qualitative and conducted from an interpretivist phenomenological perspective; the reasons for this approach were discussed.

- 7 GPs were interviewed using semi-structured interviews to explore their perceptions of clinical social media and motivation on whether or not to join such a network.

- An interpretative phenomenological analysis method was used to analyse the results and identify themes.

Summary of the analysis, key findings and discussion

The 7 GPs interviewed were purposely selected. Three were women and four men and the number of years' experience as a doctor ranged from 10 to 28. All came from London-based practices with more than one GP employed. The findings were reported and discussed with reference to relevant literature. Participants' comments were included. The strengths of the study, including the outsider researcher role, and the limitations, including all the participants being from London and experienced professionals, were discussed.

Motivations of the GPs interviewed to join a clinical social network such as Clinical Communities included perceptions that the site:

- Would be a useful tool to support their learning and ongoing CPD:

  - one GP thought Clinical Communities could be particularly beneficial and attractive to part time doctors and those returning from maternity leave while others that it could be something of value in the mandatory GP appraisal and revalidation process and a tool to help identify the learning needs of groups of GPs

  - such views supported findings in the literature citing one of the benefits of clinical social networks

being its use as a tool to learn and its ability to make learning more ubiquitous for clinicians.

- Would enable improved access to advice and more opportunity to build relationships:

  - while all participants had opportunities to talk about clinical issues at work, team members weren't always available and there weren't the same opportunities as before to get information from people outside the practice or from specialists

  - it seemed quick access to advice and building relationships could go hand in hand and Clinical Communities had the potential to open up more effective channels of communication to a wider range of health and social care professionals than a GP could normally easily access; this in turn could assist in the development of new relationships, building trust and further improving communication.

- Would reduce GP isolation:

  - a number of participants said one of their motivations to choose to join a clinical social networking site was that as a GP 'you can feel quite isolated'

  - the type of isolation described fitted descriptions of structural isolation in the literature from spending a large amount of time alone in clinics and also showed it was not just a problem for rural GPs as other literature suggested.

- Would improve patient care and service integration

  - participants saw potential in Clinical Communities to improve patient care in a number of ways, including reducing fragmented care

  - the ability of closed clinical social network to improve patient care was found in the literature; while the GPs interviewed perceived this to be true, they uncovered a perception that such networks could be used to improve integrated care through better involvement of other health and social care professionals.

- Could enable the identification of opportunities for system change:

  - an example was given about a Pertussis vaccine alert following the death of two babies from whooping cough with the GP commenting, 'someone needs to be looking at the sort of comments posted on Clinical Communities and thinking which indicate systems issues or systems failure'

  - participants perceived wider potential benefit than that cited in the literature.

A number of concerns were expressed around dealing with conflicting advice, quality control, the volume of information GPs are already tackling, the IT skills of some GPs, the site being used incorrectly and whether the site was seen as a credible source of clinical advice, supporting findings from the literature.

Summary of the conclusion of the study

The motivations of GPs in their decision on whether to join a clinical social networking site are varied and personal to each GP in question. There are a number of concerns held by GPs which could be mitigated for once fully understood. The perceived benefits of clinical social networking sites such as Clinical Communities are more numerous and wide ranging than those benefits currently documented in the literature.

Summary of the analysis of stakeholder perspectives

Part 2 of the study discussed the definition of a stakeholder and the importance of stakeholder engagement in the complex NHS system. The stakeholders of Clinical Communities were identified with reference to the NHS Institute for Innovation and Improvement's framework.

Clinical Communities was the idea of a group of GPs based on the need to: improve communication across professional boundaries; improve access to advice for clinicians; improve health outcomes for patients; reduce unnecessary referrals; and enable GPs to treat more people in the community.

The study examined the perspectives of Clinical Communities stakeholders and their alignment with these identified needs.

GPs: Every general practice is England is part of a clinical commissioning group – organisations responsible for commissioning the vast majority of NHS services. GPs have to carefully manage conflicts of interest arising from their commissioning and provider roles. The study interviews reflected motivations to use the site from both a commissioner and provider perspective. The need to make system-wide improvements and improve service integration was expressed, as was a desire to improve their own working lives as providers with better access to specialist advice, a convenient way to further their learning and reduce the professional and structural isolation experienced in general practice. These GPs also perceived the site to be a way of improving patient care.

Hospital consultants: The input of specialist knowledge is a key driver in making it a useful and

desirable tool for GPs to use. Over 200 consultants from King's College Hospital were presented to about the Clinical Communities project and their views gathered from the ensuing discussion. Reasons given why they would be keen to engage with the project were wide-ranging, including clinical benefits to patients.

Commissioners: While early discussions were positive, a strong evidence base demonstrating the effectiveness of Clinical Communities needs to be gathered during the pilot. This would be particularly useful for commissioners when making difficult prioritisation/investment decisions.

Community healthcare and social care providers: In early discussions these stakeholders expressed a keenness to join the network as they find engaging with GPs a challenge.

Patients: At the time of writing there had been some limited engagement with patients.

Summary of the conclusion of the analysis of stakeholder perspectives

From the analysis of stakeholder perspectives there appeared to be a broad agreement on the need for and benefits of Clinical Communities.

Critical to gaining the support and input of the key stakeholders is that they are able to see that the service will provide value for them, which was apparent in all key stakeholder groups from the engagement undertaken. Part of the strong clinical support for this project could stem from the fact that it has been clinically led and borne from the experience of practicing doctors.

Commissioning a pilot 24/7 crisis response service for patients at end of life – a case study

Anne Gibbins and Caroline Hopper

August 2013

Key points about the background and case study

At the time of writing this dissertation on a service evaluation, the author was a commissioner of services within a clinical commissioning group (CCG).

With previous research experience of the critical analysis of key theories supporting the prioritisation of resources, the service evaluation was an exploration of the same theme in more depth and within the context of recent changes to the commissioning landscape - the transition from primary care trusts (PCTs) to CCGs.

The study critically appraised the commissioning of a pilot 24/7 crisis response service for patients at end of life. In particular, it considered the process used by commissioners to prioritise the use of non-recurrent opportunistic funding and the wider implications for resource allocation, and also examined specific issues pertinent to improvements to end of life care (EOLC) services and the key factors for the successful implementation and evaluation of pilot projects.

Stakeholder perspectives were critically analysed in Part 2 of the study.

Following a review of funding of EOLC services, the Department of Health invited PCTs to bid for non-recurrent opportunistic funding in 2010 to improve these services, in line with the aims of the end of life strategy.

One of the successful PCTs set up a pilot EOLC 24/7 crisis response service provided by three local hospices (with the first starting in December 2010, the second in March 2011 and the third six months later) with the stated aims of: reducing inappropriate hospital admissions at end of life; facilitating death in the place of choice; and helping patients and carers navigate the range of services.

Some quantitative evaluation of the service was included within its scope, and it was expected this analysis would be used to inform commissioning decisions on whether the pilot service would continue beyond the initial funding period.

Summary of the literature review and methodology

- A literature search and review were conducted with the following key areas:

  - reviews of EOLC in order to examine the evidence base for projects relating to EOLC service improvement and evaluation

  - pilot projects – in particular the key factors identified for successful implementation and evaluation

  - prioritisation of health care funding by commissioners.

- The service evaluation project used a case study methodology consisting of:

  - semi-structured interviews with 5 individuals who had knowledge of and involvement in the EOLC crisis response pilot project; one key limitation was the unavailability of the lead commissioner for interview

  - a knowledge, attitude and practice survey of GPs within one CCG which was a sub-set of the area covered by the service

  - analysis of the pilot service evaluation framework to evidence whether the crisis response service had met its aims and objectives; a secondary retrospective analysis of data collected during the pilot was also carried out.

- A thematic analysis of the interviews was cross-referenced with other case study material. This highlighted four key areas – how the service was commissioned, stakeholder involvement, the evaluation project outcomes, and impact of organisational changes. The role of the author as an insider researcher and how this impacted on the findings was also considered.

Summary of the analysis, key findings and discussion

GP survey

- 33 practices with 130 GPs in one CCG were contacted; the response by only 6 GPs was described by the author as 'disappointing but not surprising due to the major organisational changes taking place in the transition to CCGs.

- 5 GPs were unaware of the crisis response service and one wasn't sure.

- The poor survey response was indicative of problems experienced in communicating with GPs about the new service, both evidenced through interview and by review of the project documentation. The impact of GP involvement was discussed further in the analysis of stakeholder perspectives.

Emergent themes from interviews and project documentation review

- Themes emerging from the interviews were cross referenced against the protocol questions and the three main academic themes from the literature review (see above).

- New issues also emerged, in particular the impact of organisational change on the pilot project, decision making, leadership and responsiveness to operational and service model difficulties.

- Observations made by interviewees and the resultant themes were triangulated against evidence gained from the project evaluation reports. The resultant findings were grouped into three main areas:

  - commissioning the pilot project

  - the evaluation

  - organisation and leadership.

A range of respondents' comments under each of these areas was included.

While there was general consensus from the interviewees of a perceived gap in 24 hour availability of EOLC services, none recalled being part of a priority setting process.

- 5 interviewees gave similar responses about the purpose of the service and there was agreement it was intended not just for those patients with cancer or requiring specialist palliative care.

- Most had concerns on whether the selected service model enabled the aims to be met and how it had been derived. They felt the specification was set by commissioners based on an existing crisis service supporting dementia patients and their carers and following the perceived success of the Marie Curie delivering choice programme.

- These views were supported by the project documentation review.

- Tight timescales of the bid process and the drive to commence service delivery appeared to have been largely driven by the nature of the funding; this is likely to have impacted on the number of potential providers and the success of the pilot project.

- As service providers submitted their expressions of interest before the evaluation framework was in place, they weren't aware of the scale of the data collection that would be required.

- The final evaluation reports show that for patients who accessed the service the percentage dying at home was significantly higher than the normal population.

- Of the 458 patients who accessed the service, 401 had cancer. Most referrals were made by hospice clinical nurse specialists.

- 89% of 64 carers of patients who had used the service stated in a provider survey they felt they had received the right level of support.

- The final evaluation of the pilot project, which examined impact on cancer patients only, stated the evidence as to whether the service had significant effect on reducing hospital mortality and emergency admissions for cancer was inconclusive.

- The interviews and documentation review suggested the success of the project was impacted by organisational changes, and may have also impacted on the project outcomes.

Summary of the conclusion of the service evaluation case study

The service evaluation made recommendations for commissioners on the importance of having an explicit priority setting process, which provides a framework for future commissioning decisions, including those specific to EOLC.

Stronger links to the long term conditions agenda would potentially mainstream it and give greater weight to EOLC services. This would be particularly important due to possible changes on the future funding of EOLC arising from the then current national review and the resultant resource challenges this will bring.

Summary of the analysis of stakeholder perspectives

The specific influence of stakeholders was examined in the analysis of stakeholder perspectives. The analysis of interviews identified involvement of stakeholders as a key theme of all three areas under review – EOLC, pilot projects and commissioning prioritisation. This was also reflected in the project documentation review and potentially evidenced by the lack of response to the GP survey.

- Although proposals for a crisis response service were discussed at an EOLC conference prior to the bid, the prioritisation of potential uses of the non-recurrent funding were largely determined by commissioners; there was no evidence other stakeholders were actively engaged in that decision.

- The level of referrals to the pilot service was much lower than anticipated. The case study did not evidence any significant involvement of healthcare professionals in defining the need for the service, including wider groups of GPs, community or acute providers, who would have been expected to be the main referrers.

- Information was sent to GPs but many later reported they did not know about the service; the difficulty in emailing information to GPs was also supported by the poor response to the service evaluation case study survey.

- There was little involvement of stakeholders and by potential providers as to whether the proposed service model would actually be able to deliver the aims of the pilot project.

- There was no evidence of involvement with patients or carers to define the intended service.

- There appeared to have been insufficient involvement with other commissioners, for example urgent care commissioners, by those involved in the pilot project and its evaluation.

Summary of the conclusion of the analysis of stakeholder perspectives

The analysis suggested a lack of involvement with key stakeholders in the prioritisation of need for the crisis response service led to some of the difficulties experienced, including low referral rates, applicability of the selected service model for the target group of patients, and use of the evaluation framework.

Given the wide range of views that are likely to be held by the full range of stakeholders who have an interest in healthcare, and for the potential differing views of patients, carers and the public, it was recommended that further attention is given to this aspect of commissioning, and in particular that key stakeholders are identified and involved at early planning stages.

An explicit priority setting framework, including clear agreement on values and consideration of what is important within locally agreed criteria, would help clinical commissioning groups make difficult decisions on funding, and be less open to challenge and non-compliance.

A systematic review of surgical leadership in the operating theatre: its impact on outcomes

Sean Strong and Professor Richard Vincent
August 2011

Key points about the background and review

Studies investigating the impact of surgical leadership have been diverse in methodology and outcomes reported. Authors in this field have suggested that prior to undertaking further research, a consensus was needed on the behaviours that constitute good surgical leadership and evidence these behaviours are associated with positive outcome for patients.

The author's premise was, as this question cannot be answered by relying solely on qualitative or quantitative data, a systematic review of all studies of both types was needed.

Retrospective studies of hospital case records in the United Kingdom have shown substantial rates of injuries caused by medical errors. Such events occur most commonly in the operating theatre.

Although technical skill is undoubtedly necessary for the completion of safe operations, it is not sufficient; the analysis of errors occurring in theatre demonstrates the underlying cause is normally a failure of the non-technical aspects of performance, such as communication and leadership.

The importance of leadership for safety has been the focus of much research in high risk industries, such as energy and aviation. While the importance of leadership is also increasingly being acknowledged within health care, it has been relatively slow to develop within the speciality of surgery.

One reason for the slow development of leadership training in the surgical curriculum may lie in the lack of understanding of desirable leadership behaviours.

The aim of this review was to summarise and synthesise current evidence for generating a description of desirable surgical leadership behaviours.

The review also detailed the associations that have been made between surgical leadership and outcome measures.

Summary of the literature review and methodology

- A systematic review was conducted of studies researching surgical leadership in theatre and those into the associations made between surgical leadership and clinical outcome measures.

- Both qualitative and quantitative studies were included to gain the maximum amount of available information.

- Studies of leadership in the operating theatre fall principally into four methodologies:

  - observational – in hospital theatres and simulated operating environments with observations taking place in real time and retrospectively from video recorded material; the majority of these studies focused on the use of a behavioural rating scale which aim to develop structured, reliable and valid measures of the surgeon's non-technical skills, including leadership

  - questionnaire – used to determine both the self-reported and subordinate perceived leadership styles of surgeons and the association with patient safety; results showed significant differences between the leadership style surgeons believed they practiced and the way it was perceived by other operating room staff

- interview – structured interviews have also been used to evaluate leadership in theatre and develop models of good leadership behaviours
- mixed methods studies – qualitative and quantitative research methods were used in a study of leadership during the introduction of new technology in theatre (in the form of minimally invasive cardiac methods); the finding was that participative leadership styles led to a more rapid adoption of the new technology.
- These different methodologies and research findings were discussed in detail and summarised as:
  - the studies identified many different traits of successful leadership, with definitions of leadership in theatre that vary widely
  - a number of studies have demonstrated surgeons' leadership skills are in need of development and surgeons have inflated views of their leadership style and ability to lead an operative team
  - interventions aiming at improving team work and leadership skills have been shown to be feasible and successful
  - authors publishing in this field have suggested that prior to undertaking further research, a consensus was needed on the behaviours that constitute good surgical leadership and evidence that these behaviours are associated with positive outcome for patients.
- A key part of the systematic review designed to inform the development of this consensus was the exclusion/inclusion criteria with the latter being: empiric in nature with clear explanation of methodology; studies based in real or simulated theatre environment; and studies that evaluated surgical leadership.
- A data extraction form was generated and a descriptive overview of relevant literature was performed after grouping studies according to methodological design; details were recorded for each study, including year of publication, number of participating centres and participants, outcome measures used and statistical analysis.
- Surgical leadership definitions and leadership behaviours that emerged from the studies were grouped according to similarities, using an inductive coding technique, and group titles for these behaviours devised.
- An appraisal of the methodology of the research included in the systematic review was performed to ensure the internal validity of results.

Summary of the analysis, key findings and discussion

The initial search strategy identified 2013 potentially relevant publications; 49 full papers were reviewed following the application of inclusion criteria, of which 18 articles were eligible for detailed analysis.

Desirable leadership behaviours were grouped under four leadership themes to reflect the complexity of leadership and to acknowledge that desirable leadership changes depending on task and situation.

- Inclusive - 22 associated behaviours identified including: involves; reflects on suggestions; visible; accessible; team participation in planning; values team input; delegation of responsibilities; makes decisions promptly but explains them fully; and creates trust.
- Task orientated – 17 associated behaviours identified including: subscribes to standards; monitors compliance and intervenes if deviation; demonstrates desire to achieve high standards; prioritises tasks; allocates time; and persistence.
- Authoritative – 12 associated behaviours identified including: takes control; appropriate assertiveness; instructions and explanations provided to assistants; supervision for staff lacking familiarity with technique; and clear and universally accepted authority figure.
- Change – 11 associated behaviours identified including: inspires, motivates; coaches; provides direction, instruction and explanation; communicates rationale for change; emphasises change and innovation as a way of life.

The findings of the detailed analysis of the 18 studies were presented in a series of tables and discussed in detail under the four leadership themes identified and in the wider context of leadership theory and studies in high-risk industries such as energy production and aviation.

No articles were identified examining leadership during the performance of emergency procedures and few examined leadership as the principal focus or in isolation.

Desired leadership behaviours identified were: a need to share leadership; manage task completion; take responsibility where necessary; and lead the team when delivering change.

The review highlighted that surgeons have discrepant views of the quality of their leadership in theatre; although able to self-assess technical skills accurately, they lack the ability to accurately assess their own non-technical ability and their behaviours were consistently rated poor in comparison to other non-technical skills and to those of other theatre professionals.

The quality of leadership and teamwork in theatre has been linked with desired outcomes such as reduction in the number of procedural errors and length of operation. In the studies reviewed this was achieved by observers scoring leadership behaviours using various scales to produce a numerical leadership score. These scores were statistically correlated with outcome measures such as length of procedure.

Outcome measures reported included: procedural error rates (n=4), operative time (n=2), length of hospital stay (n=1), blood loss (n=1), task completion (n=1), postoperative complications (n=1).

Regarding the need for leadership development, the studies reviewed consistently reported that leadership scores for surgeons were low, both when compared to scores obtained by other theatre professionals and when compared to other non-technical skills. This finding was described in the review as 'not surprising considering these skills have never been the focus of surgical training' but left to 'mentoring, culture, personality and exposure to positive models'.

Suggested future research

The systematic review highlighted the need for the following:

- The evaluation of surgical leadership as the principal research focus.
- As studies of non-technical skills in theatre have tended to concentrate on observations on a limited number of elective index general surgical procedures, there is a need observe more procedures and include many more surgical sub-specialities, such as plastic, paediatric and transplant surgery.
- Leadership and other non-technical skills in emergency theatre.
- A well-designed, multi-centre, randomised controlled study investigating the effectiveness of teaching interventions aimed at improving leadership and other non-technical skills.
- More research to examine the link between leadership behaviours and team effectiveness. Studies should seek to examine hypotheses of causality, thereby allowing conclusions to be drawn on the exact leadership behaviours that enhance team performance.

Summary of the conclusion of the systematic review

Desired leadership behaviours include a need to share, to involve other theatre staff in decision making, to manage task completion, and to take responsibility for leading the team and delivering change.

Successful surgical leaders are able to adapt their behaviours accordingly, depending on the task and context.

The quality of leadership and teamwork in theatre is associated with desired outcomes such as a reduction in the number of procedural errors and the length of operation.

The leadership behaviours of surgeons were consistently rated poorly in comparison to other non- technical skills and the leadership of other theatre professionals, with numerous studies concluding that these skills are in urgent need of attention. Therefore, attention should be given to ensuring leadership training and assessment is addressed by the surgical curriculum. Studies included in the review have shown local training interventions to be successful in improving leadership skills but further work is required to inform the development of national training programmes.

Perceptions of progress and factors that influence the implementation of policy and good practice guidance in learning disability

James Kerrigan and Caroline Hopper

February 2013

Key points about the background and study

At the time of writing this dissertation the author was the commissioner for mental health services for people with learning disabilities and had a leading role in ensuring there was a range of specialist services that reflected policy and good practice. As such, his role as insider researcher was discussed in detail, including his view that, for a variety of reasons, local implementation of learning disability (LD) policy had been limited. Also reported were his subsequent actions to address some commissioning issues raised by provider participants.

The study explored the perceptions of progress on the implementation of LD policy in the author's area and a second neighbouring area, selected because of the author's familiarity with suitable participants rather than its particular suitability for comparison. However it was comparable in population size and geography and also had a two-tier local authority system.

Part 2 of the dissertation was a critical analysis of stakeholder perspectives on the prioritisation of LD policy by the then current and predecessor commissioning organisations in the local health economy (LHE).

Services for people with learning disabilities became the cause of increased concern and a specific focus of attention for the government following a media investigation and subsequent serious case review in 2012 into abuse at Winterbourne View Hospital. Similar concerns were raised following preceding investigations into LD services in Cornwall (2006) and Sutton and Merton (2007). These reports highlighted a failure to implement national policy and guidance on LD. As a consequence, the expected improvements in the quality of life and outcomes for people with learning disabilities were not achieved.

As there was limited research to explain why implementation progress had been sporadic and what factors influenced success or failure, the study was undertaken to explore perceptions of progress among commissioners and providers in the chosen areas. Additional objectives were to:

- identify factors they believed had positively or negatively influenced policy implementation in order to improve understanding and knowledge and to inform a more successful approach to policy implementation and commissioning

- compare and contrast factors in the two chosen areas

- evaluate the findings in the context of relevant theory and concepts

- highlight areas for consideration by commissioners and providers, and identify areas for further research.

Two key publications were chosen as a focus for discussion with participants:

- *Valuing People (Department of Health 2001)* described as the first national strategy specific to and focusing on all aspects of the lives of people with learning disabilities in the community which had implications for all public sector agencies.

- *The Mansell Report (Department of Health, 1993, 2007):* Services for people with learning disabilities and mental health or challenging behaviour described as good practice guidance mainly aimed at commissioners and chosen by the author because it related to both the group subjected to abuse at Winterbourne View Hospital and the category of needs the author was concerned with in his professional role. The report recommended a change in commissioning practice to transform the service and support for this specific population.

Summary of the literature review and methodology

- The literature review focused on the implementation of policy and good practice in learning disability with an additional emphasis on commissioning.

- A number of case studies of LD service developments were identified and reviewed but were found to make no reference to the factors that influenced the degree of success.

- The literature review findings suggested research into LD services, whether from a policy or service model perspective, was relatively limited; specific research on factors influencing the implementation of LD public policy and good practice guidance were even more limited.

- Only one study that looked specifically at factors influencing LD policy implementation was identified.

- The author adopted an interpretivist phenomenological approach as it enabled participants to explore and express their own views in their own words.

- Of the 9 participants, 7 were selected from the author's LHE and 2 from the second area; all were selected for their knowledge of LD policy and responsibility for policy implementation.

- The interviews were recorded and an interpretative approach to data analysis then used. Data was categorised and collated.

- Analysis focused on identifying themes, concepts and semantics.

- The study included a range of participants' comments.

- Relevant theory and concepts were discussed in relation to:

  - public sector management, specifically New Public Management (NPM)

  - commissioning and principal agent theory

  - leadership and transformational change.

Summary of the analysis, key findings and discussion

Key messages of the policy

- The key message of *Valuing People* identified by participants related to the underlying principles – rights, inclusion, choice and independence – and their application across all public services.

- Health issues, access to mainstream health services, the need for collaboration and co-operation between different agencies/departments and the importance of person-centred planning (PCP) were other key messages.

- A key theme of *Valuing People* that emerged was lack of clarity about aspects of service provision; health was one area where participants felt the policy was not sufficiently prescriptive or clear at a service level and it was also identified as an area where participants felt progress had been limited.

- Participants felt the key messages in the *Mansell Report* were primarily about practice guidance for providers on how to support people who challenge; this misconception occurred despite the clear statement in the report's introduction that the guidance focused particularly on commissioners.

Impact of the policy locally

- The majority of participants felt *Valuing People* had a significant impact on publication, that progress on its wide ranging agenda was mixed, and initial progress and impetus were not sustained – views highlighted in the follow-up publication *Valuing People Now (Department of Health 2007a)*.

- The local authority provider in the LHE viewed progress much more positively than others, while NHS colleagues in mental health viewed progress less positively than the majority.

- The integration of community teams for people with learning disability (TPLDs) and PCP were identified as key areas of improvement.

- Mental health (including mainstream) services for people with learning disability and mental health or challenging behaviour needs were identified as areas of limited progress in both study areas.

- Participants identified a range of factors that influenced the level of success or failure related to five main themes - relationships, partnerships, leadership, policy and commissioning.

Factors that hinder policy implementation

- The findings under these five main themes were explored and discussed in relation to the other research and study findings, and national policy and guidance.

- The findings were also discussed in the context of NHS reforms that changed the commissioning landscape – the transition from primary care trusts to clinical commissioning groups and the new commissioning support organisations, and the establishment of new Health and Wellbeing boards - and the financial challenge faced by the NHS and local authorities.

- Following the changes, the model of LD commissioning as a separate speciality would not be an issue going forward as this function would be subsumed into more generic commissioning support roles. The potential positive and negative effects of the commissioning changes on the LD cause were highlighted.

Summary of the conclusion and recommendations

The author concluded that commissioners should focus on: developing positive relationships; increasing partnership working and integration, especially in mental health services; improving awareness of personal leadership style; developing transformational leadership skills; and developing greater commissioning expertise.

Recommended areas for further research include: pooled budgets; leadership style and skills among LD commissioners; and success factors in areas where policy implementation has been achieved.

Summary of the analysis of stakeholder perspectives on the prioritisation of LD policy by commissioning organisations in a local health economy

Stakeholder perspectives were discussed in the context of national requirements for commissioners regarding the development of effective partnerships with local authorities and providers, and the duty to consult patients, the public and local authorities over planned service changes.

The three policy strands of NPM – privatisation, competition and restructuring – were also considered together with the priority setting process and the changes in this process following the NHS reforms.

Comments by commissioners and NHS and local authority providers were reported.

Commissioners:

- Commissioners painted an unfavourable but improving picture of the prioritisation of LD policy and health needs.
- Inadequate staffing allocated specifically to LD commissioning was thought to reflect the organisation's prioritisation of LD policy.
- Commissioners highlighted their organisation had prioritised the development of commissioning expertise across all service areas rather than LD services in particular.

- Some thought LD policy was low on the list of senior management's priorities.

NHS providers

- NHS providers did not believe commissioners prioritised the implementation of LD policy.
- There appeared to be a mismatch between commissioners' and providers' aspirations for the quality of services which was reflected in the level of resource available.
- It was implied the local commissioning process was not informed by stakeholders.

Local authority providers

- There was a prevailing sense that learning disability was 'probably pretty low down on any political agenda', with specific reference made to health inequalities highlighted in the Mencap report *Death by Indifference (2007)* and the experience of people with learning disabilities in acute hospitals.
- As with NHS providers, a lack of stakeholder engagement and analysis in local LD commissioning processes was raised.

Summary of the conclusion of the analysis of stakeholder perspectives

The key points were:

- local commissioning organisations did not prioritise the needs of people with learning disabilities effectively enough
- owing to a lack of resources and awareness of issues in acute hospitals, people with learning disabilities experienced poorer outcomes than expected
- there were mixed views on whether there was an 'improving picture' and on the impact of the NHS reforms; and
- stakeholder involvement and analysis were lacking in local LD commissioning processes.

Evaluating a 'one call' service - a case study

Alicia Mason and Caroline Hopper

February 2013

Key points about the background and case study

This was a case study of the evaluation process of a transformational change project commissioned by a primary care trust (PCT) in April 2011. The service aim was to reduce unnecessary hospital admissions. Following implementation three evaluations were undertaken - one at three months, one at six months and an external one year evaluation.

The study focused on these evaluations, reviewing whether the evaluation process was effective, when the optimum time to evaluate is, who should be involved in evaluation and what should evaluation look like. The purpose of the study was to produce recommendations for how to effectively evaluate future transformational change projects.

The case study was followed by a critical analysis of stakeholder perspectives on the prioritisation of the service by the PCT.

The transformational change project began as an innovation in healthcare in April 2011. Led by commissioners, it was supported by all the providers in the local area including the acute and community trusts, the ambulance service and social services.

The project focused on designing a service whereby GPs could phone a single point of access to admit a patient to hospital. To avoid unnecessary hospital admissions, the service also provided access to community services to help support a patient in their own home or a community bed.

Alongside the development of these services, there was also a focus on changing GPs' behaviour to try to support more patients outside of the hospital environment to be cared for at home.

Following implementation internal evaluations took place at three and six months; the one year evaluation was external. The case study critically reviewed the effectiveness, adequacy and quality of the evaluations.

Summary of the literature review and methodology

- A literature search and review were conducted in two parts - initially on all material on healthcare evaluation through the NHS evidence healthcare databases and secondly following analysis of key themes from the data collection to review relevant literature for key models.
- While the reviews found literature on how to evaluate a transformational change project as a whole, there was no specific research about the usefulness or relevance of an evaluation process, factors to consider during evaluation, or the most effective time to do an evaluation.
- The study took a case study approach, using the 'one call' project as the case. The methodology involved:
  - unstructured, recorded interviews with 6 key individuals involved in the project with the key objective to understand what they felt were the successes of the evaluation process and what needed improvement, and to see if the evaluation process had any impact through additional service improvement developed as the result of recommendations produced; a range of participants' comments was included in the analysis and key themes section
  - analysis of key documents relating to the three evaluations together with relevant PCT/CCG

board minutes and agendas from February 2011 to August 2012.

- The author's observations from January 2012 to August 2012 which were recorded in a journal.

Summary of the analysis, key findings and discussion of the evaluation process

- A clear theme was there was no consensus on the purpose of the three and six month internal evaluations, the result of which appeared to be the lack of ownership by providers of the documents, which affected their credibility.

- These two evaluations had the same aims – to review on-going performance against key objectives, highlight areas for change and summarise views of frontline staff.

- There was general consensus the three-month evaluation was not as robust as the later one as not all the services were in place.

- A key theme from the data was the level of provider involvement in the evaluations with many feeling another provider had not been as involved as they should have been – raising questions about team work and whether the relationship between providers was one of partnership or collaboration.

- Another trend was the quality and type of the data in the evaluation documents with some participants questioning partners' understanding of what they were evaluating and lack of clarity about key performance indicators (KPIs).

- Analysis showed leadership of the three and six month evaluations was weak, and participants were concerned no one person or organisation held overall responsibility for the success of the project – one of the reasons why it was felt evaluation recommendations were not implemented.

- There was a mixed response to the issue of whether an internal evaluation had equal value to an externally led evaluation. Many felt internal evaluations should be done by a member of staff who was neutral, without a vested interest in success. It was felt an external evaluator was correct for the one-year evaluation.

- Providers would have liked a greater role in the evaluation process with the majority feeling a one-to-one interview would have been useful to tease out some of the project's implementation difficulties.

- The outcome of the evaluations was not disseminated to those who had contributed. Participants stated

evaluation documents should have been discussed with all key parties and an action plan with an accountable lead agreed.

- Participants felt the transition from the PCT to a clinical commissioning group (CCG) had an impact on how the service was commissioned with a focus on partnership working and less emphasis on traditional commissioning tools, such as service specifications, KPIs and contractual measures.

- While service specifications were drafted, they had not been included in the contract with providers over a year after the project's inception.

- This lack of focused commissioning at the start meant providers did not have clear KPIs to report against and there was no clear aim that all providers understood and agreed on. This appeared to weaken the focus and validity of the evaluations in the minds of the providers.

- Identification of these key themes and data analysis was followed by the author's recommendations to consider when planning a future transformational change project to ensure an effective and robust evaluation process.

- The limitations of the study, the role of an insider researcher and further areas of study were also discussed.

Summary of the conclusion for the service evaluation case study

- Evaluation is closely aligned to the commissioning of a project, so needs to be considered when planning a project.

- Ensure projects have clear aims and performance metrics before the project inception that all partners have agreed to.

- Monitoring is favourable to evaluation early on to see if a project is on the right track. Change needs time to embed, so evaluation should be considered later on once change has occurred and all implementation has taken place, ideally a year after the project inception.

- A mixed methods approach is seen favourably for both review and evaluation. Capturing qualitative data through interviews and group sessions is key at the monitoring stage to capture perspectives early on in the change.

- The quantitative focus is important to monitor the impact of change against key performance indicators.

- Communication is important to an effective evaluation. Partners need to know what is expected

of them and to have honest conversations of what changes need to be put into place to create the best chance of project success.

Summary of the critical analysis of stakeholder perspectives on the prioritisation of the service by a primary care trust

The prioritisation of the project as a commissioned service occurred in the summer of 2010 soon after publication of the NHS White Paper on NHS reforms, including the structural change from PCTs to CCGs and legal duties regarding engagement - and at a time of financial challenge in the NHS.

Commissioners: Due to financial pressures and the PCT's savings target, the service was seen as *the* commissioning project estimated to save £3.5 million annually by avoiding unnecessary hospital admissions. A successful transformational bid was made to the Strategic Health Authority for funding for additional community posts. New clinical colleagues at the PCT wanted to develop a new collaborative way of working with provider colleagues who were brought into the prioritisation of the project at an early stage and were involved in the bid and designing the clinical model with strong clinical leadership from a GP.

Acute trust: There was also strong clinical leadership from a consultant geriatrician at the acute trust. The consultant worked closely with commissioners on developing the clinical model and was pivotal in gaining senior management support for the project.

Community trust: Community colleagues were supportive of commissioning the service as it meant additional resources, including funding for additional nursing and physiotherapy staff and to increase the number of phone lines and staff at the call centre. A community nurse was involved from the start of the project.

Social care: It was noticeable social care staff were slightly more reticent about the project than NHS colleagues. Social care was also experiencing financial pressures when the service was being commissioned and although agreed to the model of care, their input as a stakeholder was less noticeable.

Ambulance trust: While the ambulance trust signed up to the service in principle, the number of identified paramedic practitioners needed for the project could not be spared.

GPs: GPs were the target audience for the transformational change. It attempted to change GP behaviour so all admissions went through the 'one call',

and not via A&E. Some GPs were fully engaged but it was difficult to gain GP opinion as a whole, with a representative approach arguably not working effectively.

Board of the PCT/CCG: The main concern was to ensure the financial stability of the project and, along with the savings, ensure the service would also become self-sustaining.

Patients and the public: Patients were not closely involved in this prioritisation except through the patient representative on the PCT board. It was felt at the time the service was not to be directly marketed to patients and the public as a service change and therefore widespread patient opinion was not captured.

Summary of the conclusion of the analysis of stakeholder perspectives

The commissioning decisions came at a time when there was large structural change in the NHS, as well as financial pressures. This led to a new more clinically focused commissioning, where all providers saw this project as a way to achieve their financial stability. This meant the commissioning was focused heavily on the clinical model and the building of relationships, which while very effective, came at the detriment of forgetting the importance of service specifications, key performance measures, monitoring and contracts. The resultant challenges faced by commissioners through implementation and delivery were often due to the lack of these traditional commissioning tools largely absent from this process.

Stakeholders who were not consulted were patients and the public and this should be a consideration for future prioritisation in the commissioning of services.

Nurses' experiences of a large scale change process in a substance misuse service – a service evaluation

Jonathan West and Breda Flaherty

February 2014

Key points about the background and study

At the time of writing this dissertation the author was employed by a substance misuse service provided by a mental health NHS foundation trust in a unitary authority area. As such he was an insider researcher, a role discussed in the study.

The reason for the change project was concern about performance shared by the trust, local commissioners, other local service providers (third sector agencies both national and locally based) and the National Treatment Agency, a specialist health authority which became part of Public Health England in 2013.

Concerns related to the whole treatment system including service commissioning and provision. As the largest provider, the author's organisation was seen as in the most need of reform. Despite the concerns, there was also a perception that a number of service providers were committed to strong partnership working and therefore an optimistic view was held at a more strategic level.

Key performance indicators (KPIs) of concern were across a range of activities, including waiting times for treatment, assessment and delivery, retention in treatment, blood-borne virus testing and vaccination for hepatitis, and numbers of clients successfully leaving treatment in a planned way.

There was also a very high incidence of drug-related deaths combined with a very meagre programme of dispensing naloxone medications which, if used correctly, will save lives when heroin overdose occurs.

The activities were not subject to any meaningful data collection which further compounded the poor performance for commissioners and managers. Staff reported low morale due to a perceived lack of direction and poor performance despite working hard and attempts to make improvements.

It was well known across the treatment system that a re-tendering process was imminent. An increase and improvement in performance were seen as vital in this context.

The change programme – or large scale change (LSC) as the author demonstrated this was by reference to criteria for such change – began in November 2010 and was live and ongoing during the study.

With change being constant and ongoing in the NHS at national and local levels, the aims of the study were to discover how nurses experienced the LSC and how effective or not each stage was from their viewpoint, and to use the findings to inform and shape future practice and change programmes.

Summary of the literature review and methodology

- The literature and evidence base for leadership and change management covers a wide range of national and international texts spanning the private, public and third sectors. The study used the LSC definition developed and conceptualised by the NHS Institute for Innovation and Improvement, now called NHS Improving Quality.

- The review included studies and models for transformational leadership of change, contrasting transformational approaches with the more traditional 'top down' approach that some commentators believe to prevail in the NHS.

- Different methodologies were discussed and the reasons for adopting a qualitative approach explained.

- The main research method used to collect the data for analysis and discussion was that of a facilitated focus group.

- 4 semi-structured one-to-one interviews were held with nursing staff from the same cohort who qualified for the focus group to establish the topics/questions for discussion by the focus group.

- To ensure the focus group topics were linked directly to the LSC literature, the individual interview questions were taken from the Institute for Innovation and Improvement's Ten Key Principles for Large Scale Change.

- Analysis of the semi-structured interviews enabled four topics/questions for discussion by the focus group to be established. These were about the vision for the LSC, individual contributions to what was being proposed, the impact of data and audit feedback, and what would they choose if there was an option to go back to the pre-LSC situation.

- All participants in the interviews and facilitated focus group were nurses employed for the duration of the LSC from November 2010 until the then present day. 4 nurses were interviewed and 8 nurses were in the focus group, including 1 interviewee, out of a total of 16 eligible staff.

- The focus group data was analysed and this produced a number of key findings which in turn fed into the conclusion and recommendations for future consideration by leaders engaged in LSC programmes.

- The type of service evaluation was that of a formative evaluation.

- The author's role as insider researcher was discussed.

Summary of the analysis, key findings and discussion

The findings were reported under the four focus group discussion topics. Themes and their significance and relevance in relation to the literature were discussed in depth. A range of participants' comments was included.

Topic 1: How could the vision for change at the outset have been clearer or better and what would it have looked like?

- There were a number of notable themes within this topic, including discussion and comments about how the vision for change was communicated, the style in which it was delivered and how it made the participants feel (or how they remembered it).

- This was directly linked to a consensus that the style and content of the communication about the vision for change was very different – in a positive way – from what had been historically or prior to the time period under discussion – although participants could not actually recall what the specific vision was or the details of it.

- It appeared low morale, negativity and resistance to change had affected their ability to listen or take a vision seriously.

- These findings were considered significant as some key authors of LSC literature put having a clear and understood vision as an initial and key step.

Topic 2: As the change programme got underway, what was your individual contribution and did you feel that it was contributing to the change programme as a whole?

- This topic generated a number of specific discussions that reflected the two parts of the question:

  - the initial thread centred more on what participants' individual contributions had delivered rather than what the individual contribution was in particular; this gravitated around the benefits to patient care/treatment and the service as well as a reflection that the benefits meant a move away from something less useful that existed before

  - the second important theme was how the participants experienced their change in individual practice and feelings and reflections about this; one commented 'it wasn't nice realising what we'd been doing wasn't brilliant' while another described it as 'quite a stressful time', but when the facilitator asked if they thought the contribution and effort was actually contributing towards something moving forward, all replied 'yeah'.

- As with topic 1, the findings were considered significant in the context of the literature and the effect change has on staff and their feelings towards it and engagement.

Topic 3: How did having data and audit findings fed back to you impact on the change process?

- The main themes related to the participants' initial, quite negative and anxiety provoking reaction to audits being done and data improved and collected/collated and how this made them feel.

- The thread then developed into their involvement in audit and the feedback it gave them personally.

- The theme towards the end of the discussion centred on their positive attitude and opinion towards the use of audit and data at that point in contrast to their

initial thoughts and feelings.

- These findings were considered significant to LSC literature for a number of key reasons, including a key principle described as 'emergent planning and design based on monitoring progress and adapting as you go' and the link between the mind set of staff and the sustainability of LSC; the overwhelming majority of LSC programmes fail to deliver on their intended outcomes as a direct result of not engaging staff in the process.

Topic 4: If there was an option to return to how things were before, would you choose this and elaborate why?

- The final topic was considered important as the whole purpose of LSC is to ultimately succeed and this is judged by the sustainability and longevity of the programme.

- This was particularly important to the LSC as only a minimum of projects are deemed a success; one study estimated 15% achieve the goals originally set and another that only a third of pilot schemes studied had 'continued to make progress and spread'.

- Within the focus group, the main discussion was a development of why the initial response from all participants to the topic question was 'no'. The main reasons were largely around two themes
  - improved patient care
  - improvement on how they were treated and communicated with by the organisation.

- The findings were considered significant from the perspective of the literature because the reasons given for not wanting to return to how things were previously link directly with indicators for sustainability.

Overarching theme

- From the focus group data across the four topics there was a clear theme around how the participants experienced the LSC and their connection and engagement with it.

- The change from the original vision being unmemorable and evoking negative responses to an end point of having no desire to return to how things were before was described as a 'discovery process' or 'journey'.

- A similar journey or shift was apparent with attitudes to audit before, during and after involvement, moving from a compliance position to an understanding and support for audit and learning attitude.

Summary of the conclusion and recommendations

The service evaluation study broadly validated the LSC literature base. It showed staff who are engaged and committed to a LSC are inclined to believe in what is happening and sign up to it, enabling the change itself and its sustainability.

The importance of having committed staff was contrasted to having compliant staff, merely observing direction and instruction. The study illustrated that staff involved in the local LSC made the journey from one of compliance to that of being committed.

Of all the factors that helped with engagement and commitment, the study explored and validated the literature's viewpoint that involvement and ongoing monitoring were essential tools and processes. The study highlighted that audit was a key mechanism that not only acted as a neutral catalyst to get the attention of staff but also demonstrated in a very factual and scientific manner how things were at that time within the service.

It was recommended leaders should reflect and consider the LSC literature base when planning or reviewing change programmes. Part of this process should be to assess how committed staff are and to consider using audit to engage and encourage their increased commitment.

Attitudes, perceptions and behaviours of clinicians to triaging minor oral surgery referrals: an evaluation

Santosh Springer and Caroline Hopper

June 2014

Key points about the background and case study

Having implemented the case study dental referral triage service as a commissioner, the author was an insider researcher but was not employed by the primary care trust (PCT) when the interviews with clinical triagers and commissioners were undertaken. The insider researcher role was discussed in the study.

Stakeholder perspectives of a PCT's prioritisation of the needs underpinning a dental referral triage service were analysed in Part 2 of the study.

Clinical triage of minor oral surgery (MOS) is used as a commissioning intervention to manage the growing demand for publicly funded dentistry in England.

While it has the potential to reduce inappropriately created referrals, enhance patient care and manage risk, there was little evidence to demonstrate these gains had been consistently delivered across geographical boundaries and clinical specialities.

Studies indicated the success of clinical triage in managing patient flows was affected by a range of factors including service model, referral trends among primary care clinicians and the clarity of interpretation of clinical guidelines.

In 2010 a cluster of three PCTs audited MOS referrals into local acute hospitals because of waiting list challenges. These audits suggested 51% of MOS referrals into hospital did not require consultant led treatment and could be managed in primary care.

The cluster subsequently procured a dental referral triage service (RTS) to route non-urgent MOS patients to the most appropriate setting – general dental practice (GDP), the intermediate minor oral service (IMOS) or secondary care. After nine months only 2.7% of the planned number of referrals had been returned to GDPs.

As anecdotal evidence indicated clinical triage decision making was influenced by factors apart from clinical need, the study explored the impact of triagers' perspectives, attitudes and behaviour on their decision making, adding to the small but emerging evidence base in this area.

Among the objectives was to identify improvements to the design of RTSs to improve patient flows, the quality of patient care and demand management.

Summary of the literature review and methodology

The review was structured along four dominant themes: commissioning; clinical triage; clinical judgment and triage decision making; and reflexivity.

Key themes and findings included:

- clinicians have mixed attitudes and perceptions to triage

- triagers generally found referral guidelines and criteria helpful where they were clinically driven and reflective of patients' needs

- a clinician's main reference point is the skills, knowledge and insight gained during undergraduate training

- attitudes, perceptions and behaviours can be influenced through external and internal motivations, persuasive messages, dissonance reduction, positive reinforcement, introspection and object appraisal

- a clinician's decision making can be altered by rising patient expectation, guidelines, education and incentives.

The review findings were discussed in detail and also in the context of the complexity of the NHS and changes to commissioning. The study was undertaken during the transition from PCTs to GP-led clinical commissioning groups (CCGs) and the transfer of commissioning responsibility for all NHS dental services across primary, secondary and tertiary care from PCTs to NHS England.

While the review confirmed oral surgery as a subspeciality of oral and maxillofacial surgery, it did not identify a definition of MOS. For the purpose of the study the definition was formed from procedures identified by the Department of Health as suitable to be undertaken by a dentist with a specialist interest (DwSI). These procedures include routine extraction of multi-rooted erupted teeth.

The study was qualitative and a case study approach used. Semi-structured face to face interviews were undertaken with 4 dentists from the case study dental RTS and 4 commissioners responsible for a dental RTS.

A general thematic analysis was employed to identify dominant themes from the interview transcripts. The process was iterative with emerging themes from the analysis of clinical triager interviews being re-examined during analysis of commissioner transcripts.

As the commissioner lead on the RTS from conception to implementation (but no longer working for the PCT when the interviews were conducted, as participants were informed), the insider researcher discussed this role and how the study would contribute to, but not duplicate, the wider service evaluation.

Summary of the analysis, key findings and discussion

The findings and analysis were presented according to six broad categories:

Three triagers' perspectives:

- clinicians' attitudes, perceptions and behaviour to triaging MOS referrals
- triage decision making
- influencing triagers for change.

All 4 triagers were accredited by the PCT as dentists with a special interest in MOS; 3 were dentists on the General Dental Council's specialist register for oral surgery while the fourth was accredited on the basis of post qualification experience.

Three commissioner perspectives:

- models of dental RTS
- the impact of clinician attitudes, perceptions and behaviour on the performance of dental RTS

- designing a service to influence triage decision making.

The four commissioners from PCTs in the cluster had commissioned a dental referral management centre or triage and assessment service – two in rural localities and two in urban localities.

The key findings were:

- Triagers and commissioners perceived triaging dental referrals was a positive commissioning intervention.
- Triagers were confident about making clinical decisions on referral appropriateness. However their triage decisions were largely influenced by the perceived skills, competencies and confidence of clinicians undertaking work in each care setting more than by referral appropriateness.
- Triagers often did not challenge the decisions of referring dentists because they were mindful referring clinicians had seen the patients while they had not.
- The service seemed to be developed without any real incentives for triagers to return referrals to referring general dental practitioners.
- Findings show that commissioned dental referral triage services are more effective when:
  - they are consultant led
  - triagers are engaged in service improvement initiatives
  - clinicians are supported by responsive administrative and support services
  - the service model is designed in collaboration with stakeholders and providers across the referral pathway.

The findings were discussed with reference to relevant literature and the changes to the commissioning landscape of publicly funded dental care. As the review had highlighted a gap in the literature, the study was seen to have added insights to current knowledge in a number of ways.

Summary of the conclusion and recommendations of the study

Clinical triage is a complex decision making process which is influenced by the triagers' attitudes and perceptions. Commissioners need to review a range of dental referral triage service models to identify how services could be better commissioned to deliver planned efficiencies. An audit of the minor oral surgery skills in general dental practice was also recommended. This further research would provide an evidence base to support improvements in the effectiveness of dental

referral triage services as a commissioning intervention.

Summary of the analysis of stakeholder perspectives

After discussing wider issues around the prioritisation of resources to meet needs in the NHS and stakeholder analysis, the second part of the study examined stakeholder perspectives of a PCT's prioritisation of non-urgent minor oral surgery (MOS) needs, focusing specifically on its decision to commission a dental referral triage service (RTS) for a population of over 1.68 million.

Prior to this decision, there was a backlog of MOS referrals which meant the acute trust was unable to meet the 18 week referral to treatment waiting target. This triggered a strategic commissioning review of MOS service provision; clinical audits highlighted that alongside lengthy waiting times, 51% of MOS referrals into four hospitals did not need consultant-led treatment and could be managed in primary care.

Eleven stakeholder groups were identified as essential for implementing the dental RTS. These were:

- general dental practitioners
- the dental RTS and intermediate minor oral surgery service (IMOS) contract holders
- clinical triagers
- secondary care service manager and business development manager
- secondary care consultants and medical director
- PCT commissioners
- dental public health consultant
- finance director and PCT cluster board
- Oral Maxillofacial Surgery Service Improvement Group
- patients and citizens.

The perspectives of each of these groups were examined and analysed. As the commissioner who project managed the service from conception to implementation, the author had what was described as 'the unique position of an insider researcher'.

Conclusion of the analysis of stakeholder perspectives

All stakeholders in the dental RTS recognised that the existing model of MOS provision needed to change. However, each stakeholder group had specific views on the model of service delivery. Furthermore, the complexity of healthcare systems meant there were

subgroups with divergent perspectives and interests.

While commissioners had some flexibility and freedom in commissioning care, delivering patient centred healthcare was predicated on interdependence with other stakeholders.

As such commissioners needed to balance the competing interests of these stakeholders to work collaboratively across organisational boundaries to prioritise the healthcare needs of their population.

Employee engagement in an NHS trust
– an evaluation of staff views

Lorissa Page and Breda Flaherty

June 2014

Key points about the background and study

At the time of writing this dissertation the author was employed by the acute trust. Personal experience of disengagement led her to explore the subject of employee engagement and to evaluate staff views of engagement in this organisation.

The author's hypothesis was the NHS, with specific reference to her employing trust, appeared on observation to equate staff engagement to the national annual staff survey. However, the survey is sent to only 13% of the trust's workforce with a response rate in 2012 of 44%, equating to just 7% of the total workforce.

The issue of staff engagement was also introduced in the wider context of 'unprecedented change' in the NHS and high level reports and reviews calling for fundamental change in the culture of organisations to improve patient care and safety with staff engagement referenced in relation to improving and delivering better quality care and reducing attrition rates. The NHS Constitution, which includes a number of pledges to staff, was also referenced.

For the purpose of the study, the Chartered Institute of Personnel and Development's (CIPD) definition of engagement was used as a key reference point. The CIPD, with the Kingston Engagement Consortium, define employee engagement as 'being positively present during the performance of work by willingly contributing intellectual effort, experiencing positive emotions and meaningful connections to other'. The three dimensions of this are:

- intellectual engagement – thinking hard about the job and how to do it better
- affective engagement – feeling positively about doing

a good job

- social engagement – actively taking opportunities to discuss work-related improvements with others at work.

The initial focus for the study was staff views on the national annual staff survey and developed and expanded to 'what are staff views of engagement within the NHS?' Specifically participants' views were sought on the trust's engagement methods, whether these were viewed as a valid form of engagement and whether they actually wanted the trust to engage with them.

The study specifically focused on the views of managers, allied health professionals (AHPs) and administrative and clerical (A&C) staff groups described by the author as 'currently under-represented in research concerning engagement in the NHS'.

Summary of the literature review and methodology

- An extensive search was undertaken but the literature base was found to make little reference to research specifically conducted in the NHS.
- Where research had been conducted the sample often concerned doctors and nurses only, and the emphasis of research, published papers and articles tended to be policy development, organisations engaging with staff, retention and performance. Few appeared to address the issues of whether NHS staff want to be engaged or how they wish to be engaged with.
- Models of engagement were researched and a number of key themes were identified and discussed, including: organisational values; culture; leadership

and management behaviour; communication; speaking out/whistleblowing; and staff surveys.

- Several studies highlighted the 'sky high' levels of employee engagement in the John Lewis Partnership.
- Staff survey studies highlighted the importance of induction programmes for new employees, engagement, and exit surveys.
- The national, annual NHS staff survey was considered in relation to the author's organisation; the Department of Health's minimum sample size equated to 850 staff in the trust, 13% of the workforce across professions and staff groups.
- The study was qualitative and an ethnographic approach adopted. The reasons for this approach were discussed, as was the insider researcher role.
- 3 in-depth purposive interviews were conducted followed by focus group discussion:
  - participants were all from 'marginalised' staff groups – A&C, general managers, and AHPs - and were considered to be a reflection of and typical of the national NHS demographics and those local to the trust
  - during the purposive interviews, participants were asked to identify potential participants for the focus group – and given the opportunity to opt-in to this group
  - with reference to the central issues of whether NHS staff want to be engaged or how they wish to be engaged with, the literature review and a pilot interview informed the questions asked in the in-depth interviews
  - the focus group discussion was extended to allow all participants time to respond to questions.

Summary of the analysis, key findings and discussion

The data from the interviews and focus group discussion were the transcripts and the primary data gathering technique in this study. The transcripts were manually searched to determine the themes and associated quotes.

Nine key themes emerged: staff surveys; employee engagement often associated with organisational change processes; employee engagement impact on performance; people want to be engaged with but not necessarily in the way the organisation engages with them; current and recognised methods of engaging with staff; culture, values and behaviours; development; leadership and management; and efforts to engage with staff focus on certain staff groups over others.

Participants' comments were included under each of these themes with reference, where relevant, to other studies.

Staff surveys: A study referenced in the literature review highlighted the need to survey employees throughout their 'employment journey' and not rely on just one survey; this was reinforced by the participants whose comments on staff surveys were 'far from positive'.

Employee engagement often associated with organisational change processes: While there were a few references in the literature to this issue, there was no literature to argue for or against participants' comments that appeared to equate engagement with a 'veneer' of consultation on proposed changes.

Employee engagement impacts on performance: All participants upheld the view, identified in other studies, that performance was dependent upon effective employee engagement. One commented it was 'critical' and another stated 'if you do it right, then behaviour will change and performance will change as a result'.

People want to be engaged with but not necessarily in the way the organisation engages with them: Participants' comments endorsed views expressed in other studies about the critical role of management in motivating and engaging people to work towards a common goal, and how top down flows of information 'from the powerful to the less powerful' can mean that 'meaningful contributions from people may not be heard'. One said: 'I feel undervalued. Un-valued. Anonymous. Disposable. Unmissable.' Another stated: 'It should be a more bottom up thing rather than a top down.'

Current and recognised methods of engaging with staff within the organisation: Participants' comments reinforced points made in other studies that without good internal communications, there was the potential for misunderstanding. Participants identified a range of communication methods in the trust – one-to-one meetings, email, team meetings, appraisals, chief executive's weekly message, intranet/infonet, staff magazine, internal blog and informal methods, such as chats in the kitchen/around the photocopier. Comments about these methods, including mixed views about the blog and over-reliance on email, were quoted. They weren't overtly concerned with the method used to engage with them so long as it was genuine and not a one-off event.

Culture, values and behaviours: Paradoxically, while participants were all able to describe the culture and behaviours present within the trust, they did not subscribe to them. Referencing a study that suggested organisational culture was determined by behaviours and actions that are encouraged and discouraged, the author found this argument was reinforced by the participants. While a specific question, the trust's culture, values and

behaviours were frequently and freely referenced.

Development: A&C and managers identified development as a means of engaging with employees – reinforcing the findings of an online survey referenced in the literature review.

Leadership and management: Frequent reference was made by participants to management and leadership in terms of lack of management engagement, their perception of management and how they believed managers should behave and lead, and being able to challenge management thinking without fear of reprisal. Comments were linked to literature in terms of 'good enough leadership', learning to be an authentic leader, and people looking for authentic leaders who were genuine, transparent and trustworthy.

Efforts to engage with staff focus on certain staff groups over others: The focus on doctors and nurses in the relatively small amount of research on engagement within health services was the reason:

- the study specifically focused on A&C, managers and AHP staff
- participants were asked in the purposive interviews if they believed 'the organisation's effort to engage with staff focused on certain staff groups over others?'

Participants felt there was a focus on the nursing and medical workforce in the trust with admin and clerical being 'always an afterthought' and 'for the rest of us it's hard, there's less recognition of the issues'.

The findings were discussed in greater detail with further reference to the literature review results and the CIPD definition of employee engagement and the three dimensions listed above. The role of insider researcher was reviewed.

Summary of the conclusion and recommendations

Overall it could be concluded that staff are not disengaged. On the contrary, they want to be engaged with but in a meaningful way where their views are generally sought and taken on-board. The study findings indicated management within the organisation was perceived to lack authenticity, as evident in the behaviours and organisational culture described by participants.

The hypothesis appeared to have been proven by virtue of the participants' commentary and their seeming antipathy towards staff surveys and apparent lack of action from one survey year to the next.

A number of recommendations needing further investigation were made, including:

- training and coaching for all line managers and an internal programme developed with input from employees across the organisation, and training for A&C staff actively offered and communicated using a range of media
- the organisation sets a clear steer as to how all employees behave with a suggestion that 'authentic leadership' is role modelled by executive leaders
- joint work by the communications and human resources departments with regards to staff communications and engagement
- ensure the findings of the national staff survey are shared at an interactive forum to discuss action and accountability to address concerns
- a suggestion to introduce a trust specific survey of all staff.

Faecal calprotectin testing in primary care: An exploration of GPs' attitudes, beliefs and perceptions, and of factors influencing adoption

Charlotte D'Alessandro and Caroline Hopper

June 2011

Key points about the background and service evaluation project study

At the time of writing this dissertation the author was a commissioner in a primary care trust (PCT) and had participated in commissioning the faecal calprotectin (FC) test for use in primary care, working on the business case and engaging with the clinical group and public health. Her role as an insider researcher was discussed in both parts of the study.

Stakeholder perspectives were critically analysed in Part 2 of the study.

The faecal calprotectin (FC) test is a sensitive stool test that detects intestinal inflammation. It had already been in use in secondary care for a year when, in 2010, the PCT commissioned a one-year pilot service for GPs to have direct access to the test.

By commissioning this service, the PCT hoped patients whose results did not indicate organic disease (inflammatory bowel disease and cancer) would be treated in primary care, thereby reducing inappropriate referrals and unnecessary invasive intestinal imaging, such as colonoscopy or sigmoidoscopy. A financial saving would be achieved through reduced outpatient appointments. Faced with increased demand for digestive diseases acute services, local trust consultants and the service manager were supportive and actively worked with the commissioner to develop the business proposal and gain GPs' support.

While the test had not been used in primary care before, there was a growing expectation among clinicians that the test was suitable for use in this setting to allow GPs to identify those patients with inflammation who required a referral and those with irritable bowel syndrome (IBS) to be managed in primary care. The publication in 2010 of a review of calprotectin in screening out IBS by the NHS Purchasing and Supply Agency (PASA) was referenced in the study as being critical to gaining approval for use of the FC test by local GPs.

The stated significance of the study was to begin to establish the evidence-base for the use of FC testing in primary care. The aims were to explore GPs' attitudes and perceptions towards using FC testing in primary care and to establish whether using the test had altered diagnostic investigation processes.

Summary of the literature review and methodology

- The literature review encompassed a number of theoretical areas including competence, dealing with uncertainty, the role of intuition, influences upon clinical judgment, and adoption theory.
- Government policy in relation to commissioning, including the transition from PCTs to groups of GPs, was discussed together with the findings of studies on medical professionalism, clinical judgment and uncertainty, and clinical competence.
- The literature on significant models – the process of innovation and influencing clinical behaviour change – were reviewed and discussed.
- The literature review highlighted that no studies had evaluated use of the FC test in primary care so this 'pioneering study' had begun to construct a specific literature base for this topic.
- The study incorporated quantitative data (a survey) and qualitative data gathered through in-depth interviews.
  - for the survey, a web-based questionnaire with

10 questions was developed using themes and issues from the literature review; it was sent by email in March 2010 - with covering information/consent form, after being piloted - to all partner GPs, salaried GPs and locums in the PCT's area who were able to respond anonymously

- 2 in-depth interviews were held; the structure of the interview was informed by the survey and literature review

- the two sets of data were triangulated.

Summary of the analysis, key findings and discussion

The 20% survey response rate was considered 'very good' with 32 out of 160 questionnaires completed. Respondents were categorised as partner GPs, salaried GPs and locums. The level of experience was evenly proportioned across participants and GP groups. The data analysis and key themes were detailed and discussed with reference to the relevant literature. Participants' comments were included.

Adopting FC testing into routine practice

- 10% of respondents were unaware a direct access service to FC had been commissioned for GPs; further analysis showed that overall 33% of locums were unaware in comparison with 4% of partner/salaried GPs – highlighting that locums were not engaged in receiving information about local service arrangements from the PCT or practice colleagues and the need for the PCT to specifically target locums to facilitate increased change

- 60% of respondents routinely used the test as part of their diagnostic investigation process while 25% had used it but did not use it routinely; almost 16% had never used it, either through lack of awareness of its availability or a conscious decision not to use it, a decision motivated by many factors

- 86% of respondents believed the test was appropriate and useful in primary care; while 7% explicitly stated 'no' it was not appropriate, the remaining 7% were unsure.

Influence of FC testing upon forming clinical judgments

- 85% of all respondents felt using FC testing had not changed the amount they relied upon their clinical intuition for investigating IBS; 5% stated using FC testing meant they relied less upon their intuition and 10% responded they never relied upon intuition for investigating this patient cohort

- as highlighted in the literature, clinical intuition is central to medical professionalism; the study found

the extent to which participating GPs relied upon their intuition was not linked to level of experience – a finding in conflict with the existing literature base.

Reasons for usage and motivating factors

- the majority of respondents used the test to affirmatively exclude organic disease while 33% of those also used it to positively diagnose IBS and 34% to reassure their intuitive diagnosis; the findings concur with literature that GPs tend to use diagnostic tests to reassure their intuitive diagnosis

- analysis of referral data over a longer period would show how GPs' confidence in using the test changed

- the majority of respondents were motivated to use the test because it removed the diagnostic uncertainty when differentiating between ISB and IBD; other highly motivating factors included patient experience, saving money and reducing unnecessary referrals

- while there was no direct financial payment to GPs to use the test, the author stated 'GPs perceive that financial savings through commissioning will be accumulated and added into their commissioning budgets'

- factors that would encourage and motivate GPs to increase adoption of the FC test were identified as further training and educational sessions, opportunities to share experiences and feedback with peers, and more contact with secondary care; this finding supported those of other studies, including supportive partnership working with other clinicians, providers and stakeholders was more influential for GPs in changing their own practice than individual pieces of evidence or guidelines.

Summary of the conclusion and recommendations

As the literature review highlighted that no studies had evaluated use of this test in primary care, the study had begun to construct a specific literature base for this topic.

This study identified that GPs were supportive of using the test, but that clinical evidence along with opportunities for clinician-to-clinician interaction would increase adoption of the test.

Recommendations highlighted the need to show clinical evidence for using this test in primary care. Additionally, evidence was needed to show whether using the test in primary care improved appropriateness of referrals, reduced demand for specialist investigations and thereby achieved financial savings.

Summary of the analysis of stakeholder perspectives

Part 2 of the study analysed stakeholder perspectives on the PCT's prioritisation of health needs with a specific focus on the decision to commission direct access to FC testing for GPs. Commissioning was discussed with reference to government/Department of Health policies and the identification of stakeholders considered.

A national priority to move more diagnostic services into community settings was reflected by the PCT in a 2008 commissioning intention for primary care 'to support the transfer of services from hospitals to more local settings'. At the time, clinical reference groups (CRGs) were responsible for identifying and agreeing service improvements to the PCT. In 2009, the digestive diseases CRG identified the FC test pilot as a commissioning priority to address 'unmanageable levels' of demand on the acute service.

GPs: While GPs were supportive of the pilot, there were concerns about the safety of using the FC test in primary care given the lack of clinical evidence. The 2010 PASA report addressed some of their concerns. Locality meetings were used to inform GPs about the pilot and financial savings. The lead consultant actively encouraged GPs to contact the acute team for advice and refer any patients they were unsure about.

Secondary care consultants/acute service manager: The commissioning proposal was primarily driven by a 'very enthusiastic' consultant. The acute consultants and service manager actively supported the commissioner to develop the business proposal for the new service as a means of reducing referrals/demand for outpatient appointments, thereby supporting the acute service to meet the 18-week waiting target and improving access and waiting times for patients to other specialist services.

Commissioner: PASA evidence was critical to gaining the PCT's approval to commission the service. The commissioner recognised the proposed service change could satisfy both primary and secondary care wishes – allowing GPs direct access to the diagnostic test and supporting the acute trust to sustain 18 weeks which would also reduce waiting times for referred patients to other specialist acute services.

Public health consultants and the director of public health: PASA evidence was also critical to gaining public health support. Public health, secondary care consultants and commissioners worked together to define a shared clinical guideline which satisfied public health and GP concerns, providing greater clarity about which patients were suitable for the test.

Professional Executive Committee (PEC) / PCT Board: A sub-committee of the PCT, the PEC

provided strategic clinical leadership. The PEC approved commissioning the service as a one-year pilot (as recommended by public health) followed by full evaluation to inform whether the service would continue.

Pathology laboratory service manager: The engagement of the manager was considered critical in terms of receiving referrals and test requests direct from GPs, and data collection for the commissioner.

Patients and the public: Patient feedback from the acute trust expressed that increasing community-based outpatient clinics and improving access for GPs to diagnostic services were pivotal to improving the service quality and accessibility.

Summary of the conclusion of the analysis of stakeholder perspectives

As studies have shown, collaborative and partnership working across organisational boundaries and care settings can cause resistance when change initiatives are imposed, but engaging and considering stakeholder perspectives throughout is crucial to facilitate change. While stakeholders are critical in commissioning activities, strategic priorities should take precedence over conflicting provider objectives to deliver services that are both patient and outcome focused through relationships based on trust.

A study to identify the characteristics of successful wards and the relationship of ward performance to staff's experience of working on well-performing wards

Frances Usher-Smith and Breda Flaherty

February 2014

Key points about the background and study

At the time of writing this dissertation, the author was a matron within the surgical division of an acute NHS trust that had recently gained foundation trust status.

Her responsibilities included elective orthopaedics, enhanced recovery programme for both elective orthopaedics and colorectal patients combined with the care of stoma nurses. With a background in practice development, she also led on this for the division.

Research governance approval was granted by the Sussex NHS Research Consortium.

The subject of identifying well performing wards and how best practices can be shared across acute NHS trusts is of particular relevance and interest in the light of the *Francis Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Department of Health 2013)*.

Under *The Code: Standards of conduct, performance and ethics for nurses and midwives (Nursing and Midwifery Council, 2008)*, all practising nurses are required to adhere to the directive 'to provide a high standard of practice and care at all times'.

The aim of the study was to identify and generate a readily accessible 'profile index' of factors which clarify what makes a ward effective.

The study explored the relationship between performance data for a specific ward - identified in the course of the study as a 'successful' ward - and staff's experience of working on the ward with the objective of providing insight to assist in the spread and adoption of good practice approaches throughout organisations.

Summary of the literature review and methodology

- A literature search and review were conducted in the following key areas:
  - effective ward performance with particular reference to *The Darzi Report (2008)* and the Productive Ward programme to examine the principles of 'good quality care' with the methodology that may be used to measure standards within a ward
  - models to measure quality
  - leadership, in particular effective ward leadership, with reference to previous studies and reports, and complaints and inspection processes
  - studies on change management, particularly in healthcare, with reference to *The Francis Report* and other reports that highlight issues of patient safety and the impact of change on staff.
- The methodology used both quantitative and qualitative data:
  - quantitative data was gathered from anonymised trust data for 2012-2013 of key performance indicators (KPIs) suggested as a measure of success in *The Productive Ward: Releasing time to Care (NHS Institute for Innovation and Improvement 2007)* and by *Nurse Leadership: Being Nice is Not Enough, (Matron's National Network, England, Hay Group Consultancy, 2008)*
  - trust statistics sourced included those for: pressure injuries; in-patient falls; healthcare acquired infection rates; staff pay spend; staff sickness record; patient satisfaction survey rates; and complaint levels

- the study considered whether, by monitoring these using a variety of tools, areas of excellence or issues relating to poor practice could be identified promptly by the ward leader and addressed with the ward team
- qualitative data was obtained from 9 semi-structured interviews with practitioners involved with care delivery and ward leadership related to the specific ward area
- the interviewees were registered nurses (3), healthcare assistants (3), and a ward manager, matron and head of nursing.
- Analysis was undertaken in two ways – statistical analysis of the quantitative data and interpretative analysis of the qualitative interviews.
- The insider researcher role was discussed.

Summary of the analysis, key findings and discussion

Quantitative data

- The analysis of the KPIs sourced from trust data over a 12-month period demonstrated the study's specific ward area had high levels of performance and influenced the questions for the qualitative part of the study. The key findings of the data analysis were:
  - infection control audits for MRSA screening, peripheral line inspection and continued care, decontamination of clinical equipment and staff hand hygiene audits all reflected a constant rate of 100% while ward cleaning audits were consistently between 98%-100%; these results were above the trust average
  - there was one episode of C difficile infection, with no incidents of hospital catheter associated urinary tract infection or surgical wound infections in the time frame
  - there were six patient complaints over the year but patient satisfaction averaged between 85%-90%
  - nutritional screening rates to identify patients at risk of malnutrition were consistently 100% while there was a single incident of pressure injury graded at stage 2 or below
  - with regard to in-patient slips, trips or falls, there were monthly incidents of between 1 and 6 patients, which for 4 of the months were slightly above the trust average, but otherwise below those levels and none of which resulted in serious harm
  - staff who had participated in an annual appraisal and completed all mandatory training were also of

a consistently high level, above the trust average
- while staff sickness rates fluctuated over the 12 months, the pay spend budget remained within target reflecting good management of flexibility with duty rosters to accommodate the demand
- from a development perspective, assistance from matrons was sought by the ward sister and given to individuals following two incidents of nursing drug errors.

Quantitative data

- Using an interpretative phenomenological approach, the 9 semi-structured interviews with practitioners identified key themes in regard to staff experiences of working within a well performing ward. A range of participants' comments was included. Key themes were:
  - teamwork was the strongest emerging theme among staff on the ward; all were 'extremely passionate' in relation to effective team working for the benefit of patients and staff
  - while around the theme 'honest, authentic leadership and ward management', answers were flexible with mild variations, a 'nurture' model was very prominent within the discussions
  - differences in responses around the theme 'development model versus performance model' were linked by the author with the level and experience of the participant, although the ward team members focused strongly on development as opposed to performance targets
  - communication emerged as a strong theme, with 'open and honest' communication' considered to play an important part in attaining a successful outcome; all participants were 'very vocal' in how they thought communication processes should occur and the way they should be fully inclusive with clear direction given
  - all participants placed an equally passionate and important emphasis on patient feedback – from informal 'thanks' and plaudits to formal patient satisfaction surveys, including the recently introduced friends and family test; they also recognised the value of receiving and learning from complaints.

Discussion

Findings from the analysis of the quantitative and qualitative data were discussed with reference to studies and reports identified by the literature review, including *The Francis Report,* the Hay Group study, and the Productive Ward Model. The main issues discussed were:

- the ward performance data reflected a high level

of compliance with all measured KPIs which led to an appreciation by the author why this ward was considered 'well performing' by the trust; with the exception of in-patient falls, the ward was above the divisional average in aspects monitored

- this finding led to discussion during the interviews about the relationship between high performance, leadership and staff experience of working on that ward

- the interviews enabled participants to discuss what good practice meant to them and for the researcher to understand staff experiences of working within a well performing ward

- themes identified as the result of the interviews were further discussed with reference to a range of models, reports, policies and guidance, including the nursing '6Cs' (care, compassion, communication, commitment, competence and courage) model which represent the values of staff delivering high quality patient care and which had been conceptualised by the staff interviewed.

Summary of the conclusion

The study was relevant, current and significant to both national and local agendas.

The then current debate about safe staffing levels to enable teams to deliver the national agenda of meeting the public's expectations as well as performance indicators set by the government, including the issue of 'minimum' staffing levels, were discussed briefly.

The study found that the quantitative data showed high level compliance against the key performance indicators for a high performing ward.

The qualitative data showed the themes of teamwork, honest authentic leadership, the development model versus performance model, communication, and patient feedback were significant factors for staff in achieving high performance. There was an 'interesting tendency' in the data to favour a developmental approach and the author stated this warranted further investigation.

As a result of the study, the profile index the author would initially suggest would be those indicators of the current productive ward model representing both patient and staff measures as they appeared to provide a clear indication of the physical care factors with regard to aspects of patient safety.

In addition the author suggested a greater emphasis be given to the more psychological and experiential factors with regard to leadership styles exhibited, a team working approach including those of the multidisciplinary fraternity, communication methods together with delivery and finally, pertinent training and development

programmes for staff to ensure they have the right skills to deliver the right care in the right place at the right time and that this care is effectively communicated.

In what ways did a collaborative commissioning approach help the establishment of a new integrated care service?

Kenneth Gregory and Breda Flaherty

June 2013

Key points about the background and study

At the time of writing this dissertation, the author was the lead commissioner of the drugs and alcohol service in a London borough and had evaluated the impact of the integrated care service, provided by a consortium of providers. The insider researcher role was discussed.

Part 2 was a critical analysis of stakeholder perspectives of the local partnership's prioritisation of needs underpinning the collaborative commissioning process and the integrated treatment consortium.

In December 2009 a London borough initiated a service redesign process of its community-based drug and alcohol treatment services. The primary care trust (PCT) agreed to implement a collaborative commissioning process involving commissioners, service users, and statutory and voluntary sector providers.

This resulted in the integration of NHS and voluntary sector service providers into a single service. Known locally as the integrated treatment consortium, it sought to significantly reduce costs, and improve access, patient satisfaction and outcomes for service users in line with the 2010 national drug strategy. The author evaluated the impact of the integrated treatment consortium following its first year of operation (October 2010-October 2011).

The aim of the study was to:

- understand the lived experiences of participants with the commissioning process that led to the establishment of the consortium

- determine the ways in which it may have contributed towards the success of the service.

The service evaluation assessed improvements in perceived and actual performance using qualitative and quantitative methods. The evaluation illustrated 'several improvements' in performance a year after implementation of the consortium. Key themes in the evaluation guided the data collection component of the study.

The central proposition of the study was that 'a collaborative commissioning approach will lead to an enhanced and improved implementation of an integrated care service'.

Summary of the literature review and methodology

- A literature review was undertaken to identify and critically appraise the evidence base relating to: collaborative commissioning; relationship management between providers and purchasers of health and social care; stakeholder analysis within commissioning; and service user involvement in commissioning. The insider researcher role was discussed.

- In the context of the study, collaborative commissioning was defined as 'an approach in which a range of partners go through a commissioning process together, pooling needs data, joint service user engagement, service specifications based on identified needs, re-designing services, establishing collective responsibility for collective service monitoring and evaluation'.

- While the review outlined limited research in relation to commissioning and specifically collaborative commissioning, it did illustrate collaborative commissioning as a process in which commissioners,

providers and users collaborate to achieve improved outcomes.

- Integrated care followed the same principles of improving care and patient experience via a collaboration process.

- While co-production and user engagement are essential features of integration and commissioning, the literature was limited.

- An explanatory case study design was applied, informed by the previous evaluation, to gain key stakeholders' views and experiences of the collaborative commissioning approach.

- Purposive sampling was used to select participants from several agencies who had been involved in the process, ranging from those who provided leadership and direction to individuals who had attended meetings and responded to consultation.

- 9 semi-structured face to face interviews were held with managers, clinicians, commissioners and a volunteer.

- An interpretative phenomenological analysis was applied to the data using a thematic analysis approach and considered three components of the study question:

  - the collaborative commissioning process and its contribution to the development of the integrated treatment consortium

  - the definition of integrated care as described by participants

  - would a competitive tendering approach have achieved the same or similar outcomes in establishing the consortium and evidencing progress (as defined by the previous research)?

Summary of the analysis, key findings and discussion

The key themes that emerged from the interview data were: leadership; market testing; market management; re-commissioning; relationship management; engagement; and communications. The findings were reported with reference to the three study components under these themes and discussed with reference to relevant theories and studies. A range of participants' comments was included.

The collaborative commissioning process and its contribution to the development of the integrated treatment consortium:

- The leadership theme generated the most responses with the influence of the mental health trust in the development of the process being particularly

significant; while acknowledging tensions among delivery partners, an adaptive/facilitative leadership approach was suggested.

- The engagement theme outlined that all partners had an opportunity to be engaged fully in the development process; the involvement of service users was recognised as a particular strength.

- Relationship management and communication were key features of responses with communication eliciting both positive and negative responses.

The definition of integrated care as described by participants

- Participants provided various definitions but the central tenet was the delivery of integrated care pathways.

- Several participants' comments recognised there had been some improvements across the system, and a suggestion the changes had not impacted negatively on service users' progression through the service.

Would a competitive tendering approach have achieved the same or similar outcomes in establishing the consortium and evidencing progress (as defined by the previous research)?

- Market testing (procurement) as a theme was prevalent throughout the interviews. Despite varying perspectives on the element of control participants had over the collaborative process, there was a general sense of anxiety throughout the interviews in relation to the partnership initiating a competitive tendering process.

- The re-commissioning theme also illustrated some anxieties related to competitive tendering, although two participants presented a more positive view with both recognising it provided an opportunity for agencies to present their locally specific proposals.

- The market management theme highlighted aspects of vested interest in an attempt to control the local market. Respondents implicitly outlined an opportunity to control entry into the local market as a result of the collaborative commissioning exercise.

- Generally responses signified an element of self-interest or preservation within the local system but two responses also signified a suggestion that local providers had more to offer the system than new entrants to the market.

- The efficiency theme suggested that while financial savings were not the most significant issue for the participants, it was reported the budget reductions had no impact on staffing levels and capacity and service improvements were achieved in terms of performance data.

- Discussion of the findings included the issues of

competition, markets and re-commissioning. In summary the author stated: 'Despite tensions regarding aspects of the process, clear commitment was expressed to the collaborative approach and reinforced an attempt to influence local market entry by new providers'.

Summary of the conclusion and recommendations

Collaborative commissioning is an emergent process that builds on the knowledge and skills of existing providers, service users and commissioners. Control of entry to the market may be an unintended consequence and an approach that focused on client focused outcomes was not evident.

Further research was recommended on:

- service user experience in the commissioning process

- inter-organisational relationships within the commissioning process

- the impact of co-production on commissioning and development processes.

Summary of the analysis of stakeholder perspectives

Following discussion of needs assessment processes for drug and alcohol treatment services and the definition of the term 'stakeholder', the key stakeholders in the local drug and alcohol treatment system were identified.

GPs: A key milestone for the collaborative commissioning process was a GP forum when the process and service model were outlined and comments invited. General feedback on both was supportive. Further feedback was provided as part of the evaluation.

Public health: The director of public health - represented by a public health consultant - was a member of the commissioning group.

Pharmacists: As pharmacists were contracted by the CCG to deliver enhanced services for substance misusing individuals, they were invited to key stakeholder sessions to consider the proposed service model and approach.

Mental health trust – medical and non-medical staff: Senior managers and clinical leads participated in all stages of the development of the consortium, and the trust was nominated as operational and clinical lead. The trust was also the main provider. The trust team was pivotal in implementing the delivery model within the agreed timescales and worked with commissioners

to agree and realise the significant savings target in the business case.

Service users and carers: The annual service user audit was used to help determine some of the strategic priorities outlined in the business case. A series of workshops was held to ensure the service model was co-produced.

Councillors: The proposed changes were communicated to councillors via the local health overview and scrutiny committee. General feedback was positive due to the chair's specific interest in drug and alcohol treatment provision.

Voluntary sector: These providers were key contributors to the development process and re-configuration of services. While there was some anxiety about their lack of influence, the general feedback was the model and approach were the preferred choice of all the providers.

Commissioners: Local authority and primary care trust commissioners were responsible for overseeing the development process.

Criminal justice agencies: The local probation service and criminal justice intervention team were on the periphery of the process.

Summary of the conclusion

Although anxieties were expressed regarding inter-organisational relationships, the gains for all the consortium providers appeared to outweigh the disadvantages as commitment to make the process a success was evident throughout.

While collaboration was extensive, there were several key stakeholders who could have been encouraged to engage to a greater degree.

How to commission well against opportunistic funding: A case study exploring the attitudes of different levels of staff across organisational boundaries to service change brought about by small sources of opportunistic funding

Harry Whitburn and Breda Flaherty

December 2013

Key points about the background and case study

At the time of writing this dissertation the author was a commissioner in a clinical commissioning group (CCG). He came in as project officer for the case study service change part way through the commissioning cycle.

The study explored how to commission well against small sources of opportunistic funding. 'Commissioning well' was defined as commissioners using the NHS 2013 outcomes framework as a benchmark alongside key indicators suggested by The King's Fund 2013 policy paper *Ten priorities for commissioners.*

The service change examined was the move of ear microsuction from the acute trust to primary care with the aim of increasing efficiency in the trust and bringing one common aspect of ear, nose and throat (ENT) care closer to patients' homes.

Stakeholder perspectives were analysed in Part 2 of the study.

The case study explored attitudes of different levels of staff to seek to understand their thoughts, feelings and experiences and how this could help commissioners plan and implement services.

Attitudes are seen as particularly significant as attitudes of staff in monopoly provider organisations to smaller providers entering the market and taking activity from them will be invaluable as the NHS moves towards a market-based system and is useful when attempting to overcome some of the barriers at implementation, as well as motivating staff during periods of change.

The study used mixed methods:

- the explanatory case study method
- 5 semi-structured interviews to explore attitudes of staff in different parts of the system and at different levels of seniority
- quantitative data analysis was used to test and corroborate interviewees' accounts, based on numerical data in service progress reports.

The author stated the study was 'not so much about the service shift as about the commissioning conversations with providers about the use of the small opportunistic funding pot' and stated there were two main outcomes to be explored – 'what can be learnt for the commissioning process and what can be learnt for commissioners?'

Summary of the literature review and methodology

- A literature search and review were conducted with the following key areas:
  - commissioning and organisational change, including guidance and policy about commissioning services closer to people's homes and patient-centred care; commissioning models; the forces shaping market strategy; and the difficulty some providers like GP practices often face in trying to enter monopoly markets
  - guidelines for the location of ENT services including ear microsuction, which can be safely provided in primary care as it treats common ear conditions such as otitis externa and earwax;

- research methodology.
- Semi-structured interviews with 5 stakeholders - a director of the commissioning organisation; 2 practice managers (1 instead of a GP in the same practice who terminated the interview at an early stage), a commissioning manager; and a junior sister in the acute trust - with the core questions taken from the emerging themes in the literature review.
- Numerical data in service progress reports - from April 2012 to March 2013 – used where relevant to test and corroborate the accounts of participants.
- The roles of the author as a commissioner involved in the service change and as an insider researcher were discussed with reference to other research.

Summary of the analysis, key findings and discussion of the case study

The findings included insights on: the effects of the existing pattern and model of health care provision; following phases of the commissioning cycle; the need for staff at all levels and across organisational boundaries to feed into a collective knowledge base; and the effects of setting up small services with small funding sources on demand at major acute trusts.

Emergent themes from the interviews and literature review

- Central themes in the research were change management, market strategy, vision, timescale pressures, transparency and openness, and outcomes.
- A range of interviewees' comments under each of these themes was included.
- Quantitative data was used where relevant to add a dimension to the analysis.

Change management

- Interviews with lower levels of staff suggested a feeling of lack of control and influence to make a change. A recurring theme within this was the drive and energy to make a change and the related issues of timescale pressures and the small windows of time within which small pots of money must be spent.
- How to motivate clinicians and managers to be more creative within the structure and framework came up as an issue with staff across the system together with a feeling of frustration with the level of bureaucracy as a barrier to motivation. It also emerged an emphasis on 'keeping costs down' often impacts on motivation.
- Participants seemed unanimous in their opinion that little difference was made to the system through this type of small scale change.

Market strategy

- Both practice managers alluded to the time spent setting up services and clinical time delivering them - and questioned whether this was worth it for the size of the service and potential income.
- These views were not shared by commissioning staff when thinking about taking activity out of the acute provider.
- There appears to be a balance to be struck between serving the interests of the organisation in bringing care closer to home while driving up quality and value for money, and making sure service change was not going to de-stabilise the acute sector.
- Quantitative data of microsuction carried out in GP practices and in the acute trust in one year showed GP referrals were still largely going to the trust.

Vision

- The director endorsed the view of vision as a central component of leadership, and emphasised the importance of linking the use of opportunistic funding to priorities, such as bringing care closer to home.
- However, a manager of a host practice suggested this was not always what patients wanted and described 'the small pocket of resistance' about the service shift and patients' complaints.
- It was suggested that systematic ways of feeding patient experience into the commissioning intentions by GPs would help to minimise and mitigate such dissatisfaction.

Timescale pressures

- The process followed almost the reverse of the usual commissioning cycle of planning and mapping out each stage with the money needing to the spent and benefits realised by the end of the financial year.
- Transparency and openness
- It was very difficult to involve every GP in every practice and some GPs were unintentionally affected in a negative way.

Outcomes

- While improved access was highlighted, data showed only whether the desired outcome for the organisation was achieved (value for money and cost savings), not the quality of the service from the patient perspective.

Summary of the case study conclusion

The findings included insights on: the effects of the existing pattern and model of health care provision; following phases of the commissioning cycle; the need

for staff at all levels and across organisational boundaries to feed into a collective knowledge base; the effects of setting up small services with small funding sources on demand at major acute trusts.

Recommendations included: further research into this important area of funding to help commissioners and providers potentially achieve better outcomes from opportunistic funding sources and building relationships across organisational boundaries early in the commissioning process.

Summary of the analysis of stakeholder perspectives

In shifting the ear microsuction service from the acute trust to primary care, attention had to be given to all stakeholders affected by the change, including GPs, the ENT department, patients and the public, audiology services and commissioners.

Planning took place as the primary care trust was preparing to become a CCG.

Acute trust staff were asked about their level of support. A patient survey was placed in the ENT ward. GPs' views were canvassed about how they wished a small pot of funding to be used and, later in the planning process, via GP locality and cluster meetings. CCG director involvement came at the point of approving the business case.

GPs

Those involved in the service were keen to start as quickly as possible. Other GPs were by and large in favour of the service shift; a few wanted assurances about the training GPs had received.

ENT department

Staff saw the service change as a way of helping them meet the 18-week waiting time target by freeing up space in their clinics. However, there was concern GPs would not be skilled enough if they found a problem behind the wax, and junior staff expressed a feeling of powerlessness.

Patients and the public

The ENT patient survey suggested patients would welcome a service closer to home but there were anxieties about GPs' qualifications.

Audiology: Conversations with local audiologists proved very useful, not just in relation to the microsuction service but also for other issues which were addressed.

Commissioning and finance managers and PCT/CCG directors

These were the agents of the change. The

commissioners, in conjunction with the operational forum acting as the clinically represented decision-making body of the new CCG, agreed the service change would improve the patient experience by providing a service closer to home and it had the potential to reduce outpatient attendances, thus saving money and contributing to shorter waiting times at the acute trust.

Summary of the conclusion of the analysis of stakeholder perspectives

Understanding the views of different stakeholders is an integral part of introducing service change. In a large and complex organisation, such as the NHS, it can be difficult to ensure all stakeholders are heard.

However this case study showed that opening up the dialogue can help confirm the proposed change is in line with organisational priorities and also help guide staff through the change on a more personal level. Many argue an organisation's effectiveness is driven by a strong culture born from group identities. Agents of service change can only hope to achieve this organisational effectiveness if they understand these group identities involved in the change.

Postscript: Some student reflections on the impact of the Masters course

Feedback from students who have completed the Masters course on leadership and commissioning of health and social care evaluates their experience highly. This reflects the significant impact of their studies both on their professional development and benefit to their sponsor organisations.

The MSc course enables those tasked with planning, commissioning and providing health and social care to make sense of the many complex changes they are experiencing. This was summed up by one student who described the course as:

'Grounding theories and ideas in practice and government policy. It also provided a practical and flexible learning environment which allowed freedom to explore issues fully.'

The student commented how the course had:

'A very positive impact on my career. The teaching and qualification are recognised and respected and students who make the commitment will get a lot out of it.'

The course is appropriate for people working in health and social care for the first time as well as those with some years' experience. One student who started the course at the same time as starting work for the NHS reflected:

'The programme has had a profoundly positive influence on my professional development. The tools and knowledge I gained from the very start have helped me considerably both in ability and confidence. The Masters was specifically in commissioning, but a strong focus on leadership and change management has meant that it has been transferable and highly relevant to my role now as an operational manager in an acute hospital. We are working in a time where services need to be ever evolving and improving and I think I have been able to use the knowledge and skills learnt in this programme in my day to day work to implement real and hopefully sustainable service improvements.'

A student already working as a commissioner commented that the course:

'Developed my ability to critically analyse commissioning processes and interventions. The rigour of postgraduate study and the design of the BSMS programme improved my confidence and ability to persuade and negotiate for change with board level stakeholders. These skills enabled me to progress my career within the NHS.'

Another student, whose dissertation was on a significant service change, described having the Masters as:

'Really useful for my professional development, especially as my organisation is committed to improving staff engagement and changing its culture to address and embed learning. The dissertation deals directly with these issues as well as large scale change which provides me with credibility and some level of authority in my role within leadership.'