Leading change in clinical practice
Empowering front line staff to lead change.

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

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ABSTRACT

This practice-based study investigates the implications for NHS leadership, leadership development and organisation development of the current government's vision of the future NHS as set out in the NHS Improvement Plan (2004). The study is based on two projects; an in-depth organisation development programme located in a high security mental health hospital and a pilot project on the future role of leadership carried out on behalf of the five Strategic Health Authorities in London.

The research paradigm is that of naturalistic inquiry using action research and a single case method involving participant observation. Focus groups and a modified Delphi-consultation are used to elicit views about future leadership roles and competences. The two-project design was developed to address the range of leadership roles to be explored, the interplay between leadership development and organisation development and the need to understand both current realities and future developments.

The study concludes that successful realisation of the vision set out in the NHS Improvement Plan will require a re-conceptualisation of the roles and competences of both organisational leaders and leaders working at the interface with service users. The study suggests that organisational leaders will need to become adept at shaping the cultures and practices of organisations and systems of organisations (enabling leadership) whereas leaders working at the interface with service users will need to become adept at case management. The study also suggests that leadership development and organisation development need to be closely integrated if either is to make a worthwhile contribution to the development of the NHS.

Finally, the study suggest that success in past or current leadership roles in the NHS is likely to be a poor predictor of future success as the leadership requirements of the future will be significantly different from those which prevail currently or which have prevailed in the recent past.

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ACKNOWLEDGEMENTS

This study and the two projects on which it is based are essentially collaborative efforts. Nothing worthwhile would have been written and, more importantly, no change would have taken place without the contribution of many other people.

I would particularly like to acknowledge the following:

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Dr. Julie Hollyman who inspired me to get involved again with organisation development in the NHS at a point in my life at which I had decided that I was wasting my time trying to fix a "basket case".

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All the NHS staff and patients whose stories are the real data on which this study is based.

Finally and perhaps oddly, the Secretary of State for Health who, in the NHS Improvement Plan, has produced a genuinely aspirational vision.

PREFACE

This project report is written to offer evidence that I have "*integrated (my) learning and experience into cohesive work that makes a significant contribution to (*my*) professional and/or organisational development"* (Programme Handbook, p50) and that I have the capabilities detailed in the level 5 criteria.

It draws on my learning and experience as an organisation development practitioner who has worked with the National Health Service for some fifteen years. More particularly, it draws on my learning from three earlier organisation development projects which have been accredited as part of my programme of study:

- Rhetoric and Reality – developing culturally sensitive practices in health visiting.

- Transdisciplinary practice – a patient-centred model of practice in neurological rehabilitation.

- Exploring Clinical Practice – eliciting the educational implications of new models of care for a range of client groups.

A summary of each of these projects is included in Appendix G.

I have also drawn upon the Expert Seminars (Module 5001) provided as part of this programme of study and upon post-graduate work undertaken at Bath University on action research and action learning.

This report is based on two projects which I have undertaken in the course of my practice and which, taken together, have enabled me to explore the factors which influence the ability of front line staff in the NHS to lead change effectively. One of the projects is an in-depth case study situated in a high security mental health hospital; the other seeks to develop a consensus view of the likely context of leadership and change in the NHS in the near to medium future. The case study has employed both

ethnographic approaches, primarily participant observation, and action research interventions. Figure 1 (below) summarises the relationships between the components of my work.

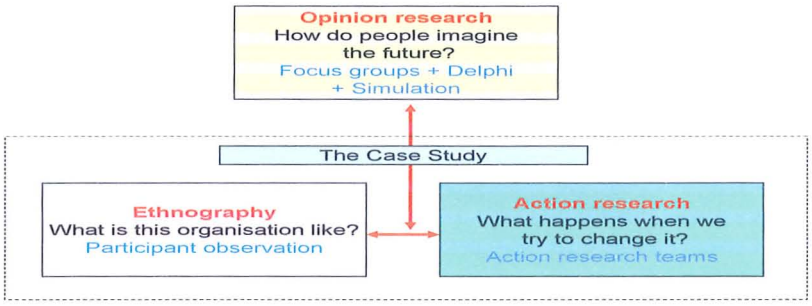

Figure 1 Components of research strategy

My rationale for drawing upon two distinct pieces of work is that the nature of leadership work and change management needs to be considered in the wider strategic and political context in which it will be undertaken. As this project and my practice more generally is about building bridges into the future, I felt it necessary to attempt to form a view of what that future might look like.

In terms of the Level 5 descriptors, this project has considerably widened my understanding of ethical issues both in terms of research ethics but also in a consideration of wider ethical issues surrounding treatment of patients who are compulsorily detained in a high security setting. The project was carried out under the delegated authority of the Chief Executive of the NHS Trust involved who determined, after consultation with her own advisors, that the project did not require consideration by the Local Research Ethics Committee (see Appendix E). I have also discussed with my academic advisors the idea that the Research Governance Framework for Health and Social Care is not always a sufficient or appropriate model for research which is embedded in practice and I have proposed a different framework. This issue is discussed in some detail in Chapter 3 and a working paper on ethics and practice-based research is included in Appendix E. The project interprets existing knowledge in the fields of leadership and organisational change and suggests that to meet the aspirations set out in the NHS Improvement Plan (2004)

there needs to be a radical shift in how the NHS thinks about leadership and change both at the level of the whole organisation and at the interface between the health and social care system and the individual consumer.

The development and management of the two projects which underpin this work have demanded high levels of professional skill and knowledge and have required me to deal with many complex and unpredictable situations. The projects are inherently collaborative and have required the effective use of human, technical and financial resources.

A number of products have been generated in the course of this work designed to communicate its outcomes to audiences including the Chief Executive of the NHS and the Chief Executives and Directors of organisations within the NHS. Other products have been designed to communicate with Primary Nurses and with Health Care Assistants. I anticipate developing other forms of communication including articles for peer-reviewed journals.

This report draws together many of my own reflections and insights about my practice during the course of two projects which I have found intellectually and emotionally challenging. I find some grounds for cautious optimism in the feedback which I have received from my professional peers and, more importantly, from the changes in practice which are already taking place both at the clinical interface and nationally in approaches to career management and leadership development.

INTRODUCTION

The focus of this project

This project is concerned with leadership development and organisational development in the National Health Service (NHS) in England. The findings suggest that the behaviours and practices of leaders at all levels within organisations are important determinants of organisational success. The findings also suggest that the tasks facing leaders in the NHS in the future will be significantly different from those which have applied in the recent past. This change is a result both of the political context of the NHS and of wider social trends such as consumerism. Finally, the findings suggest that the development of individual leaders should be closely integrated with the development of the organisations in which they practice.

The research strategy

As indicated in the preface, this study draws on data from two separate projects which I was leading; an organisation development project in a high security mental health hospital (the case study) and a pilot project for the NHS Leadership Centre to inform career development and succession planning in the NHS. The case study enabled me to explore issues of leadership and change in a real world operational setting whilst the career development work enabled me to explore these issues from a strategic and conceptual perspective. I believe that the combination of the two projects provides a richer and more robust set of outcomes than would have been achieved by either alone.

The Case Study

The high security mental health hospital in which the case study is set forms part of one of the largest mental health Trusts in the NHS in England. The role of the hospital is to provide care and treatment in secure conditions for patients who are considered to represent a "grave and immediate danger to the public" (Statement of Purpose). It has 16 wards for male patients and 5 wards for female patients providing

accommodation for approximately 360 patients in total. The average length of stay is about nine years. All patients are compulsorily detained.

Although an integral part of the NHS, the hospital has to conform to standards set by the Home Office and HM Prison Service. It is surrounded by a high perimeter wall, has an elaborate closed circuit television monitoring system and a thorough search regime for patients, staff and visitors. Despite these precautions, staff and patients are exposed to violent assaults sometimes resulting in death and the risks of self-harm and suicides are high.

The hospital is best considered as a hybrid of a hospital and a prison. The organisational culture is, therefore, extremely complex; for example, some nursing staff belong to the Royal College of Nursing whereas others choose to belong to the Prison Officers' Association; both bodies are recognised for negotiation and representation. This study explores in some depth the tensions experienced by staff between their therapeutic roles and their custodial roles.

The unusually prolonged length of stay can lead to an attitude of "warehousing" rather than actively treating patients; simply containing risk rather than promoting improvements in the mental and physical health of the patients. One of our goals in the organisation development project in which we were engaged was to reduce the average length of stay by implementing a regime of "assertive rehabilitation".

The prolonged length of stay of patients is mirrored by an unusually (for the NHS) stable work force which is also characterised by marriages and civil partnerships between staff members and parents and their adult children being members of the workforce. The reasons for this unusual workforce stability are explored in Chapter Four of this report.

The combination of a relatively enduring patient population and a relatively enduring staff population leads to a high degree of institutionalisation and the evolution of a co-existence between the two populations; a shared *modus vivendi*. This stability presents significant challenges both to new staff joining the organisation who are under considerable pressure to conform to the prevailing cultural norms and to the

organisation development practitioner or change agent who encounters a strong network of norms and relationships which holds the status quo in place. It is important to recognise that a strong staff culture is essential in this organisational setting; it is a potentially dangerous place and staff do need to depend on each other for their safety.

Two other features of the organisation are worth highlighting from an organisation development and leadership of change perspective. Firstly, things do not happen quickly in this hospital; the leisurely pace of the patient journey tends to be mirrored in (or possibly cause) an expectation that everything else will be leisurely. For example, patients waiting for two years for psychotherapy is not seen as an unacceptable situation. Decision-making, other than in response to a threat to staff or patient safety, is slow and tortuous.

Secondly, it is a very rule-bound institution with elaborate policies and procedures, particularly in connection with safety and security, which leave little room for interpretation or the exercise of discretion. This study suggests that the rule bound nature of the organisation presents particular challenges to the practice of rehabilitation which needs to be individually tailored, responsive and to some degree opportunistic.

This study explores the paradox between the rule-bound nature of the custodial face of the organisation and the more chaotic approach to patient treatment. I suggest, in Chapter Four, that this apparent paradox can be understood in terms of complexity theory.

The case study organisation is, therefore, a strange place but one which, I argue, exemplifies many of the organisational and leadership issues which confront the wider NHS.

The Career Development Project

The career development project sets out to explore the changing role of leaders and leadership in the National Health Service (NHS); one of the largest, most complex and most heterogeneous organisations in the world. It takes place at a time at which there is a clear political intent to "reform" the NHS and specifically to transform it into a modern 21st century service organisation which is both "national and personal" (NHS Improvement Plan, June 2004, p4)

This political intent is reinforced and complemented by wider social changes such as the growth of consumerism, wider access to once privileged information through resources such as the Internet, legislative changes such as the European Working Time Directive (European Community, 1993), challenges to respect for "professionals", media coverage of singular events such as the "Harold Shipman case" (Taylor, 2004) and radical changes in the scientific and technological base of health care such as advances in genetics and in imaging.

Thus the project is addressing issues of how we identify and develop leaders capable both of leading radical transformation and of operating successfully in a world of work which will be very different from that which currently exists. An associated problem is how we enable leaders to survive in the transitional period during which they are expected both to both to deliver on a challenging short-term agenda in terms of concrete measurables (such as waiting times) and to deliver long-term transformational change.

About the NHS

The NHS, founded in 1948, is the largest employer in Europe, employing over a million people. It currently consumes 6.8% of GDP and the current government plans to increase the proportion of GDP spent by the NHS to 8% by 2006. The performance of the NHS directly affects most[1] citizens of and visitors to the UK each year.

[1] There are over 300 million consultations in primary care annually. About 5.5. million people are admitted to hospital for planned treatment annually and there are 13.3 million out-patient consultations

Indirectly through its role in public health, it affects every citizen and visitor to the UK. The average spending per head of the population by the NHS is currently £1,345 (Source NHS Improvement Plan 2004, p 8). The NHS is a politically sensitive area. Opinion polls[2] suggest that it is a key issue influencing voting intentions. Elections in particular constituencies such as Kidderminster[3] have been won or lost entirely on issues to do with the NHS.

Since the general election of May, 1997, the government has been pursuing an ambitious policy of reform and investment in the NHS. The evolving policy has been set out in a number of key documents (The NHS Plan, Shifting the Balance of Power, The NHS Improvement Plan) and in a series of Acts of Parliament[4].

Reform of the NHS may also be seen in the wider context of the public service reform agenda (OPSR, 2002).Although many of the issues touched upon in this project apply to the NHS throughout the UK, I have focussed upon the NHS in England. Since 1998, the NHS in Scotland and the NHS in Wales have become the responsibility of those assemblies. The NHS in Northern Ireland is the responsibility of the Northern Ireland Assembly (currently in suspension). The devolution of responsibility for the NHS to local assemblies makes it unsafe to generalise from work in the NHS in England to other areas of the UK.

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each year. In 2003, 13.9 million people attended A&E. (Source The NHS Improvement Plan, 2004, p 64)

[2] Mori September, 2003 – identified as a key issue by 62% of respondents followed by education with 53%

[3] See The Observer of 1st April, 2001

[4] National Health Service (Primary Care) Act 1997, National Health Service (Private Finance) Act (1997), Health Act (1999), Health and Social Care Act (2001), Care Standards Act (2000), National Health Service Reform and Health Care Professions Act (2002), Health and Social Care (Community Health and Standards) Act (2003), Community Care (Delayed Discharges etc.) Act (2003), Health Protection Agency Act (2004), Carers (Equal Opportunities) Act (2004).

The social and political context

Although I believe that policy for the NHS in England is not entirely coherent and contains within it a number of contradictions, I think that a number of major policy themes can be detected:

Expectations

The general public and people using the NHS in particular, increasingly expect to be treated as "customers" rather than patients.

Market forces

A belief by the government that market forces, particularly competition, are a potent force for driving up the efficiency and effectiveness of public sector organisations.

Local accountability

Increasing disillusionment with the central command and control and micromanagement which characterised the first five years of the current government and a move towards more autonomy for health service organisations with some element of local accountability.

Other important contextual features include advances in medical technology, labour market pressures, the impact of European legislation, particularly the Working Time Directive (1993), trends towards a more litigious society and changing patterns of health and health-care need exemplified by current concerns about obesity.

The policy framework for the NHS in England over the period 2004 to 2008 is set out in The NHS Improvement Plan – "Putting People at the Heart of Public Services" (DH, June 2004). The vision set out in this document is summarised in the following extract:

> "*Our vision is one where the founding principles underlying the NHS are given modern meaning and relevance in the context of people's increasing ambitions and expectations of their public services.*
>
> *An NHS which is fair to all of us and personal to each of us by offering everyone the same access to, and the power to choose from, a wide range of services of high quality, based on clinical need, not ability to pay." (P6)*

The main themes of this project

This research suggests that, given the political and social context summarised above, NHS organisations and their leaders are faced with a number of important and difficult challenges:

- Creating a responsive and customer-focussed culture.
- Succeeding in a competitive environment.
- Delivering satisfactory patient experiences and outcomes across the whole health and social care system.

Through the project, I have explored the implications for leadership development and for organisational development of the novel challenges described above and proposed a number of practical stratagems which could be employed to help NHS organisations and their leaders to prepare for and to respond to the novel challenges. Some of the suggested stratagems have been embodied in particular products of the project.

I have reached the conclusion that, taken together, the changes in the context of the NHS and the novel challenges which are presented constitute a fundamental shift in the nature of the NHS and consequently in the nature and focus of leadership within NHS organisations. This fundamental change could be summarised as a change from the NHS as a state bureaucracy and monopolistic provider to that of a (largely) state funded ***service industry*** driven by consumer demands and competitive pressure rather than by producer interests. Arguably it constitutes a fundamental reinvention of or replacement for the "welfare state" of the 1940's.

I have also reached the conclusion that the leadership values, behaviours and practices which have been thought appropriate for the NHS to date will not be appropriate for a consumer-focussed NHS or wider health and social care system. Thus we may need to re-think how we develop leaders for the NHS and re-think too, how we develop organisations within the NHS.

The title of the project "*Leading Change in Clinical practice: Empowering front line staff to lead change*", reflects my belief that the success or otherwise of NHS leadership and organisation development must ultimately be judged by what goes on at the interface between the health and social care system and the individual citizen.

Personal relevance of the project

I am an independent organisation development practitioner whose field of practice is predominantly the NHS. I am closely involved in leadership development for the NHS in London as Professional Adviser to Leadership London[5]; a forum for addressing strategic leadership issues in the NHS in London. I lead major organisation development projects within the NHS such as that which constitutes part of this project. The project is, therefore, central to my field of practice and the issues addressed in this project constitute a major element of my current practice. As an independent practitioner but one who works almost exclusively with the NHS, I occupy an interesting and, at times, problematic, position on the insider:outsider

[5] Leadership London was established by the (then) London Regional Office to lead leadership development in the NHS on a pan-London basis. In 2004, it became a strategic forum for debating leadership issues across London but without a formal commissioning role. The author is professional adviser to Leadership London.

spectrum; this report offers some reflections on the concept of "insider-ness" in the contexts of both research and practice.

Methodological approach

The research strategy which is described fully in Chapter 3 is set in the paradigm of *natural enquiry* (Erlandson et al., 1993) and is embedded in my organisation development practice. In developing a research strategy, I found that no single methodological approach would adequately address the research questions which I had formulated and which are set out in Chapter 2. As I am concerned with leadership *at all levels*, I used a single case study design to investigate leadership at the interface with the consumer and a combination of focus group and modified Delphi technique to investigate organisational and system leadership. Similarly, because I wished to investigate the interplay between leadership and organisation development, I used the single case method to investigate how these two domains interact in practice in a living organisation.

Because the project is practice-based real world research, the project is situated primarily in the traditions of action research (Lewin, 1946) and process research (Pettigrew, 1990, 1997). A single case method (Yin, 2003) has been used to explore issues of leadership and organisation development in a particular organisation and other methods such as Focus Groups (Morgan, 1997) have been used to investigate future leadership and organisational change requirements.

The practitioner researcher, of course, has to use the work situations which are available at a particular time to plan and undertake the research enterprise. Similarly, he or she has to plan the enterprise in a way which will both deliver useful and credible research outcomes ***and*** the practical real world changes which his/her client demands. I have been particularly fortunate to be able to draw upon a complex and extensive organisation development project in a high security forensic mental health setting for my single case study and upon a pilot project to investigate career management and succession planning across London in the light of the aspirations set out in the NHS Improvement Plan (2004).

Balancing and integrating the requirements to produce credible research, to change clinical practice in a large hospital and to produce practical recommendations about the future of leadership and leadership development nationally in the NHS has presented significant challenges. It has not always been possible or desirable to hold rigidly to a research plan; I have had to adapt and augment as I started to engage more deeply with the organisations with which I was working.

Organisation of this report

Chapter Two sets out the specific research objectives of the project and reviews the literature which has influenced my thinking. This chapter also draws upon the Expert Seminars which are offered as part of this doctoral programme.

Chapter Three sets out and discusses the research strategy and methodological approach which has been taken. My approach to data analysis is also discussed in detail in this chapter. As the data itself is extremely rich and voluminous, key documents and illustrative field notes have been included as appendices.

Chapter Four is an account of the activities which have been involved in the project and the findings emerging from those activities. In Chapter Five, I discuss the wider implications of the study for leadership development and organisation development in the NHS in England. Chapter Five also explores the problematic nature of practitioner research with a particular emphasis on research which is embedded in practice.

Chapter Six draws out the conclusions which I have reached and the recommendations made to address issues of leadership development and organisation development in the NHS in England. The conclusions are linked to the research questions set out in Chapter 2.

The appendices contain documents which are referred to in the text but which do not form part of the central narrative.

As this report is submitted as part of a portfolio of work for the award of a professional doctorate, a supplementary volume is available containing the ***products*** from the study. The products in the supplementary volume are:

- Taking Charge of your Career – a guide for potential leaders.
- Identifying and Developing Leadership Potential – A guide for organisational leaders.
- Development Centre tool-kit.
- Career Management in the NHS – Report of a Pilot Study.
- Implementing assertive rehabilitation in a high security environment.

A brief description of each of these products is provided in Appendix F.

Some of the conclusions and recommendations from this project have already been translated into action and been reflected in changes in policy and practice. I anticipate that the products from the study will have a useful and extensive impact on the theory and practice of leadership, leadership development and organisation development in the NHS in England and, possibly, more widely.

PROJECT OBJECTIVES AND LITERATURE REVIEW

Overall aim

The aim of the project is to derive a number of general principles and practical measures which can be applied to enable effective leadership of change within the NHS. Through my role as professional adviser to Leadership London, I plan to reflect the lessons emerging from the project in future leadership development strategies for the NHS in London and to disseminate useful principles and practices more widely within the NHS and its partner agencies through the products from this project and through articles, workshops and conferences.

Objectives

- To achieve a clearer understanding, based on credible evidence, of the interaction between individual and organisational learning in relation to the leadership of change.

- To develop and disseminate principles and practical guidelines to inform the design and commissioning of leadership development activities in the NHS.

- To embody evolving principles and practical guidelines in the future work of Leadership London.

Boundaries of the project

As indicated in the Introduction, the project focuses on the NHS in England. Although I believe that many of the issues explored in this project will be relevant to health and social care in other parts of the UK, the conclusions which are drawn and the recommendations made should only be regarded as pertinent to the NHS in England.

The field work for the project has been undertaken exclusively within NHS organisations in and around London. In certain respects, the NHS in London differs from the NHS in other parts of England; particularly in terms of population characteristics, labour market conditions, mobility of the work-force and the relatively large number of tertiary centres and teaching hospitals. Caution must, therefore, be exercised in generalising findings from this study to other areas of the NHS in England.

The project is also situated at a particular point in time. The field work was undertaken between 2001 and 2004[6]. Even within this relatively tight time frame, there have been significant changes in the political context of the NHS in England. A change of government could lead to further changes in the political context and the findings from this study would need to be re-examined and re-interpreted in the light of that context. Having studied the policy statements of the three major political parties, I believe that there is a political consensus about major features of the context in which the NHS functions. These major features are shown in Figure 2.1 overleaf.

[6] The mental health project started in December, 2001 and is on-going. The career management and succession planning project started in December, 2003 and will be completed in October, 2004.

Political consensus

- Increasing investment in the NHS.
- NHS largely funded from general taxation.
- Services largely free at the point of delivery.
- Plurality of providers.
- Move towards a service which is more responsive to the needs and aspirations of users.
- Increased local accountability.
- Increased local autonomy.
- Shift from hospital-based care to community-based care.

Figure 2.1 Political consensus on the future direction of health and social care in England.

THE RESEARCH QUESTIONS

The project sets out to address five specific research questions:

1. In what ways do leadership behaviours and practices influence change in clinical practice[7] and, therefore, in the experiences of patients[8] and the outcomes which are achieved?

2. What organisational factors encourage and enable front-line staff to innovate in their practice and what factors inhibit innovation?

3. To what extent is it necessary or desirable to blend individual development and organisational development to achieve the best return on investment in these activities?

4. What new leadership challenges will be presented in meeting key policy objectives for the NHS in England?

5. What approaches to leadership development are likely to help to meet these challenges?

I recognise that each of these is an extremely large research question. However, given that my starting point is a belief that leadership development and organisation development are, or should be, intimately connected, I think it is necessary to consider them together. As my aim is to develop and implement ***practical*** measures to contribute to the ***future*** development of the NHS, I have to investigate both current practice and future challenges. In presenting my conclusions in Chapter 6, I have sought to relate the conclusions to the research questions so that the reader may judge the extent to which each has been addressed.

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[7] Throughout this paper, the term "clinical practice" is used to mean how clinical services are delivered to patients. It includes, therefore, the work of ancillary and administrative staff in patient contact as well as the work of clinicians

[8] The word patient is used to include everyone using NHS services and their friends, families and carers.

As I have indicated in the Introduction to this report, the scope of the research questions dictated my choice of research strategy. It combines an in-depth case study to explore leadership and organisational development issues in the "here and now" with a future-oriented methodology using focus groups and a modified Delphi technique to reach informed conclusions about the future. The research strategy is described fully in Chapter 3.

As this is report is being submitted as part of a portfolio of evidence for the award of a professional doctorate, my approach to the research questions is both informed by and constrained by the research enterprise being embedded in real-world practice. This is often untidier and more complex than a research project which is not also aiming concurrently to produce real change in real organisations; the real-world researcher needs considerable flexibility of approach.

APPROACH TO THE LITERATURE REVIEW

This section of the project report summarises both a formal literature review and the thinking and discussions which have been stimulated through the Expert Seminars which form an integral part of the professional doctoral programme. I have drawn particularly on Expert Seminars presented by Peter Senge, Sarah Fraser, Anton Obholzer and Rosabeth Moss Kanter.

The literature which has been reviewed can be considered under three main headings:

Leadership.
Organisational change/organisation development.
Healthcare policy.

In developing an appropriate methodological approach, I reviewed a number of texts concerned with methodology, particularly Robson, 1998, Reason and Bradbury, 2001 and Erlandson et al., 1993.

During the course of the project, I have had to give much thought to the development of an appropriate ethical framework within which to locate projects which are fundamentally about the *practice* of organisation development rather than about "pure" research. This literature review, therefore, encompasses work on research ethics and on the ethics of managerial practice.

Given the aims and context of the study, I have been particularly concerned to focus on leadership behaviours as they relate to change in the experience of "customers", to leadership and its relation to organisation development and to leadership of change in situations in which there is a significant shift in organisational context. Although I have not ignored writings based on work in other settings, I have concentrated on writings based in service enterprises. Similarly, although there is now a growing body of literature on public service leadership, to confine myself purely to this literature would, I believe, have been too restrictive.

In planning my literature review, I started a number of books each of which had been published within the last five years and each of which offered an overview of the current literature and state of knowledge in the domains in which I was interested. Two of the texts (Mark and Dopson, 1999 and Harrison, 2001)) focussed particularly on organisational behaviour in health care, whilst the other texts selected looked more broadly at issues of leadership and organisational behaviour. I anticipated that these texts would "sign-post" me to useful areas of the literature. . I then followed up what appeared to be potentially useful references. This strategy was complemented by an internet (Google) search using relevant key words and key word combinations. In filtering the large body of literature, particularly on leadership, I placed greater weight on those items which seemed to be grounded in a reasonably robust research methodology and rather less weight on the (much greater) number of reports, books and articles which appeared to be largely anecdotal.

LEADERSHIP

As Storey (2004, p3) states, "*the literature on leadership is enormous and expanding apace. A search of the Amazon.com website in the Spring of 2003 using the single word 'leadership' netted an overwhelming 11,686 results.*"

In reviewing the literature, I was struck by the cyclical nature of research on and assertions about leadership. Much of the early research on leadership was concerned with leadership in small groups (McGregor, 1960), that is, "near" or "close-in" leadership. During the late 80's and through most of the 90's, the focus appeared to shift to "distant" leadership; that is, Chief Executives and other "top leaders" and their role in influencing corporate culture and performance (Peters, 2004). With the work of, amongst others, Alimo-Metcalfe (2001) who has been particularly influential with respect to public sector leadership in the U.K., I note a return to "near" leadership and something which approaches a re-invention of leadership competences. Arguably, provided one took a sufficiently broad view of "task", it would not be difficult to map the scales of the Transformational Leadership Questionnaire (Alimo-Metcalfe and Alban-Metcalfe, 2001) onto the task/relationship grid proposed by Blake and Moulton in 1964 (1964).

An emerging area of interest in research on leadership is that of "integrity" associated with the ethical dimension of leadership. Mangham (in Storey, 2004), in particular, has commented on the ethical dimensions of leadership in a post-Enron world. Mangham suggests that "*there was in fact little or no conflict between the thoughts and practices of Enron leaders* and *employees and the values and ways of interacting approved of by the wider community.*" (2004, p 48). This is a salutary reminder that leadership is not something which exists in isolation from wider society. The statement that the effective leader "*regards values as integral to the organisation*" (Alimo-Metcalfe and Alban-Metcalfe, 2001, Transformational Leadership Questionnaire), invites the question what values should the organisation hold. Similarly, in stating that "*leadership is the process by which individual's effectiveness is increased....*" (Story, J. ed., 2004, p 174), Alimo-Metcalfe glides over the question of what constitutes effectiveness. In a public-sector organisation such as the NHS, the questions of "what values" and "what is effectiveness" seem to me to be of

fundamental importance in any discussion of leadership or organisational development. The question of values is highlighted in the Foreword to the NHS Improvement Plan (2004, p3). The same document implies that "effectiveness" can be measured by the extent to which the service meets the "*needs and aspirations of its patients*" (p3). Even this is an over-simplification which ignores the role of the NHS in promoting public health and in addressing the needs of citizens such as pregnant women who are not "patients".

A growing field of writing on leadership is concerned with applying findings from complexity theory[9] (e.g. Kauffman, 1993) to the practice of leadership and the development of leaders. Influential writers include Wheatley (1996, 1999) and Stacey (1993, 2000, and 2001). Complexity theorists argue that complex social systems such as organisations exhibit many of the same characteristics as complex physical, chemical or biological systems. These characteristics include:

- The inherent unpredictability of such systems.
- Small changes in one part of the system leading to large effects elsewhere in the system.
- The tendency of complex systems to be self-ordering.

In applying complexity theory to leadership, writers such as Plsek (2001) suggest that leaders should give up the illusion of control in the sense of particular actions leading to particular outcomes other than over very short time-scales. However, it may be possible for leaders to shape or influence organisational behaviour indirectly. There is also an implicit suggestion that whatever other characteristics leaders may require, tolerance for ambiguity, unpredictability and uncertainty is a *sine qua non*!

Considering the roles and limitation of leaders in complex organisations is, at the very least, a helpful counter-balance to the perhaps over-simplistic ways of thinking which tend to characterise leadership trait and leadership competence models.

[9] The study of complex systems such as weather and the behaviour of viscous fluids.

In reviewing the literature on leadership, it becomes clear that there is little consensus about what it is, how to do it well, what sort of people are good at it and how "good leaders" might be developed. However, some useful themes do emerge.

Leadership is a process which adds value to the work of the individuals who make up organisations – it is an *organising* process.

It may be possible to define some practices or behaviours which are characteristic of effective leadership although some of these may be context-specific.

It may be possible to define some areas of skill and knowledge of which effective leaders should have mastery; emotional intelligence (Goleman, 1998) may be an example.

There may be personality traits which characterise effective leaders although there is considerable uncertainty about the interplay between personality characteristics and learned behaviours.

Successful performance in ***many*** organisational roles requires the exercise of effective leadership practices; it is a common rather than a rare organisational requirement.

ORGANISATIONAL CHANGE and ORGANISATION DEVELOPMENT.

As much of the more recent research on and assertions about leadership displays a strong focus on the leadership of change, there is inevitably considerable overlap in the literature on leadership and that on organisational development. As indicated in the Introduction (p2) and in my first research objective, it is a thesis of this project that leadership development and organisation development should be considered and addressed in a more integrated way than is currently practised in the NHS in England.

Just as leadership is not a tightly defined concept or domain of study, organisation development too has rather fuzzy boundaries. It draws on insights from many disciplines including psychoanalysis, [10]social psychology[11], anthropology[12], and organisational behaviour[13].

Morgan (1998) suggests that organisations can be considered through a number of lenses or theoretical models. Each lens, Morgan suggests, will illuminate part of the picture whilst casting other aspects of organisational life into shadow. An important aspect of Morgan's writing which is not always well-reflected when he is referenced in other works is that these ways of seeing and thinking about organisations are ***metaphors*** – ways of thinking about rather than descriptions of the "real thing". Arguably, the "real thing" does not exist at all other than, perhaps, as a legal institution.

Sims (2000) suggests that organisation development is about organis*ing* rather than organisations – it is about people and processes rather than structures and entities. Here there is a clear resonance with the complexity theorists, particularly Stacey (2001).

[10] De Board (1978)
[11] Lewin (1946),
[12] Gellner and Hirsch (2001)
[13] Mullins (1985)

Kanter (1997) has addressed an issue which is of particular relevance to this project; the issue of how large complex organisations can remain (or become) flexible and adaptive. Based on research in companies located in "Silicon Valley", she suggests that for large organisations to be flexible and adaptive, they need to have a clear sense of ***focus*** on the purpose of the organisation. They also need to be ***flexible*** and capable of adapting priorities and methods of working to accommodate changing environmental circumstances. Successful adaptive organisations need to be ***fast***, in the sense of having rapid decision-making processes, short "chains of command" and considerable devolution of decision-making authority. Finally Kanter suggests that successful adaptive organisations need to be ***fun***; placing an emphasis on creativity, innovation and personal fulfilment. These observations are sometimes described as Kanter's 4F model. As discussed in Chapters 4 and 5 of this report, the absence of clear focus, flexibility and fast decision-making processes contribute heavily to problems of service delivery and change adeptness in the case study organisation.

An approach to organisational development which has attracted considerable attention and whose principles are reflected in much of the work of the NHS Modernisation Agency is that of process re-engineering or business process re-engineering (McNulty and Ferlie, 2004). The approach suggests that the performance of an organisation can be significantly improved by re-designing how it does its work. Each process can be investigated and re-designed to eliminate or reduce such impediments to efficiency as "bottlenecks" and imbalances in "supply and demand". Research into the approach (McNulty and Ferlie, 2004) suggests that the claims made for it have been somewhat exaggerated and that the results have often been somewhat disappointing and sometimes dysfunctional. I believe that process re-engineering, as with many of the approaches to organisation development which have been advocated, suffers from exaggerated claims rather than from being fundamentally unsound. The approach should be helpful in addressing some problems of organisational inefficiency which is a good and useful thing to do. It may not, however, take us far in the direction of the responsive and customer-focussed NHS to which we aspire.

Senge (1993, 2003) introduced the concept of the "Learning Organisation" into the field of organisation development. Senge argues that knowledge and organisational learning is a critical source of competitive advantage particularly as we move into knowledge-based economies and enterprises. He suggests that much of our thinking about organisations is conditioned by "industrial age thinking" and an industrial age educational system through which we have to prepare people to fit into a "production line".

In one of the Expert Seminars, Senge (Seminar, 2003) suggests that learning is a natural human capability which starts with *action*. He proposes that there are three core learning capabilities:

Aspiration.
Conversation.
Understanding complexity.

Aspiration includes:

Purpose – why we are here.
Vision – what we are trying to achieve.
Values – how we go about our business.

He further suggests that there are only two drivers for organisational change – aspiration and desperation. He believes that desperation is a more frequent driver for change than aspiration.

Conversation is about reflective and empathetic conversation through which we might come to understand our own and other's mental models. He suggests that this might lead to an appreciation of differences rather than similarities and to disagreement rather than agreement. The importance of organisational conversation is also stressed by Argyris et al (1985) and is reflected in my own approach to organisation development and in the conclusions from this study.

Given the diverse perspectives from which work on organisational change and organisation development emerges, I believe that Morgan's idea that there are many different metaphorical lenses through which organisations and organising can be understood is particularly helpful provided that one bears in mind his proposition that a given metaphor will illuminate particular aspects of organisational life whilst casting others into shadow. This way of thinking about organisations also suggests that the *practice* of organisation development is likely to be eclectic and multi-disciplinary and that the practitioner must be adept in applying a range of approaches, tools and techniques to in his or her practice.

In the context of *transformational change*, I have found Senge's work of particular value especially the notion of having to change "mental models" in order to bring about fundamental changes in organisational behaviour. Examples of relevance to this project include the idea of "patient" as passive recipient of "expert care", the role of organisational leader as "commander and controller" and the idea of "illness" as purely a biological phenomenon.

In reviewing the literature on organisations and organisation development, I have also tried to be alert to important differences between organisations whose primary purpose is maximising shareholder value and organisations such as the NHS which do not have this as their primary purpose. Much of the literature on both leadership and organisation development is based on work in shareholder value maximising organisations. That is not to say that it lacks relevance; only that it needs to be treated with caution in translating finding from such settings to organisations such as the NHS.

HEALTHCARE POLICY

During the time in which this project took place, the NHS was exposed to an unremitting flow of policy development linked together by the government mantra of "Investment and Reform". A commitment was given by the government to bring the level of spending on health care as a proportion of GDP up to the average of the European Union countries but Ministers constantly stressed the requirement to match increased investment with fundamental reform.

Out of the plethora of policy documents[14] emanating from the Department of Health and its agencies, I believe that three documents are of particular importance:

> The NHS Plan (2000).
>
> Shifting the Balance of Power (2001).
>
> The NHS Improvement Plan: Putting people at the heart of public services (2004).

The underpinning document for a review of health care policy under the present (Labour) government is the NHS Plan. Although, in my view, the NHS Plan is not an entirely coherent strategy, it lays out many of the main features of government policy in health and social care which have characterised the first two terms of the current government's office. The focus of the first term was very much upon meeting quantitative targets, particularly those which were manifesto pledges for the May 1997 election. This focus was accompanied by micro-management of the NHS from the Department of Health and what some would consider an unduly punitive culture. Shapiro, for example, asserts that "*The NHS is currently risk averse, punitive and highly disempowering to its professional staff.*" (Shapiro, 2004, pp 12-13).

[14] As an indicator, the number of Statutory Instruments applying to the NHS ranged from 99 in 1997 to 204 in 1998. In 2003, there were 106.

In response to concerns being expressed about over-centralisation and micro-management, the government published a policy document Shifting the Balance of Power (2001). The measures set out in this document included:

- The abolition of Regional Offices.
- The creation of Strategic Health Authorities.
- The creation of the Modernisation Agency incorporating the NHS Leadership Centre.
- The introduction of the concept of "earned autonomy" whereby "successful" Trusts would have more control over their own affairs and would be subject to less intense performance management.
- An increase in the proportion of NHS spend which would be channelled through Primary Care Trusts (PCTs).

The third key policy document is the NHS Improvement Plan: Putting people at the heart of public services" published in June, 2004. This document sets out key commitments on waiting times, patient choice and managing long term conditions.

Significant policy documents were also published in relation to:

- Introducing payment by results.
- Information technology in the NHS.
- The relationship between the NHS and Local Authorities.
- Public and Patient Involvement.
- The creation of Foundation Hospitals.

Over the period 1997 to 2004, we have seen a development of policy from an initial view that the NHS could be managed centrally in quite an authoritarian manner using a system of targets, rewards and punishments to a view of the system which is characterised by:

- Patient choice – the recognition of the need to empower patients as consumers.
- Market forces – successful organisations being allowed to thrive and grow and less successful ones being allowed to "fail" or being exposed to some form of "special measures".
- A plurality of providers with greater involvement of the private and independent sectors.
- Increased local autonomy and, less obviously, local accountability.
- A framework of national standards but recognition that there may be trade-offs between equity and choice, between consistency and local autonomy and between efficiency and individual choice.

RESEARCH ETHICS

As the field work for this project was undertaken in the NHS, my starting point in relation to research ethics was to review the Research Governance Framework for Health and Social Care (2001). I also reviewed the Statement of Ethical Practice of the British Sociological Association (2004), the International Organization Development Code of Ethics (1991), the Code of Conduct of the British Psychological Society (2000) and the Code of Conduct for NHS Managers (2002).

What is clear from these reviews is the problematic nature of research ethics. As the statement of ethical practice of the British Sociological Association states:

> *"Sociologists, in carrying out their work, inevitably face ethical, and sometimes legal, dilemmas which arise out of competing obligations and conflicts of interest".*

The same document states that:

> *"The statement is meant, primarily, to inform members' ethical judgements rather than to impose on them an external set of standards. The purpose is to make members aware of the ethical issues that may arise in their work, and to encourage them to educate themselves and their colleagues to behave ethically. The statement does not, therefore, provide a set of recipes for resolving ethical choices or dilemmas, but recognises that often it will be necessary to make such choices on the basis of principles and values, and the interests of those involved."*

In documents such as the Research Governance Framework (2001), I believe that there is a tendency to over-codify and over-bureaucratise the ethical dimensions of research; to attempt to provide the "recipes" against which the BSA warns. A possible consequence is that the correct procedures have been followed, the required signatures obtained but the genuine ethical dilemmas have been brushed over.

It also seems to me that the Research Governance Framework and the BPS Code of Conduct deal only with formal research projects undertaken in isolation and fail to address adequately the ethical dimensions of research which is *embedded* in practice and which may be, to some extent, *incidental* to that practice.

I have suggested that it may be necessary to develop an ethical framework which is more appropriate for research which is embedded in practice and which is situated in work-based learning. In the context of this study, I have set out the ethical guidelines which I and my co-researchers sought to follow in carrying out this project (Chapter 3, p45). In managing the day to day ethical dilemmas, conflicts and problems which inevitably arise in practice-based research, I sought to apply a consistent set of principles and values rather than relying on compliance with a procedure.

SUMMARY

In undertaking this project, I feel that I am grappling with three extremely slippery domains of knowledge:

- Views about the nature of leaders and leadership in a post-Enron world and in a world in which acceptance of authority, positional or professional, is becoming increasingly questionable.
- Views about the nature of organisations with perhaps, as Sims (2000) suggests the field of study being about "organising" rather than "organisations".
- Views about public policy in relation to health and health and social care situated in a wider debate about the nature of public services in the 21st century.

In a professional doctorate, it is not sufficient merely to try to understand better what is going on; as a practitioner-researcher, I am interested in trying to develop ***practice*** as well as knowledge.

Both the literature and my own research suggest that how leaders behave, the practice of leadership, is important in determining how people organise themselves or are organised to deliver better experiences for patients, to achieve better clinical outcomes and to improve the health and well-being of the population.

In a world which is less accepting of positional and professional power and in which the delivery of better and individually focussed services often requires the integration of resources and efforts across conventional organisational or institutional boundaries, the exercise of leadership becomes a significantly more difficult and sophisticated process than might have been the case in a traditional "Taylorist" organisation.

The literature and my own research suggest that both close-in and distant leadership are important. Without effective close-in leadership, the aspirations of policy-makers and organisational leaders are unlikely to be achieved. Equally, the efforts of close-in leaders such as Ward Managers and Team Leaders are likely to be thwarted if organisational cultures and processes disable them and render them impotent in their desire to lead change and deliver good services.

This research suggests that, whilst leadership and organisational behaviour are domains in which knowledge and praxis are imperfect and contested, there are practical measures which, if consistently implemented, would be likely to deliver worthwhile improvements in the experiences of patient using the NHS and of staff working within the NHS. I hope and anticipate that the products from this project will make implementation of some of these measures easier and more probable.

THE RESEARCH STRATEGY

In this project, I set out to investigate a complex phenomenon (leadership) in a complex organisational setting (the National Health Service). As the project forms part of a portfolio of work being submitted for the award of a Professional Doctorate, it is designed to bring about changes in practice and to be grounded in the realities of organisational life.

In investigating the phenomenon of leadership in the NHS and, in particular, the leadership of change, I wished both to understand the phenomenon at a strategic and conceptual level and to explore how the leadership of change plays out in a real world organisational setting. To reflect these two perspectives, I developed a methodological approach in which there could be a continuous dialogue between two separate pieces of work; one with a conceptual and strategic focus on leadership and change and one with a practical or operational focus on the leadership of change in a functioning organisation. I hoped that this design would lead to a better fusion of understanding (know about) and practice (know how to) than might be the case with a more traditional research design. I also hoped that a design in which ideas had been tested out in practice would lead to more robust conclusions and recommendations and improve the likelihood of recommended changes in practice being accepted. Figure 3.1 below summarises the structure of the investigation.

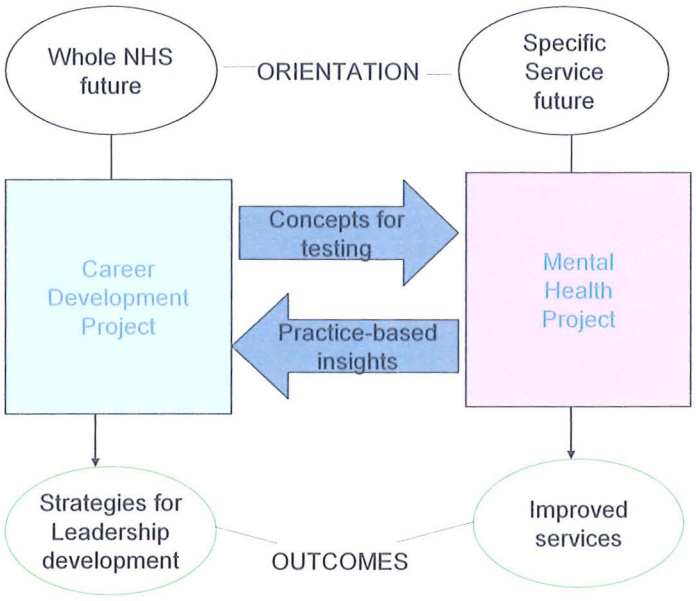

Figure 3.1 Dialogue between sub-projects

As the figure indicates, the career development project is orientated towards future leadership requirements in the NHS in England and aims to deliver strategies for developing leaders who will be "fit for purpose" in the future. The mental health project is oriented towards the future of a particular service (assertive rehabilitation in forensic mental health) and aims to deliver improved services which manifest themselves in better patient experiences and better outcomes for patients.

The design allows for insights arising in the course of the mental health project to be fed into the career development project and for ideas arising in the career development project to be "field-tested" in the mental health project.

The two linked projects could be thought of as a macro-project and a micro-project being pursued in parallel and with a cycle of information flow between them. I expected that such parallel processing would create and/or release synergy between the two projects and would shorten the time taken to move from conceptual understanding to change in practice.

The career development project draws primarily upon eliciting expert opinion using focus groups (Morgan, 1997) and a modified Delphi method (Weaver, 1971). Data gathered in this way is further enriched by capturing and interpreting information from a development centre which sought to simulate dimensions of future leadership roles. By contrast, the mental health project is a single case study (Yin, 2003) and is grounded in the traditions of action research (Lewin, 1946).

The methodologies applied to the two projects are now discussed separately in detail.

METHODOLOGY FOR THE CAREER DEVELOPMENT PROJECT

This project is concerned with developing a set of working assumptions about the challenges facing people in leadership roles in the NHS over the next three to five years, the competences which leaders are likely to require and how such competences might be developed. The project is itself predicated on the belief that the combined effect of key government policies in relation to the NHS will constitute a fundamental change in the nature of the NHS and, therefore, in the requirements placed upon leaders in the NHS.

In any research project, the nature of the research question will strongly influence the choice of methodology. In "practitioner research" undertaken in the course of "real work", the goals agreed between the practitioner and the commissioning agency (in this case the London Strategic Health Authorities) will be an equally strong influence on the choice of methodology.

Figure 3.2 (below) summarises the research questions which are addressed through this project and the work goal which I was required to achieve.

THE RESEARCH QUESTIONS

What new leadership challenges will be presented in meeting key policy objectives for the NHS in England?

What approaches to leadership development are likely to help to meet these challenges?

THE WORK GOAL

To develop and pilot a set of practical tools to support the development of leaders for the future NHS.

Figure 3.2 Research Questions and Work Goal for Career Development Project

As the project is concerned with generating assumptions about the future, I decided to draw upon two research tools which the literature suggests are appropriate for eliciting expert opinions and seeking to establish a consensus or at least to identify major clusters of agreement and disagreement. The two tools employed are:

Focus groups.

A modified version of the Delphi technique.

The outcomes from the focus groups and a Delphi-like electronic consultation, were then used to design a development centre which sought to simulate key aspects of the future leadership role, particularly that of the future role of Chief Executive Officers of NHS organisations. Feedback on the development centre experience was then sought from participants and from development advisers.

Focus Groups

Gibbs (1997) summarising a review of focus group methodology conducted for the Department of Social Medicine at Bristol University in March, 1997 suggests that:

- Focus group research involves organised discussion with a selected group of individuals to gain information about their views and experiences of a topic.
- Focus group interviewing is particularly suited for obtaining several perspectives about the same topic.
- The benefits of focus group research include gaining insights into people's shared understandings of everyday life and the ways in which individuals are influenced by others in a group situation.
- Problems arise when attempting to identify the individual view from the group view, as well as in the practical arrangements for conducting focus groups.
- The role of the moderator is very significant. Good levels of group leadership and interpersonal skill are required to moderate a group successfully.

In this case, four focus groups were established each consisting of between eight and twelve members[15] meeting for two hours in a conference room in the Headquarters building of one of the Strategic Health Authorities. Each focus group was audio-taped and verbatim transcripts were prepared.

A list of potential focus group members was assembled by each of the five Strategic Health Authorities on the basis that they were individuals who would have some insight into the future direction of NHS policy and into the likely implications for people in leadership roles. This reflects Burgess's suggestion (1996) that people with specific interests and expertise will have to be recruited by word of mouth or through existing social or professional networks. An analysis of the membership is included in Appendix A.

Potential focus group members were sent a briefing document (see Appendix A) about two weeks ahead of the scheduled dates for the focus group meetings. I moderated each focus group and notes were taken by another experienced facilitator and researcher.

When the four focus groups had been completed, the members of each focus group were sent notes from their group and invited to comment. I constructed the notes drawing on my own contemporaneous notes, the contemporaneous notes of the other facilitator and the transcripts of the audio tapes. Minor modifications were made in the light of the feedback from focus group members and a discussion paper (see Appendix A) was then prepared based on the outcomes of all four focus groups. This discussion paper was then used as a starting point for the modified Delphi-consultation.

[15] In her review of the literature on focus group methodology, Gibbs states that "the recommended number of people per group is usually six to ten but some researchers have used up to fifteen people or as few as four".

Modified Delphi technique

Jones and Hunter (2000, Chapter 5), state that

> *"The Delphi process takes its name from the Delphic oracle's skills of interpretation and foresight and has widely been used in health research within the fields of technology assessment, education and training, priority setting, developing nursing and clinical practice, workforce planning, forecasting and health service organisation. The procedure enables a large group of experts to be contacted cheaply."*

In its "pure" form, the Delphi technique uses a structured questionnaire which enables experts to express their agreement or disagreement with a number of propositions contained in the questionnaire. The rankings of agreement are then summarised by the researchers and the exercise is repeated. This iterative procedure enables experts to modify their views in the light of the views expressed by other experts. Jones and Hunter state that "*respondents are commonly asked to rate the confidence or certainty with which they express their opinions*". In the pure form of the Delphi technique, the opinions expressed by experts are anonymised.

In this study, the conclusions from the focus groups were published on the Leadership London Website and members of the London NHS leadership community were invited to comment on the conclusions from the groups. NHS leaders in London were notified by email that this electronic consultation exercise would be taking place. As with a pure Delphi exercise, respondents were able to see the comments made by others and could, therefore, modify their own views in the light of other opinions being expressed.

As it turned out, the level of comment was relatively low and the only important new dimension that was added through the electronic consultation was that of "*achieving a work-life balance*".

The Development centre

Development centres were derived from the technology of assessment centres (Carrick and Williams, 1999) and whilst having a quite different purpose and value system, share many of the same operational characteristics. In both cases, the philosophy is to simulate key aspects of a particular role or range of roles, to observe the behaviour of participants in response to the simulations, and to make inferences about the likely future behaviour of participants in the real roles which were simulated. These inferences can then be used to inform selection decisions (assessment centres) or to inform development advice (development centres). In practice, assessment centres and development centres can be considered on a spectrum from pure selection decision making through to pure development advice. In my experience, it is unhelpful and, sometimes, unethical to mix the selection intention and the development intention.

In the context of this study, the development centre was designed and delivered (on a pilot basis) because it was one of the products required by the commissioners. However, I believe that the process of designing, running and evaluating the centre produced useful data which helped to create a "rich picture" (Monk and Howard, 1998) of future leadership roles.

During the design process, the design team which I led had to construct a framework of activities which would simulate key aspects of the future Chief Executive role and to populate the framework with future-relevant issues. Both the framework and the future relevant issues were derived from the focus group discussions described above. The outline design is included in Appendix B.

During the running of the centre, which included a half-day development adviser conference, opportunities were created to observe the behaviours of participants in response to the activities and issues presented and to analyse the observations through a systematic process which sought to separate observations from interpretations and to reach a sufficiently precise consensus to enable accurate and useful feedback to be given to each participant. This process enabled the development centre team to form a view of the extent to which participants were adequately prepared for the demands of the future role and to identify patterns of deficit. Serendipitously, the centre suggested

that the quality of performance and development feedback which leaders receive at work is often unsatisfactory.

An immediate evaluation of the experience of the development centre was carried out using an informal conference of development advisers immediately after the centre and a semi-structured questionnaire distributed by email to participants and development advisers two weeks after the centre. After four weeks, respondents were contacted by telephone to remind them about the request for feedback. After telephone prompting, a 100% return rate was achieved.

Key findings from the evaluation included:

- A consensus that the design framework and issues simulated quite accurately the envisaged future role.
- That there were patterns of deficit against the likely future requirements of NHS leaders.
- That the current processes for providing feedback and guidance on leadership performance are often inadequate.
- That the development adviser conference methodology was a significantly more robust and systematic way of evaluating competence and potential than other processes with which the development advisers were familiar.

Detailed feedback on ways to improve the design and the process was also collected and will be reflected in future designs and implementations.

Products from the career development project

The work goal of the career development project was "*to develop and pilot a set of practical tools to support the development of leaders for the future NHS*". (see Figure 3.2 above). The achievement of this goal is reflected in the following products of the study:

- A discussion paper on future leadership in the NHS prepared for the NHS Leadership Centre.

- A Guide for people considering moving into leadership roles or who wish to extend and develop their existing leadership careers (Taking Charge of your Career).

- A Guide for Chief Executives and other senior organisational leaders on how to identify and foster people with leadership potential for the future.

- A policy agreement to run one or two development centres for aspiring Chief Executives in London each year.

METHODOLOGY FOR THE MENTAL HEALTH PROJECT

This project is a study of a complex system. Plsek and Greenhalgh (2001) have suggested that a complex system is characterised by:

> Many individual agents each of whom enjoys some freedom of action in the organisational context.
>
> A web of relationships such that the context of the actions of each of the agents may be influenced by the action of other agents in the web.
>
> Positive and negative feedback loops which cause both damping and amplification effects resulting in the possibility of small changes in one part of the system leading to relatively large changes elsewhere in the system.
>
> Inherent unpredictability in the behaviour of the system.

An important consideration in developing an appropriate methodological approach to the project was, therefore, to ensure that the methodological tools employed would be sufficiently powerful to do justice to the complexity of the system under study. A methodological approach such as the laboratory experiment or the randomised control trial (RCT) which usually assumes that there will be relatively simple and possibly causal connections between independent and dependent variables is contra-indicated by the inherent properties of complex systems.

The project is a study of a living system over time. It is constantly changing and co-evolving with the other systems to which it is linked. In this sense the study is what Pettigrew (1990, 1997) describes as "*process research*". That is "*the dynamic study of behaviour within organisations, focussing on the core themes of organisational context, actions and sequences of actions that unfold over time*". This suggests that the methodological approach will draw upon the traditions of anthropology and ethnography with its focus upon "*getting an insider's view of a particular society*" using tools and techniques such as observation and participant observation.

Finally, the project exists in the context of organisational development practice. I had been commissioned to help to ***change*** the organisation not merely to study it. Such research as does take place is, from the point of view of the commissioners and, to a lesser extent, the practitioner a means to an end rather than an end in itself. This suggests that an approach which draws on the traditions of action research (Lewin, 1946) is likely to be appropriate.

These three considerations, the complexity of the organisation, the study of the organisation as a living system over time and the commissioning of the work as an organisation development strategy taken together suggest that an appropriate methodological approach is likely to:

Use a multiplicity of tools and techniques.

Draw upon a variety of research traditions.

Be exploratory and open-ended rather than investigating a tightly defined question or testing a tightly defined hypothesis.

A further important factor in developing an appropriate methodological approach is the changing locus of the researcher. Robson (Robson, 1998) has written on the issues confronting the insider researcher or, to use Robson's term, the "*practitioner researcher*" (Robson, p 447). Robson seems to believe that in a particular case, the researcher either is or is not an "insider". In the context of this project, I and my research colleague (G) gradually become more and more "insiders" as the project unfolds. We start off fairly clearly as external to the organisation but gradually become more and more part of it. An illustrative and symbolic example of the gradual transition from "outsider" to "insider" is G undertaking those parts of the induction programme which would enable her to have an identity card rather than a "visitor's pass", to go through the security systems for staff rather than visitors and, most visibly symbolic, to hold keys signalling to all that she is now "staff" rather than "visitor". Her employment status has not changed but she has gone through a "rite of passage" to become an insider. In an attempt to have the advantages of both insider

and outsider perspectives, I chose not to go through this rite of passage and I have, in other ways, sought to remain an "outsider" albeit a familiar one to the organisation. Later in this section, I will describe how we have developed and employed the technique of the "critical conversation"[16] to facilitate a productive and critical dialogue between "mostly outsider" and "mostly insider".

Figure 3.3 (below) summarises the research questions which are addressed through this project and the work goal which I was required to achieve.

THE RESEARCH QUESTIONS

In what ways do leadership behaviours and practices influence change in clinical practice and, therefore, in the experiences of patients and the outcomes which are achieved?

What organisational factors encourage and enable front-line staff to innovate in their practice and what factors inhibit innovation?

To what extent is it necessary or desirable to blend individual development and organisational development to achieve the best return on investment in these activities?

THE WORK GOAL

To develop a more effective assertive rehabilitation service which will enable patients to move into less restrictive settings as quickly as possible.

Figure 3.3 Research Questions and Work Goal for Mental Health Project

The aim of the project is to answer the research question in ways which are of practical value to people in leadership roles within the NHS in England. The organisation development project also has the explicit intention of learning lessons and developing practices which can be applied elsewhere in the Trust of which the assertive rehabilitation service forms a part.

[16] Based on the work of Harri-Augstein and Thomas (1991)

The nature of the research question further emphasises the need for a methodological approach which facilitates exploration and discovery rather than setting out to prove or disprove a pre-existing hypothesis.

Choice of the single case method

After considerable thought and discussion with my academic advisers, I came to the conclusion that the most appropriate methodological strategy to address this particular research question is that of the single case study.

A case study methodology has been chosen for three reasons:

> The nature of the research question which is to seek and test explanations of phenomena.
>
> My wish to focus on contemporary events.
>
> The impossibility of controlling behavioural events in investigating complex organisational behaviours.

Yin (2003, p 5) suggests that the case study is the method of choice given these three design considerations.

In developing the research strategy, I considered the desirability and feasibility of using more than one case study thus possibly increasing both the explanatory power of the research study and the extent to which findings could reliably be generalised across a range of settings. As is often the case in real-world research, I was faced with a trade-off between breadth and depth. I did not have the time or resources to conduct more than one study in the depth which I considered necessary or over the time-scale which I thought desirable given the scope of the research question which was being addressed and the complex nature of the organisations to which the question was being applied. I had a fortuitous opportunity in my organisation development practice to move ahead with a single in-depth case study. This was a compelling argument in the decision to proceed with a single case study which I *could* conduct rather than choosing to spend time trying to set up a multiple case study, an endeavour which I judged to have rather a low probability of success.

Design of the study

Within the overall framework of the single case study, the study employed two parallel research strategies:-

> An ethnographic strategy designed to enable us to "see the society from the social actor's 'point of view'" (University of Lancaster, ca 2000). The same article suggests that "*the study of social life should begin with coming to terms with meaning and the experience of social actors within their natural circumstances*"
>
> An action research strategy (Lewin, 1946) designed to enable us to act in the organisation, to observe the effects of our actions, to construct theories based on those observations and then to engage in further cycles of action and reflection,

The need to draw upon ethnographic traditions and to make use of the tools and techniques of ethnography is suggested by the proposition that the project is a study of a complex system consisting of individual agents with some freedom of action but with the contexts of their actions being influenced by actions elsewhere in the web of

relationships which constitutes the complex system. In this sense, the organisation is viewed as a human community which can be appropriately studied from an ethnographic perspective.

The need to draw upon action research traditions is suggested by the aspiration implied in the research question to discover "*ways of blending individual and organisational development*".

These parallel strategies reflect the proposition that this is a research study taking place within the context of an organisation development strategy.

The allocation of roles within the research team reflected the two parallel strategies within the case study. One researcher (G) would take the role of participant observer (Jorgenson, 1993) working within an ethnographic tradition, "*living with the tribe*" and seeking to understand the organisation from the multiple perspectives of its members.

By contrast, I would take the role of action-researcher – designing and implementing interventions, seeing what happened, developing theories to make sense of observations and planning further cycles of enquiry.

The researchers developed the procedure of the critical conversation to enable a constructive and critical dialogue between the two strategies in the hope that they might inform each other and operate synergistically in understanding and changing the behaviour of the organisation.

The ethnographic strategy

Robson (1998, p148) in discussing ethnographic studies in the context of case study design suggests that "*the intention is to provide a rich, or 'thick' description which interprets the experiences of people in the group from their own perspective*". In common with most research traditions, ethnography relies on observation to collect and, possibly, to interpret data. In the context of ethnography, Robson (1998, p 194) suggests that it is useful to consider two dimensions of observation in developing and implementing an appropriate research strategy:

> Formal or informal information gathering
>
> The extent of participation of the observer in the life of the society under study.

Formal information gathering would tend to involve attending only to pre-specified aspects of the society under study with the pre-specification being determined by the research question. By contrast, at the informal end of the spectrum anything may be of interest and any observation may be significant. Researchers working at the informal end of the spectrum use field notes, diaries, stories and so on to capture information which is largely unstructured and complex.

The participation dimension runs from one extreme of the "fly on the wall" assumed not to be noticed by the society under study and, therefore, presumably not to be influenced by the presence of the observer through to the full participant, living and working in the society but with an overt or covert observational and research agenda. Robson rather neatly summarises the implications of levels of participation in the sentence

> "*While the pure observer typically uses an observation instrument of some kind, the participant observer is the instrument.*" (1998, p194).

In this study, the researchers chose an informal approach to information gathering to reflect:

The exploratory nature of the research question.

The complexity of the society under study.

The emphasis in complexity theory on the unpredictable relationships between actions in one part of the system and actions in other parts of the system.

In making this choice, the researchers accept the difficulties which they would then face in the "*synthesis, abstraction and organisation of the data*". (Robson, 1998, p194).

In terms of participation, the researchers chose to be close to the participant observer end of the spectrum. For very practical reasons, "fly on the wall" was not available to them and they envisaged that conversations with members of the organisation would be an important data collection tool.

Equally, the researchers could not be fully participating members of the society under study because they did not have the skills, knowledge or qualifications to work safely or usefully as "normal" team members. Over the course of the project, we have gradually moved into a more participative role through measures such as holding keys (see above), writing policies and conducting clinical training.

Figure 3.4 illustrates the positioning of this study in terms of formality and participation with the red circle indicating the positioning of this study.

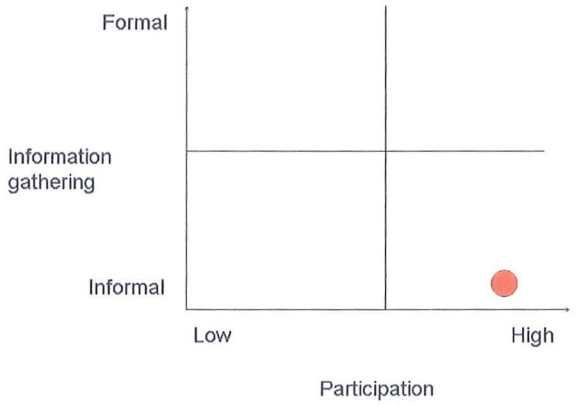

Figure 3.4 Formality and participation (after Robson).

In the context of the organisation development project, one researcher (G) was positioned as a "ward-based coach and facilitator" (see Appendix C – Organisation Development Proposal). In this role, it was envisaged that she would

> Coach staff on the ward and in its associated clinical team.
>
> Identify problems in practice.
>
> Facilitate the implementation of change at ward level.

This role description positions her reasonably well as a participant observer. Her own clinical background in nursing and rehabilitation helped her to gain entry and to establish rapport with clinical staff and with patients. The fact that she was not "mental health trained" prevented her from being seen as an externally imposed "expert".

Robson suggests that "*the case study relies on the trustworthiness of the human instrument (the researcher) rather than on the data collection techniques per se*" (1998, p160). Miles and Huberman (1984) suggest that the researcher in this sort of context needs "*some familiarity with the phenomenon and the setting under study; strong conceptual interests; a multidisciplinary approach...; good investigative skills, including doggedness, the ability to draw people out, and the ability to ward off premature closure*" (p46).

During the course of the project, G spent an average of six days each month in the ward settings, engaging with staff and with patients, having conversations with staff including those in leadership roles. She also sat in on clinical team meetings and care planning meetings, took part in training events organised for staff and observed staff to staff and staff to patient interactions.

She visited off-ward settings in which care is provided such as the Occupational Therapy Room and the primary care centre and visited the Regional Secure Unit to which many patients are discharged. She was also able to inspect documentary evidence such as care plans, ward policies, clinical audit reports and so on.

In all, the project draws upon some 500 hours of participant observation.

The methods used to record observations are described fully later in this chapter.

The action research strategy

Carr and Kemmis (1986, p165) suggest that action research is characterised by

> "*firstly, the improvement of a practice of some kind; secondly, the improvement of the understanding of a practice by its practitioners; and thirdly, the improvement of the situation in which the practice takes place.*"

The term "Action Research" was coined by Kurt Lewin (1946). Lewin envisaged action research as involving a spiral of cycles of planning, acting, observing and reflecting.

Later workers, particularly Argyris (1985) have considerably developed the approach and, in the case of Argyris and his co-workers, have developed the concept of action science which seeks to blend the change-making power of action research with the methodological robustness of more traditional forms of qualitative research.

The influence of action research can also been seen in the R.A.I.D.[17] model for implementing change advocated by the NHS Modernisation Agency in the Clinical Governance Development Programme. For an organisation development practitioner, action research is a natural approach to the kinds of problems which they address in their practice. Indeed, the formulation proposed by Carr and Kemmis above would also be a reasonable summary of the goals and methods of organisation development.

Whilst the ethnographic strategy in this study is designed to yield a rich understanding of the organisation as a community from the perspectives of its own members without seeking to disturb that community, action research sets out to disturb the organisation in particular ways and to learn about the organisation from what happens in response to that disturbance. If you like, the ethnographer is bathing in the pool of the organisation whilst the action researcher is tossing stones into it and observing the ripples.

[17] Review, Agree, Implement, Demonstrate. (NHS Modernisation Agency, Clinical Governance Development Programme).

Some writers on action research such as Whyte (1991) see it as an empowering and democratising form of research which blurs the distinction between researcher and subject (or object) of research. Lewin, himself, envisaged action research as a more democratic form of enquiry. Robson states that

> "*This democratic aspiration is important. Lewin, writing and working just after the Second World War, saw action research as a tool for bringing about democracy*" (1998, p439)

This principle of action research as a democratic process resonates with some of the principles of complexity theory. For example, Plsek (2003) argues that "*a decision to change is ultimately made by individuals in a complex system according to personal mental models about such things as the benefits and risks associated with the change*". Plsek also argues that "*it may be more helpful to think of the spread of ideas as the result of an individual or group decision adoption process....*"

In this project, the researchers used action research approaches for the following purposes:

To build shared ownership of the organisation development process using the democratising power of action research.

To understand how and why the organisation and its individual agents might respond to particular proposed changes.

To tease out the often complex factors which cause the organisation to behave in the way in which it does.

To triangulate the observations from the ethnographic strategy against the behaviours elicited through action research interventions.

A number of action research activities have been pursued in parallel:

Action research groups

Seven facilitated action research groups were established early on in the project to investigate and change particular aspects of the behaviour of the organisation. Each group consisted of six to eight people from a range of disciplines, teams and hierarchical positions.

The domains of enquiry of these groups were (some domains were explored by more than one group):

How and why we break promises to patients.
The physical environment of care.
The role of the Health Care Assistant.
The changing role of qualified nursing staff.
Relationships with non-clinical support services.

For reasons which are explored in the discussion at the end of this chapter, these groups were not particularly successful in bringing about change although the attempt to set them up and sustain their momentum proved a useful source of insights into the culture of the organisation and the beliefs and behaviours of its members.

Ward-based groups

The researchers facilitated a number of workshops with each ward team/clinical team to explore with them how to deliver a more effective rehabilitation service. Each group progressed through a series of cycles of enquiry focussed on the implementation of assertive rehabilitation in the context of their own unique circumstances.

These groups have made a certain amount of progress both in introducing useful practical change and in gaining insight into their own feelings and beliefs about their practice.

Directorate-based groups

The researchers facilitated a number of workshops for Directorate teams to explore with them their roles as organisational leaders in facilitating organisational change.

These have been partially successful with one of the two Directorates taking a much more proactive role in facilitating change than had been the case previously. These groups have also started to open up debate about and reflection on leadership roles within the organisation and the nature of leadership.

Maintaining the patient environment.

There is one opportunistic action research project running which involves training patients (who volunteer) to play a part in maintaining their own physical ward environment. This project is symbolically important in that it is genuinely building on a suggestion from "front-line" staff.

Using action research in the context of an organisation development project inevitably surfaces tensions in the organisation and in the practitioner-researcher between learning (the research component) and delivering expected and timely change. Although my own experience as a practitioner and the literature on organisational change both suggest that the rate of change is reasonable, it is difficult not to experience the rate of change as painfully slow and to experience the anxiety and self-doubt which accompanies that perception.

The methods used to capture, analyse and organise the data from the action research enquiries are discussed in the next section of this chapter.

Data collection

In considering how to collect, organise, analyse and interpret the data in the case study, I have followed the "six sources of evidence" framework proposed by Yin (2003, p86). The table below summarises this framework and gives examples of the type of evidence which have been collected in this case study.

Source of evidence (after Yin)	Examples of evidence in this case study.
Documentation	Minutes and other documents from meetings. Reports and proposals generated by the author in the course of his work as an OD practitioner.
Archival records	Care plans. Reports of serious untoward incidents.
Interviews	Interviews with members of staff.
Direct observations	"Sitting in" on meetings. Observing interactions between patients and staff.
Participant observations.	Facilitating action research groups. Coaching on the ward.
Physical artefacts.	Layouts of wards and other clinical areas. Computer-based information systems.

Table 3.1 Types of evidence

In developing a strategy for data collection, I have followed Yin's three principles (2003, p97) of data collection:

Use multiple sources of evidence.

Create a Case Study Database.

Maintain a Chain of Evidence.

The case study data base is primarily held on computer and consists of:

Field notes written by the researchers.
Reflective diary entries.
Summaries following critical conversations.
Documents produced by the researchers in the course of the study.
Emails sent and received in the course of the study.

Documents originating in the organisation have not always been made available in electronic form and are, therefore, in a paper-based archive.

Some documents such as care plans, patient records and sensitive security procedures can not be removed from site or reproduced in a document of this nature. Where appropriate they have been referred to in sufficient detail for a suitably authorised researcher to access them.

Examples of field notes and reflective diary entries are given in Appendix D.

The format used for field notes is shown in Box 3.1 overleaf.

FIELD OBSERVATION RECORD				Nr.
Date	Start	End	Location	
Themes				
Notes				
Observer				

Box 3.1 Field Observation Record Format.

The format used for summarising identified themes is shown in Box 3.2 below. A full analysis of themes is included in Appendix D.

THEME	Number of mentions in field notes	Number of mentions in documents
SECURITY AND NURSING		
Security policies and procedures are imposed.	37	2
Tilt report recommendations set us back.	12	0
Time spent on security duties	42	1
Conflict between nursing role and security role.	18	1
Performing security duties therapeutically.	3	0
EXPRESSION OF SEXUAL NEEDS		

Box 3.2 Format summarising themes.

Data analysis and data integration.

The project database may be considered as consisting of a number of texts of various kinds. The texts have been analysed following the protocol suggested by Smith and Osborn (2003 Chapter 4) for thematic analysis in relation to interpretative phenomenological analysis (IPA) in the context of psychological investigations. Although Smith's work is concerned particularly with the analysis of transcripts of interviews with individuals, I believe the protocol which Smith suggests provides a rigorous framework for the systematic analysis of the range of texts which this study generates. Smith also suggests an approach to data integration in terms of clustering of themes and looking for convergence and divergence amongst themes from a number of texts. Smith emphasises that IPA is essentially an iterative and interpretative process in which the researcher is seeking to make sense of how an individual makes sense of his or her life-world.

Products from the mental health project

The work goal of the mental health project was "*to develop a more effective assertive rehabilitation service which will enable patients to move into less restrictive settings as quickly as possible*" (see figure 3.3 above).

Work towards the achievement of this goal is reflected in the following products (see also Appendix C) :

A framework for assertive rehabilitation.

A development programme for primary nurses.

A development programme for Clinical Nurse Managers and Team Leaders.

Redefinition of the Clinical Nurse Manager role and, where necessary, appointment of new post-holders.

A continuing organisation development programme.

DISCUSSION OF THE RESEARCH STRATEGY AND METHODOLOGY

The research strategy developed was designed to meet the following requirements:

> To be embedded in real-world organisational development practice.
>
> To be capable of delivering the work goals associated with the real-world organisation development practice.
>
> "To create new knowledge and new applications" (Level 5 Descriptors, Module Handbook, p 32).
>
> "To communicate complex or contentious information effectively to a range of audiences" (Level 5 Descriptors, Module Handbook, p 32).
>
> To reflect and be adaptable to the "complex and unpredictable situations in professional environments". (Level 5 Descriptors, Module Handbook, p 32).

As part of a portfolio of work submitted for the award of a professional doctorate, the research strategy and methodological approach had to be capable of demonstrating

> "*expertise in the wide-ranging areas related to real-world enquiry which emphasises problem-solving in addition to gaining knowledge, looking for robust results and implementing change where feasible rather than solely concentrating on relationships between variables*" (Robson, 2002 quoted in Project Modules Handbook, p 4).

Johnstone, writing on health service research in practice and the use of mixed methods, quotes from Lincoln and Guba (1985) who suggest that one of the defining characteristics of a research problem is that it is "*a state of affairs that begs for additional understanding*" and "*the purpose of research enquiry is to 'resolve' the problem in the sense of accumulating sufficient knowledge to lead to understanding or explanation*". Johnstone argues cogently that undertaking research to address complex real-world problems may require conventional paradigmatic boundaries to

be challenged and for the researcher to be prepared to draw on a mix of approaches to adequately understand the research problem. (2004).

One of the criticisms which could be made of my research strategy is that it is overly complex drawing as it does upon two major leadership development and organisation development projects each of which, on its own, might constitute a project of sufficient scale and complexity to meet the module requirements. In my view, however, neither project, on its own, was capable of generating conclusions about leadership and organisation development in the NHS which would be sufficiently robust, credible and practical to bring about worthwhile change both in knowledge and in practice. The first (career development) project could be criticised as consisting only of informed speculation about the future; tested only through simulation rather than in reality. The second (mental health) project could be criticised as being too located in the present (failing to look into the future) and as being too specific to a particular organisation which some might regard as too idiosyncratic to enable valid generalisation to other settings. I believe that, by creating a dynamic conversation between these two quite different projects, the design overcomes the inherent weaknesses of each of the projects and creates and elicits a degree of synergy between them.

I believe that the "two-project" strategy also reflects the organisational reality of both addressing current performance and leadership issues and preparing for the future. Real-world organisational leaders do not have the luxury of concentrating on the present or the future; they have to do both – should the practitioner/researcher set out to do less?

I accept the dilemma that, although it is notoriously difficult to draw robust conclusions about the future, leadership development and organisation development are inherently future-oriented disciplines. However problematic investigating the future may be, it is necessary. A methodology which relied solely on gathering data about the present, which, by the time conclusions were drawn, would have become the past is open to the criticism that it draws robust but no longer relevant conclusions.

In seeking to understand the future, or at least to make some "good enough" assumptions about it, I decided to use a combination of focus groups, an electronic "Delphi-like" dialogue with the leadership community and a development centre to create a richer picture of the future. The creation of the products of the study, including the wide consultation which underpinned the development of the products, also helped to enrich and to "flesh out" the findings from the three formal activities.

Other methodologies were considered such as a formal Delphi exercise and a future simulation not in the form of a development centre. On reflection, a formal Delphi exercise might have added robustness to the conclusions reached although the technique has been criticised as manipulative and as creating the illusion of participation (Stuter, 1998). I believe that focus groups complemented and moderated by wide consultation and the development centre simulation enabled a reliable and credible consensus to be achieved within the resources and time-scale which were available for the project. Although focus groups are not representative and focus group members should never be regarded as constituting a representative sample from which inferences about wider populations can be drawn, criticism could be made of the way in which these particular focus groups were selected. I am aware that the nomination of focus group members was influenced by the need to engage and to be seen to engage the five Strategic Health Authorities who were commissioning the project and who, if it were to bring about change, would have to have some "ownership" of the outcomes. To me this seems, particularly in the context of real-world research, to have been a legitimate consideration.

My main concern about the mental health study is that of generalising conclusions from a particular and unusual setting to other parts of the NHS. As with most case studies, the mode of generalisation will be analytic rather than statistical (Yin, p23).

Robson, drawing on the work of LeCompte and Goetz (1982), highlights the following threats to external validity:

> Selection – findings being specific to the group studied.
> Setting – findings being specific to, or dependent on, the particular context in which the study took place.
> History – specific and unique historical experiences may determine or affect the findings.
> Construct effects – the particular constructs studied may be specific to the group being studied.
>
> (1998, p73)

In considering issues of selection and setting, it is important to recognise that the organisational landscape of the NHS is a remarkably varied one populated by quite different kinds of organisations – acute hospitals, GP practices, Strategic Health Authorities, Mental Health Trusts and so on. This organisational heterogeneity suggests that it would be difficult to identify "representative" organisations or even to construct a "representative sample" of organisations. Once the notion of organisational history is factored in, organisations start to look very individual and idiosyncratic. The table overleaf (3.2) summarises some of the important ways in which the organisation in which this case study is set is unusual and the ways in which it shares commonalities with many other NHS organisations.

HOW "TYPICAL" IS THE CASE STUDY ORGANISATION?	
Differences	Similarities
Focus on a narrow range of diseases and disorders.	Patients with complex health and social care needs.
Patients are detained by the state.	Complex care delivery processes involving multi-professional working.
Few emergency admissions.	Involvement of many other agencies in delivering the service.
Involvement of Home Office in decisions about discharge.	Untoward incidents likely to attract adverse media comment.
Unusually long average length of stay.	Weak level of agreement about what constitutes best practice.
Discharge to the community or to the patient's own home is rare.	High levels of uncertainty about how to achieve good outcomes and about what constitutes good outcomes.
Environment of high security.	Increasing levels of "consumerism" amongst patients and their advocates.
Long organisational history.	Hierarchical management structure overlaid with professional hierarchies.
	Difficulties in maintaining an appropriately skilled workforce.
	Capital resources very constrained.
	Relatively disempowered workforce.

Table 3.2 How typical is this organisation?

Although at first sight, the organisation studied is rather atypical, one of only three such institutions in the NHS in England, in terms of the issues which this project is exploring, I believe that it is "enough like" many other NHS organisations to enable the findings from this study to be relevant to other settings.

The "two projects" research strategy is designed to improve the external validity of the study. By placing this particular project in the wider context of the overall enquiry, I have sought to triangulate the findings from this study both with the relevant literature and with other organisation development projects in which I am now or have recently been involved.

Figure 3.5 below illustrates how the case study is located in a wider consideration of individual and organisational development.

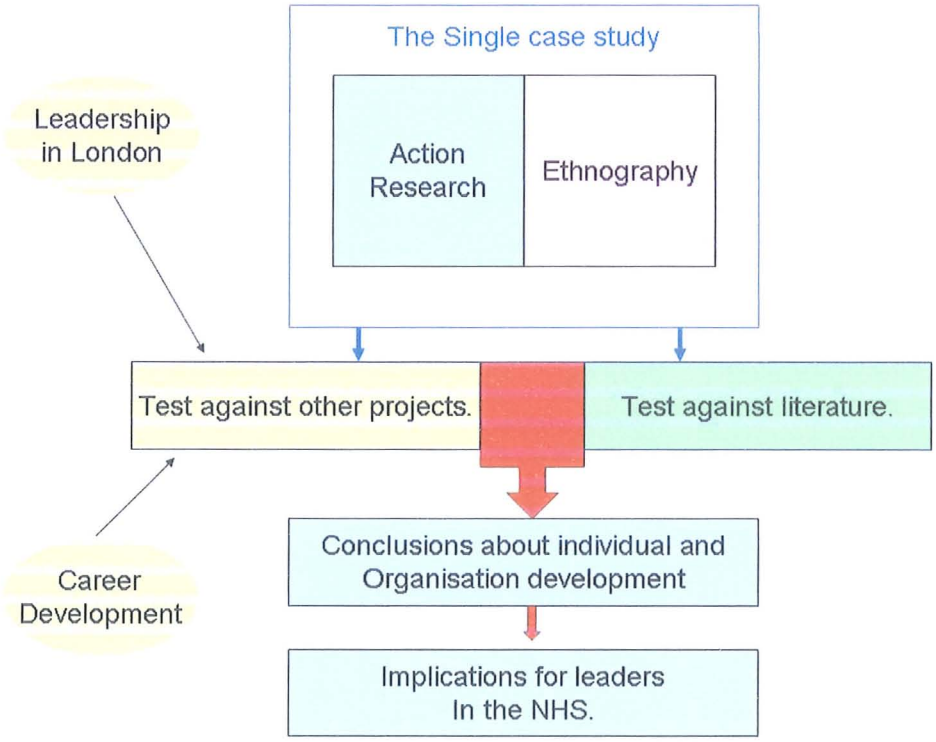

Figure 3.5 Triangulation of projects and literature

Ultimately, NHS leaders and practitioners are more likely to adopt practices based on the findings from this project if they perceive them to be relevant and useful and if the issues discussed resonate with their own experiences, beliefs and aspirations.

It is for me, in writing up the project, to make the case that it is reasonable to generalise from this particular case study to other organisational settings. This is a matter of presenting the emergent theory cogently and robustly and without distracting the reader with the idiosyncrasies of this particular organisation,

fascinating though they may be. It is also a matter of communicating the richness of the case study so that this organisation "feels a bit like ours". The story must be one with which the reader can identify.

ETHICAL CONSIDERATIONS

Perhaps one of the most challenging aspects of this project has been the management of the ethical issues which are implicit in it, especially in the mental health study. In particular, I have struggled to accommodate the ethical considerations which are appropriate to organisation development practice within the ethical frameworks designed for "purer" research.

Ethical frameworks such as "The Research Governance Framework for Health and Social Care" (2001) are designed to achieve two purposes:

> To protect people from being abused, exploited or disadvantaged by research activities.
>
> To promote and safeguard standards of research.

A cardinal principle of traditional clinical research is that of "informed consent". However this becomes problematic when engaging staff in discussions and activities the likely outcome of which is that they will be asked to change their practice. In reality, staff cannot refuse to take part in some elements of the project nor can they refuse to implement agreed changes provided that both participation and implementation of new practices fall within the scope of their contractual relationship with their employer (The Trust). It would be disingenuous to pretend that they are "consenting" in anything like the same way as a patient is consenting to treatment or a participant in a clinical trial is giving their consent.

For this sort of practice-based research, the ethical considerations applying to a "good employer" are more pertinent than those addressed in documents such as The Research Governance Framework. It may be more appropriate to rely on guidelines such as "The Code of Practice for NHS Managers" (2002).

Some of the other ethical issues surfaced by the project include those which will be familiar to anyone providing clinical supervision. For example, what does the researcher do when he/she becomes aware of behaviours on the part of staff members

which are abusive or neglectful of patients or fraudulent? At best both conversations and field observations can only take place under conditions of "qualified confidentiality" – conversations and observations will be treated in confidence unless there is an over-riding argument to do otherwise.

Similarly the researchers' commitment to openness and honesty has to be qualified. In the course of the project, the researchers did have "private" conversations with the Chief Executive and other organisational leaders about the performance, behaviours, capabilities and attitudes of members of staff. It is possible that some such conversations will, in the longer term, potentially work to the detriment of the members of staff concerned.

Ethical issues in relation to patients are more straightforward. Although the intent of the project is to benefit patients, they are not directly involved in the project. However, the researchers see them, talk to them, look at their care plans and discuss their needs with members of the clinical teams responsible for their care. In these activities, the researchers were governed by codes such as the NHS Confidentiality Code of Practice (2003) and by the Trust's own Corporate Governance policies and procedures. One of the researchers, who is more closely involved with patients than I am, is also governed by the Code of Professional Conduct of the Nursing and Midwifery Council (June, 2002).

Given that the ethical issues in the project are not straightforward or "black and white", the researchers endeavoured to follow the principles set out in Table 3.3 in conducting the project.

Ethical Guidelines for the Project
Staff taking part in conversations and events in the course of the project will be made aware of the circumstances in which confidentiality will not be observed and will have an opportunity to question, debate and discuss our view of qualified confidentiality.
Observations about named members of staff will only be discussed in the organisation where there is a compelling reason to do so in terms of the well-being of patients and/or staff. Observations will be discussed in as constructive a way as we can manage with a view to minimising any possible detriment to the members of staff concerned.
We will apply the precepts set out in the Code of Conduct for NHS Managers in all our dealings with the organisation and its staff.
We will adhere to the Trust's policies and procedures in relation to corporate and clinical governance.
We will adhere to all individually relevant Codes of Professional Conduct.
Data gathered in the course of the project will be stored securely.
Where there is a perceived conflict between the interests of patients and that of staff, the interests of patients will prevail.

Table 3.3 Ethical Guidelines for the Project

Although these guidelines proved extremely helpful, their value would have been greatly enhanced had we thought to build them in partnership with members of staff in the organisation or at least to share them with the staff involved in the project. Unfortunately, it did not occur to us to do so and this is an important lesson which I have taken away from this project.

Formal ethical approval

Given the view that the sort of practice-based action research which is involved in this project is not appropriately governed by frameworks designed primarily for traditional clinical research or for "pure" social science research, the Chief Executive has, after discussions with the Trust's Director of Research and Development, certified that the project does not require approval from the Local Research Ethics Committee.

Considerable discussion with my academic advisers took place over the issue of formal ethical approval and approval to proceed was given only after careful thought and clarification of the ethical guidelines in which the work would take place.

As a consequence of the debates about an appropriate ethical framework for this sort of research in this context and elsewhere in the NHS, I have been commissioned to develop a set of guidelines on ethical approval for research of this nature. An early draft of this work is attached as Appendix E to this document.

Quality of research

Although the primary purpose of the Research Governance Framework is to safeguard the interests of patients and other potential subjects or participants, the Framework also exists to assure the quality of research undertaken in the NHS.

In the context of this doctoral programme, the quality of the research design is assured through presentation to a programme panel of the Programme Planning and Rationale document which is then discussed and defended. In my own case, I was asked to strengthen aspects of the design before proceeding.

I have also benefited considerably from the on-going advice from my academic adviser and project consultant. Ultimately, of course, the responsibility for assuring the quality of the research is my own.

Wider ethical issues

The preceding section discusses the immediate research ethics issues which had to be addressed in planning, undertaking and writing up this project. The setting of the case study raises a number of wider ethical issues which the researchers have had to confront. These include:

The extent to which the patient's "normal" rights in terms of privacy, dignity and consent are severely compromised when they are detained under the provisions of the Mental Health Act (1983), the Terrorism Act (2000) and similar socially coercive legislation.

The role conflict which (some) nurses in particular experience in reconciling trust-based therapeutic relationships with duties and tasks associated with safety and security such as searching patients and their rooms.

The extent to which the discharge of patients is delayed for "political" reasons on the direction of the Home Office.

The fact that patients might, in some respects, be better off in prison where they would have a definitive release date.

How staff manage their own feelings of loathing and disgust for some patients who have committed "terrible crimes".

The dehumanising effects of long-term institutional care which is normally regarded as "bad practice" in other domains of health care.

The effects of near-complete gender separation on the social context of patients and on their needs for sexual expression. It is interesting but sad to note that, rather unproductively, sexual expression is always identified as an area of unmet need.

An important emergent ethical issue is the proposal to amend mental health legislation to enable the detention of people with "Dangerous and Severe Personality Disorders" even if they have not yet committed a crime. This is particularly germane in the context of this case study as a purpose built DSPD unit is currently being constructed on the site where the researchers are working.

For both of the researchers in this project, encountering the reality of these wider ethical dilemmas has been a profound and salutary learning experience – they have brought to our attention difficult and distasteful issues which hitherto, like many in society, we have preferred not to have to think about.

PROJECT ACTIVITY AND FINDINGS

As indicated in Chapter 1, I have drawn upon two projects in which I am currently engaged; a large scale organisation development project in a mental health hospital and a career development and succession planning project for the NHS in London.

In this chapter, I describe the key activities in the mental health project and in the career development project and summarise the key findings of each. Supporting data and detailed data analyses are included in appendices A-D partly because of the volume of data generated by enquiries of this nature and partly because of the confidential nature of the data. As one of the institutions is readily identifiable because of its specialist nature, I may have to ask for some of the appendices to be excluded from publicly accessible versions of this report.

LEADERSHIP IN A MENTAL HEALTH HOSPITAL

As discussed in Chapter 3, an organisation development project in a high security mental health hospital is used as a case study for the exploration of leadership in practice with a particular focus on "close in" leadership and on the interaction between organisation development and leadership.

This project is still very much work in progress. This chapter describes emergent findings and a mix of actions which have taken place, are in train or are planned for the future. It reflects both the exploratory nature of the project and the action research orientation with its cycles of enquiry each grounded in preceding cycles and likely to lead to future cycles.

The organisational context

The project is set in one of the three high security forensic mental health hospitals in England. Managerial arrangements for the high security hospitals have been subject to considerable change over the life of the institution but, during the time of this project, it formed part of the Forensic Division of one of the largest Mental Health Trusts in the NHS in England. The merger of the special hospital into the Trust took place in April, 2001.

The hospital is designed to "*provide care and treatment for patients with a mental disorder who represent a grave and immediate danger to the public*". (Extract from Statement of Purpose, 2003). All patients are compulsorily detained under the provisions of the Mental Health Act (1983) or similar legislation with a small number detained under recent anti-terrorist legislation.

The hospital presently has 16 wards for male patients and five wards for female patients providing accommodation for approximately 360 patients in total. The average length of stay is about nine years. As part of a national strategy, it is intended that services for female patients in the hospital should be discontinued from 2005. A new unit is currently being built to serve the needs of patients with "dangerous and severe personality disorder". This unit is being constructed in anticipation of the passage of new legislation in the form of the Mental Health Bill in which it is currently proposed to create a single definition of mental disorder and to provide powers of compulsion whether or not a crime has been committed.
Although the hospital is managed by the NHS and forms an integral part of it, the Home Office exercises considerable influence on policy and on the fate of individual patients.

Culturally, the organisation is a complex mix of a hospital and a high security prison. Following the Tilt Report published in February 2001, considerable investment has been made in improving security at the hospital and many staff perceive the effects of the implementation of the Tilt recommendations as including creating a more restrictive regime for patients and requiring nursing staff to carry out duties such as

the searching of rooms and of patients which they perceive to be in conflict with their role as nurses (Field Note 13).

It is impossible to generalise about the "staff culture". In a group of staff who attended a Primary Nurse Development Workshop which I ran recently, I elicited the following range of illustrative comments:-

> *"I used to hate opening the doors when they still had slopping out".*
> *"In my country, patients leave their rights behind when they come into the hospital".*
> *"We've got to use evidence-based nursing here".*
> *"Our job is to empower the patients – give them back a sense of self-esteem".*

A number of factors contribute to the complexity and diversity of the staff culture:

> Some staff having made life-time careers in the hospital, having trained there, never worked anywhere else, being married to other members of staff and, often, with sons and daughters on the staff.
>
> Some staff are attracted by the relatively high levels of pay (and other benefits such as overtime) offered by the hospital and effectively cannot afford to leave.
>
> Some staff are attracted by the complexity of the clinical work and of the pathologies exhibited by patients.
>
> Recently, the hospital has been recruiting nurses from overseas, particularly South Africa. These "new" nurses bring an extra level of diversity and complexity to the staffing mix.

In common with other NHS institutions, the hospital is characterised by a multiplicity of different professional cultures, each of which has its own effects on the culture and behaviour of the organisation as a whole.

As I have suggested in Chapter Three (see Table 3.1), this hospital is in some ways representative of other NHS institutions and in other ways quite unlike them. It is not, for example, faced with problems of waiting lists or waiting times in A&E or balancing emergency and elective admissions. Atypically too, its patients are compelled to be there; notions of privacy, dignity and autonomy which would be normal in other settings are severely compromised in this setting and staff, other patients and the public are perceived to be at grave risk of violence from at least some patients. To be afraid of your patients is relatively rare in other NHS settings but commonplace and arguably prudent here. Members of staff also have to manage the feelings of hatred and revulsion[18] which they may have towards some patients resulting from the behaviours (index offences) which caused them to be admitted to this hospital. (Field Note 60).

Background to the project.

Immediately before the organisation development project started, a number of allegations of sexual abuse and harassment of female patients had been made. The Trust has responded by imposing almost total segregation of the sexes amongst patients so that mixed gender social activities have now been suspended. A short investigation into the allegation was carried out by the (then) London Directorate of Health and Social Care. It was as the result of one of the recommendations of this investigation, that I was invited to assist the Trust in developing an organisation development strategy.

At this stage, I had not envisaged working with the organisation extensively to develop and *implement* an organisation development strategy. I had only been asked to help them to *write* such a strategy. I am not even sure that there was a genuinely felt need to have an organisation development strategy, perhaps just a need to comply with the recommendations of the investigating team.

[18] An excellent exploration of this issue can be found in Bowers, L. et al (2000)

The initial study (See Appendix C), which took approximately ten days, suggested a number of organisation development issues which the Trust should address. These were:

- Clarifying and reaching consensus about the purpose of the organisation.
- Placing more emphasis on the therapeutic role of the organisation as opposed to its "custodial" role.
- Encouraging and enabling internally driven change as opposed to reacting to external requirements.
- Ensuring better continuity of care during the whole "patient journey".
- Ensuring better consistency of care – both mental health and physical health.
- Improving clinical leadership.
- Investment in facilities.

Given the recommendation about encouraging and enabling internally driven change, the initial study suggested that the organisation should take an action research approach to organisation development to engage front-line clinical staff in the organisation development process.

The conclusions and recommendations in the initial study were accepted by the Chief Executive and the Trust Board. I was asked by the Chief Executive if I would be willing to give support to the organisation in the implementation of the strategy. Despite my reservations about being involved in large scale organisation development projects in the NHS, I agreed to put forward a proposal to provide organisation development support to the organisation in the form of a pilot project based on two wards and their associated clinical teams (see Appendix C). The proposal for a pilot project was accepted and work started on the pilot project in January, 2003.

In describing the aims of the pilot project to the organisation as a whole, I made the following statements:

> *We want to ensure that practice on a day to day basis delivers the purpose of the organisation as a hospital.*
>
> *We want front-line staff to learn to take responsibility for and to feel "empowered" to maintain and improve the quality and purposefulness of practice throughout the organisation.* (Appendix C - Supporting the OD Strategy 20/11/02)

Subsequently (September, 2003), the aim of the pilot project was refined and articulated as:

> *To develop a more effective assertive rehabilitation service which will enable patients to move into less restrictive settings as quickly as possible.*

The decision to refine and re-formulate the aims of the organisation development project was driven by:

- A change in my perception of the "readiness" of front line staff to lead the change process based on my experience with the initial action research groups.

- The introduction of the term "assertive rehabilitation" by the Associate Director of Nursing into the vocabulary of the organisation.

- A request from the Director of Forensic Services to extend the organisation development programme from two wards to all six wards expected to provide a rehabilitation service.

The initial organisation development design

For reasons which are discussed above, I had originally conceived of action research as the key strategy for bringing about sustainable change in the organisation. The choice of approach was strongly influenced by my conclusion that the organisation should become better at:

> *Encouraging and enabling internally driven change as opposed to reacting to external requirements.* (Appendix C).

I believed that the organisation development design should reflect this intention. It was an approach with which I was confident and familiar and in which I had some professional expertise. I also hoped that the approach would build on work which the Trust had already started in the form of Clinical Improvement Groups (CIGs).

In response to the organisation's request for support, I recommended a relatively small scale pilot involving just two wards and their associated clinical teams. I thought that the pilot would:

> Elicit lessons some of which could be generalised across the hospital and more widely within the Trust.
>
> Identify problems which, if solved, would benefit other areas of the hospital and, possibly, the Trust.
>
> Develop some internal expertise and capacity for the Trust to continue its own organisation development work.

I believed that the pilot was sufficiently small that I would be able to implement and support an effective organisation development intervention with the time and resources which I had available and with the level of commitment which I was prepared to make at that time.

The Chief Executive of the Trust, in consultation with her Executive Team and me selected the two pilot wards. A strong influence on her choice was the attitudes of the two consultant psychiatrists responsible for the wards selected; they were relatively new in post and had expressed a strong desire to improve the quality of practice on their wards.

Initially, I agreed that the pilot would run over about six months and then there would be a pause to review progress. A Steering Group, chaired by the Chief Executive, was established for the project.

My previous experience using action research within the NHS suggested that:

> Action research groups often experience real difficulty in clearing time to undertake the action research activity.
>
> Action research groups often became "blocked" by organisational policies and procedures and by the behaviours of senior people within the organisation.
>
> Action research groups often require support in between "formal" meetings.

In the light of this previous experience, the project design included the following measures:

> A *relief team* within the organisation which would enable complete clinical teams to leave the ward to take part in action research activities.
>
> A *dynorod* group chaired by the Chief Executive the role of which would be to clear organisational blockages identified in the course of the action research activity.
>
> A group of "*care champions*" nominated by the Chief Executive. These were people (all clinicians) who were thought to be influential in the organisation and who were thought to be broadly sympathetic to the aims of the organisation development strategy.

A *ward-based coach* (one of my colleagues) who would work with action research group members and others in the clinical setting to help them to implement change.

The extent to which these measures were implemented in practice and had the desired effects is discussed below.

The programme was formally launched (see Appendix C) on 12th March, 2003 at a one day workshop for staff from the two pilot wards. Following the launch event, seven action learning groups were established focussed on clusters of issues identified during the workshop (see Appendix C). Six of the groups were facilitated by senior managers or clinicians and the seventh by my research colleague.

The evolving organisation development design.

Earlier in this Chapter, I suggested that design in organisation development practice needs to be regarded as an emergent process rather than as an event or a stage. The design might need to evolve both in response to changes in the organisational landscape and in response to the perceptions of the practitioners working with the organisation. A third factor is that some initial planning assumptions turn out to be incorrect.

The following examples illustrate each of these three cases in the context of this project:

Changing landscape

In May, 2003, the organisation published a policy document "Assertive Rehabilitation" which presented a "new" model of care which these two wards (and others) were expected to implement.

In April, 2003, the Trust published a new policy on the Care Programme Approach (CPA) which significantly changed the process of care planning and, importantly, sought to change the role of Primary Nurses in the care planning process.

Changing perceptions

As I became more closely engaged with the organisation, my perception that staff would welcome more "empowerment" came to seem less and less credible. Nursing staff, in particular, seemed reluctant to engage in conversations about what *they* might do to change the experience of patients.

I also started to have serious concerns about the competences of (particularly) nursing staff to deliver therapeutic as opposed to custodial care and about the competences of Clinical Nurse Managers (Ward Managers) to provide effective leadership for their wards (Field Note 93)

I realised that the design left out an important "tier" of the organisation, the Service Managers to whom the Clinical Nurse Managers were accountable.

Planning assumptions

The assumption about the organisation's ability/willingness to release staff from their ward duties proved very fragile.

Some of the people identified as care champions turned out not to be particularly influential, often for reasons of time, in relation to the pilot wards.

In August, 2003, the Chief Executive announced that she would be resigning from the Trust in December, 2003.

In the light of these and several other factors, I undertook a review of the strategy in August, 2003. I reported to the Chief Executive that, while a certain amount of progress was being made, it was extremely slow and modest.

I agreed with the Chief Executive that the project should be "refreshed and re-focussed" in a way which:

- Would encompass other initiatives such as Assertive Rehabilitation and the new Care Programme Approach policy.
- Make the aims and the process more concrete and less exploratory.
- Place less reliance on the action research groups.
- Recognise the need to improve the skills and knowledge base of the nursing staff.
- Improve the quality of leadership at ward level and above.

- Align the project more closely with the line management structure of the organisation.

A further workshop "Moving on and Speeding Up" was arranged for the 24th September, 2003 (see Appendix C) to review progress and to share our thoughts about how best to take the project forward. Shortly after this workshop, I was asked to extend the project to cover all six wards in which the assertive rehabilitation model was to be applied to ensure consistency across the rehabilitation service in the hospital.

The current implementation (see Appendix C)

The key strands of work in the current implementation of the organisation development strategy are as follows:

Developing the rehabilitation model

Producing a document which seeks to tease out the aims, philosophy, key processes and roles involved in the implementation of assertive rehabilitation in the wider context of a Trust wide policy on the Care Programme Approach (CPA).

Clarifying roles

Establishing clear roles, responsibilities and standards both in terms of clinical responsibilities and leadership responsibilities throughout the rehabilitation service.

Building competence.

Designing and delivering an educational programme designed to equip practitioners, particularly primary nurses, with the skills, knowledge and attitudes required to fulfil their role requirements to the required standard.

The programme consists of both formal classroom-based learning and ward-based coaching.

Enhancing leadership practice

Inadequate leadership is seen as a major block to progress. I am currently seeking, through a range of measures, to ensure that Clinical Nurse Managers, Team Leaders and Service Managers become competent to provide effective leadership in their areas of responsibility. This process is complemented by informal coaching with more senior managers and clinicians to ensure that

they create the conditions in which effective leadership is likely to flourish at ward level.

Enhanced and new roles

I am exploring how roles might be reconfigured to better match the demands of the service and its patients. I am, for example, exploring how to equip some Health Care Assistants (HCAs) with skills and knowledge traditionally associated with Occupational Therapy staff and how to equip some nurses with skills and knowledge traditionally associated with Clinical Psychology staff.

In the longer term, I am considering the development of Rehabilitation Practitioners who would be able to draw on the competence base of many disciplines to address the needs of their patients.

Opportunistic action research

Although I believe that the project should not rely on action research to deliver the changes which are necessary, I am still encouraging front-line staff to come up with and carry through ideas which they believe will improve the experiences of and outcomes for patients.

As an example, I am supporting one of the Domestic Supervisors in implementing a project to engage patients in the care of their own physical environments.

Sustaining the project

One of the challenges facing an "external" organisation development practitioner is that of planning his or her own exit from the organisation. The effective practitioner will aim not only to address the specific problems and issues with which he or she has been commissioned to help but will also seek to leave the organisation in better shape to carry forward organisation development work in the future.

In this case, I hope that by working with organisational leaders, managers and clinicians, in the design, development and implementation of the project, I will have enhanced their understanding of and competence in organisation development.

More concretely, I am working with the organisation to select and train a number of clinical practice facilitators who will take over the ward-based coaching and facilitation role currently being carried out by my co-researcher.

I am also discussing with the organisation changes in the management structure and, particularly, the clinical leadership structure to create and maintain an emphasis on continually improving clinical practice.

KEY FINDINGS FROM THE MENTAL HEALTH STUDY

Complex adaptive systems

The organisation which forms the focus of the case study does display the characteristics of a complex adaptive system characterised by:

- A network or web of heterogeneous autonomous agents (including patients) in which the actions of an agent or agents in one part of the web of relating can have large-scale and unpredictable effects elsewhere in the web.

- The existence of shadow systems and shadow attractor patterns which influence the attitudes, beliefs, values and actions of agents in the system under study. Key examples in this case study include:

    - Wider social attitudes towards the often horrifying past actions of patients (their index offences) leading to feelings of hatred, disgust and anger amongst professional staff.

    - The social network of the institution which is unusually strong characterised by patterns of social relationship including marriage, civil partnership and parent-child relationships and by exceptionally long periods of continuous service.

    - The organisation as an income maximisation/effort minimisation system characterised by high levels of pay, extensive opportunities for overtime and high absence levels.

    - Professional networks of relationship running alongside formal multi-professional structures.

- The capacity of the system to be self-organising often over-riding attempts by organisational leaders to impose different forms of order.

- Interaction between system and context. "*System and context form and are formed by each other at the same time*". (Stacey, 2003, p263).

Complexity, simplicity and chaos.

A constant theme which emerges in our dialogue with the organisation is that of the dual nature and purpose of the organisation as prison and as hospital, providing both custody and therapy. I have come to the view that the institution can legitimately be regarded ***both*** as a complex (or chaotic) system and as a simple one. Arguably, the system as custodial institution displays many of the characteristics of a simple system in which there is both high agreement and high certainty (see figure 4.1 below). This (custodial) view of the organisation is characterised by detailed and tightly enforced rules and regulations which have the effect of making agents behave homogenously rather than heterogeneously.

Discretion is deliberately engineered out on the grounds that discretion would present staff with "*decisions which they are not sufficiently skilled or confident to make*" (Conversation with Chief Executive, August, 2003).

Conversely, there are relatively few guidelines, protocols, or rules in relation to the clinical treatment of patients. I and my co-researcher observed great variation in clinical practice across those areas of the institution with which we[19] were working and different systems of knowledge, attitude and belief amongst different practitioners. If the custodial work of the organisation was characterised by high levels of agent homogeneity, its therapeutic work was characterised by equally high levels of agent heterogeneity.

[19] Unless stated otherwise, "we" refers to my co-researcher (G) and myself.

I considered that the following could be important explanatory variables in seeking to understand the heterogeneity which we observed in clinical practice:

- The complex pathologies presented by the patients in this hospital often combining severe mental illness, personality disorder and substance misuse.
- The absence of a strong evidence-base in mental health generally. (CRD, 2001).
- The influence of non-clinical factors on patient journeys such as decisions by the Home Office and the availability of "discharge destinations" such as Regional Secure Units (RSUs).

I came to the view, as shown in Figure 4.1 below, that the hospital as a therapeutic institution could be seen as a chaotic rather than complex system with few patterns of consistent organisation behaviour observable over time.

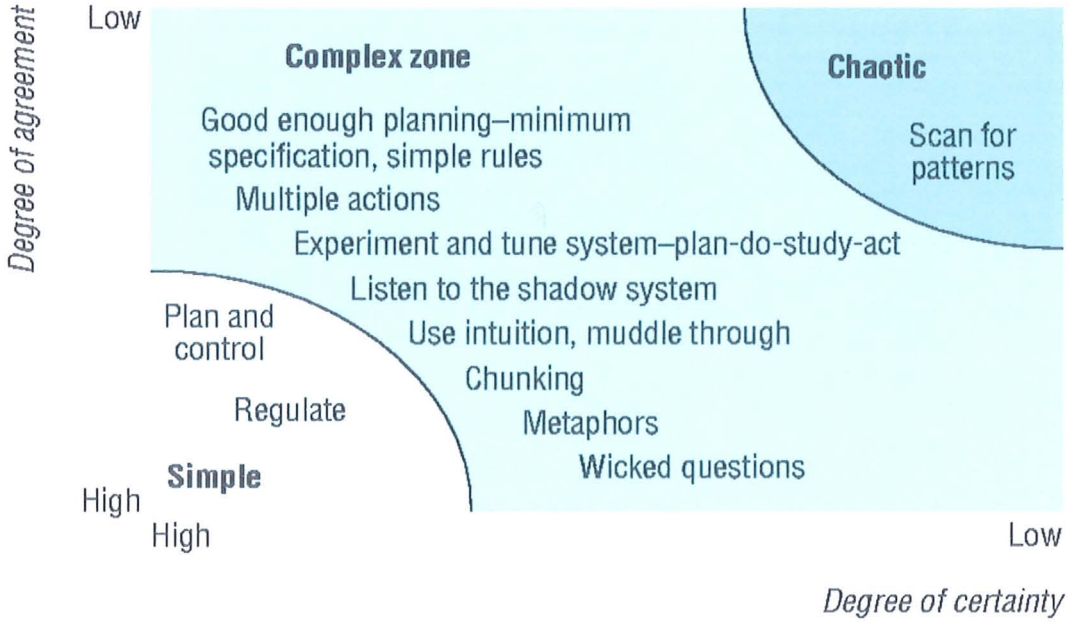

Figure 4.1 Simplicity, complexity and chaos (after Stacey and Zimmerman)

I found that leadership, particularly at ward level, was a critical factor in influencing the extent to which the organisation delivered against its declared purpose. During the course of the organisation development project, a number of ward leaders (Clinical Nurse Managers) were replaced and we were able to observe significant, positive and relatively rapid changes in the behaviour of the teams on wards where this had occurred. (Field Note 43)

We also observed that changes in medical leadership could change the experience of patients in some ways, for example, significantly better care plans, but did not lead to significant changes in the behaviours of the rest of the ward team. (Field Notes 64 and 110). I came to the conclusion that the doctors were not seen by other staff as legitimate leaders of the "clinical team" and also that doctors had neither the time nor the skills needed to deliver change across the team although they could be quite influential.

During the course of the organisation development project, I worked intensively with one of the Directorate Teams but, as it happened, not with the other Directorate Team. We observed that ward performance improved more significantly in the Directorate in which the Directorate Team had taken time out to reflect on their own behaviours as leaders than occurred in the other Directorate. Based on this rather serendipitous "experiment", I concluded that a shift in style from what might be unkindly called a "laissez faire" style to a more assertive style was effective in changing behaviour amongst ward staff as was a clear focus on patient journeys and clinical effectiveness. (Field Note 111).

At the "Moving on and Speeding Up" Workshop in September, 2003, the Chief Executive who had by then announced her intention to resign stated that she would, in her last week with the Trust, visit each of the wards involved in the organisation development project. During these visits, she would inspect care plans and discuss with patients the quality of care which they were receiving. It is important to stress that this announcement was expressed in terms of a commitment rather than a threat! The visits did indeed take place and, in my view, direct, balanced and accurate feedback was given by the Chief Executive to ward staff and to Directorate Teams. (Field Note 57).

Taken together, these observations about leadership lead me to a number of important if not surprising propositions about leadership:

- The day to day behaviours of local leaders (ward managers/Clinical Nurse Managers) is of critical importance in shaping the behaviour of ward staff and in determining the extent to which the organisation is able to fulfil its purpose.

- Other leaders, such as doctors, can be very influential but are not sufficiently present and do not have sufficient leadership legitimacy to deliver sustainable change in the patient experience.

- The behaviours of more senior leaders, the Directorate Team, exercise a critically important reinforcing and enabling influence upon the behaviours of ward teams probably mediated through shaping the behaviours of local leaders (ward managers/Clinical Nurse Managers).

- The focus of the Chief Executive upon patient care and clinical effectiveness and her declared intention to make time to "see things for herself" further reinforced the focus of ward teams and their local leaders on these aspects of organisational behaviour.

Change in the behaviour of ward teams occurred most effectively in conditions where there was effective local leadership, reinforced by consistent and assertive leadership from more senior leaders focussing upon the quality of care and further reinforced by a similar focus from the Chief Executive.

These findings are now being translated into practice in the organisation under study in the following ways:

- Job descriptions and role specifications for Clinical Nurse Managers/Clinical Team Leaders are being updated to clarify and emphasise their role in clinical leadership. A number of new appointments have been made to these posts.

- The middle management structure is being reviewed to place greater emphasis on clinical leadership probably by introducing "modern matrons" and incorporating into those roles the current responsibilities of Service Managers.

- Two new Service Directors have been appointed with a clear emphasis on the leadership of clinical services.

- A new performance management framework is being developed which clarifies roles within the leadership structure, sets standards expected of leaders and emphasises quality of clinical practice and clinical effectiveness as key performance indicators.

- Training and development programmes are being put in place to equip Clinical Nurse Managers and their Team Leaders with the skills and knowledge required for the newly defined role.

- *In-situ* coaching and facilitation is being undertaken by my research colleague pending the appointment of two new Clinical Practice Facilitators.

Roles and competences

As the purpose of the wards/teams with which we were working became clearer to us and to the staff working in those teams, it also became apparent that numbers of staff were not competent and/or confident in carrying out the required roles although they had been competent and confident in carrying out what had always been expected of them in terms of the custodial role. Of particular concern was the role of the Primary Nurse who, under the Care Programme Approach is expected to co-ordinate the care of the patients for whom he/she is responsible.

I was also concerned that few, if any nursing staff had an understanding of rehabilitation as a model of care. In so far as it was understood, it was seen as an activity which took place "off-ward" by occupational therapists and other disciplines.

These findings are now being translated into practice in the organisation under study in the following ways:

- A clear specification of the role of the Primary Nurse has been developed establishing measurable standards of performance.

- An educational programme is in place to equip Primary Nurses with the skills, knowledge and attitudes required to fulfil the role successfully.

- Policy is being changed to ensure that Primary Nurses are not scheduled for long (more than six weeks) periods of night duty.

- A competence framework is being developed for all nursing staff in the rehabilitation teams.

Empowerment

Empowerment has become a rather fashionable term in writings about organisations and about leadership. It is particularly fashionable in the NHS which has invested heavily in initiatives such as the LEO programme (Leading Empowered Organisations). In exploring the role of the Primary Nurse and the Clinical Nurse Manager, I came to the conclusion that they did not have the authority (power) necessary to deliver the rehabilitation programmes for which they were, at least notionally, accountable.

This finding is now being translated into practice in the organisation under study in the following ways:

- Primary Nurses maintain a rolling audit of breakdowns in planned care so that they can initiate action when there are systemic failures in service delivery. Clinical Nurse Managers carry out monthly reviews of such service failures.

- Primary Nurses, rather than medical staff, will in future lead the care planning and care review meetings for their patients. It is worth noting that at the moment they may not even be present.

The conversation of the organisation

Several writers have identified the conversation which goes in an organisation as an important shaper of organisational behaviour either in terms of complex adaptive processes (Stacey, 2003) or in terms of sense-making (Weick, 1995). Our observations suggested that much of the conversation of the organisation at ward level was about safe custody and the management of "dangerousness" and little was about clinical effectiveness, rehabilitation or even the quality of the lives of patients. My research colleague reported that she observed little (although some) directly abusive behaviour towards patients but observed a good deal of indifference to their needs and wants. (Field Note 93).

Amongst local and directorate leaders, a good deal of the conversation was "managerial" concerned with budgets, overtime, staffing levels and so on.

Some progress has been made from the findings and through the actions described above. However, I am now trying to promote a specific ***rehabilitation discourse*** in the organisation through the following measures:

- Writing rehabilitation plans rather than "care plans" and ensuring that goals are described in patient-centred functional language.

- Introducing terms such as "Rehabilitation Manager" to replace "Primary Nurse". This is both to place a focus on rehabilitation and to emphasise that the role is about co-ordinating ***all*** care not just nursing care.

- Developing a new role of Rehabilitation Assistant which will combine the competences of Health Care Assistants and Occupational Therapy Assistants.

In the longer term, I hope to develop the role of Rehabilitation Practitioner which will be an extended nursing role incorporating competences from social work, occupational therapy, psychiatry and clinical psychology.

Performance management is an important aspect of organisational conversation. In my work on leadership development, I aim to have leaders at all levels focus much more clearly on rehabilitation outcomes and on the development of rehabilitation skills in processes such as performance reviews and appraisals.

In my view, it is important that the organisation sends out consistent signals about what matters.

CAREER DEVELOPMENT IN THE NHS

This project was commissioned through competitive tender (see Appendix A) by the five Strategic Health Authorities in London on behalf of the NHS Leadership Centre.

The project aimed to pilot practical tools and approaches for use by the NHS in managing career development and succession planning. In our tender (see Appendix A), we proposed developing the following "products":

- A discussion paper setting out the implications for leaders and leadership in the future of current government policy for the NHS.

- A pilot development centre for aspiring Chief Executives.

- A guide or workbook which would support people in managing their own leadership careers.

- A guide designed for Chief Executives and other senior organisational leaders on how to support career development within their own organisations.

- A "development centre tool-kit" which would enable Strategic Health Authorities and NHS Trusts to design and deliver their own development centres.

A project team was established with three staff from the lead Health Authority plus me as project consultant.

Focus Groups and Internet Conversation

I facilitated a number of focus groups consisting of people who were regarded (by Strategic Health Authority Chief Executives and Directors of Development) as "leading edge" Chief Executives together with Directors of Development/ Modernisation and Work Force Development Chief Executives.

One set of focus groups explored the future of Chief Executive roles and the other the future of Director level roles. The starter questions used for the two sets of focus groups are shown on boxes 4.1 and 4.2 below.

> In what ways will the requirements for success in Chief Executive roles be different in three to five years time from those which apply now?
>
> In identifying people with the potential to become successful Chief Executives, what indicators help you to form your view?

Box 4.1 Focus Group Question for Chief Executive Group

> In what ways will the requirements for success in Director level and similar senior leadership roles be different in three to five years time from those which apply now?
>
> In identifying people with the potential to become successful Directors or equivalents, what indicators help you to form your view?

Box 4.2 Focus Group Question for Director Group

The findings from the focus groups were disseminated using the Leadership London website and comments and additions were invited. A further iteration of the findings was then published by email and the Leadership London website.

The focus group and internet conversation methodology is explained and discussed more fully in Chapter 3.

Pilot Development Centre

The pilot development centre for aspiring Chief Executives was designed to reflect the findings of the focus groups and internet conversation and to simulate key aspects of the envisaged future Chief Executive role. Twenty people took part nominated by their Trusts and selected by their Strategic Health Authorities. Participants were aware that this was a pilot centre and that, whilst they would be likely to benefit from the process in terms of informing their own personal career development planning, their primary role was to help the NHS to test and evaluate the design.

Guide1 – "Taking Charge of your own Career"

This guide was designed for NHS staff who wish to pursue a leadership career in the NHS or who wish to further develop an existing leadership career in the NHS. The Guide sets out a career development philosophy and contains a number of self-assessment and career planning tools focussed on leadership development. A copy of the Guide is included with the "products" associated with this project.

Guide 2 – "Identifying and developing leadership potential"

This guide is designed for Chief Executives and other senior organisational leaders who have a role to play in identifying people with leadership potential and in supporting their career development.

Its focus is on creating an infrastructure which is supportive of early identification of potential and "positive career management" and it includes brief explanations of

concepts such as mentoring and coaching. A copy of this Guide is included with the "products" associated with this project.

Development Centre Toolkit

Development centres are fairly time-consuming and expensive undertakings. Within the NHS in London there is no formal method of providing or funding such activities on a pan-London basis other than as an *ad hoc* activity. The idea of the development centre tool-kit was that we should be able to disseminate and share good practice about development centre design and implementation so that Strategic Health Authorities and Trusts would be able to apply development centre technologies in their local contexts. The tool-kit is supported by a training programme for development centre designers, administrators and development advisers ("assessors"). It is also planned that new materials should be developed and shared using the Leadership London web-site.

KEY FINDINGS FROM THE CAREER DEVELOPMENT PROJECT

Future leaders and leadership

A consensus emerged that the requirements of leaders and leadership in the NHS in the future (three to five years out) would be significantly different from those which have applied over the last (say) seven years. The key differences are summarised in Box 4.3 below.

- There would be a shift of focus away from autonomous leadership of institutions (e.g. NHS Trusts) towards shared or collaborative leadership of whole systems of care.
- There would be an increasing focus on the quality of the whole patient experience and on the outcomes achieved by the health and social care system with measures such as waiting times being seen as a means to an end rather than as an end in themselves.
- The role of NHS bodies as employers, purchasers and controllers of physical and intellectual resources in their communities would gain increasing prominence.

Box 4.3 Key differences in future organisational leadership roles

There was also a consensus that current performance would become an increasingly unreliable indicator of future success.

Early indicators of potential

There was consensus that it is possible to identify early indicators of potential and that these might be different to and occasionally at odds with measures of current performance – participants in the focus groups and the wider internet discussion described this as the "maverick factor" – people with high leadership potential might well behave "awkwardly" and "non-compliantly" in their current jobs. The early indicators of potential are summarised in Appendix A.

Future critical competences for Chief Executives

The focus groups and internet discussion identified a number of competences which would become of critical importance for Chief Executives in the future. These reflect the views about the future context of leadership summarised in Box 4.3 (above). Participants in the focus groups and the internet discussion were struck by the extent to which information about current performance, even as a Chief Executive would be unlikely to be a good predictor of future success. The future critical competences for Chief Executives are summarised in Appendix A.

Future critical competences for Directors and people working at a similar level in the NHS.

The focus groups and internet discussion identified a number of competences which would become of critical importance for Directors and people working at a similar level in the future. These both reflect the views about the future context of leadership summarised in Box 4.3 (above) and the notion that Directors will need increasingly to become "alternative Chief Executives" – fully capable of representing and taking decisions on behalf of their "institutions" as part of a network of collaborative and shared leadership. The future critical competences for Chief Executives are summarised in Appendix A.

The role of development centres

Feedback about the pilot development centre was elicited carefully both from participants and from the development advisers[20]. Key points which emerged were:

Although all participants were currently regarded as ready for Chief Executive roles within two years, all had significant competence gaps ***measured against the requirements of the future role*** although fewer in relation to the current role.

The development process and, in particular, the systematic way of capturing, interpreting and evaluating ***evidence*** was reported as being significantly more robust than previous experiences in making selection or development decisions.

Learning needs were identified of which participants seemed unaware although, in the view of the development advisers, they should have been readily apparent within their current work roles. This suggested that existing processes for identifying and planning to meet individual learning and development needs could be unreliable.

[20] Development Advisers were senior managers and/or development specialist who were responsible for observing participants, reaching decisions about future development needs, through a development adviser conference, and giving feedback to participants.

COMBINING THE FINDINGS

The quality of leadership at organisational, service and local (close-in) levels is a critical determinant of the extent to which an organisation is successful in terms of fulfilling its purpose.

For local leaders to perform effectively, organisational and service leaders need to create the organisational conditions which enable effective performance in terms of clarity of purpose, organisational culture, performance management systems and the policy infrastructure of the organisation.

Poor local leadership is likely to frustrate the intentions of organisational and service leaders as local leadership strongly determines the day to day behaviours of those actually delivering services to patients and other "consumers".

Confusion about organisational purpose is an important inhibitor of good organisational performance.

Past performance in a highly structured and institutionally focussed setting is unlikely to be a good predictor of future performance in a more complex and collaborative setting.

Current practices in the NHS in London in relation to identifying leadership potential and developing good leadership performance may be inadequate for the future needs of the service.

SUMMARY OF RESULTS

1. Clarity about organisational purpose is a necessary condition for effective organisational performance and for purposeful and focussed change.

2. A key role of organisational and local leaders is to articulate and re-articulate the purpose of the organisation; to constantly remind members of the organisation what it there for and, therefore, what they are there for.

3. A key role of organisational leaders is to align the work of the organisation with its purpose.

4. The day to day behaviours of local leaders are of critical importance in shaping the behaviours of members of staff and in so doing, in determining the extent to which the organisation is able to fulfil its purpose.

5. The behaviours of more senior leaders including Chief Executives exercise an enabling and reinforcing effect upon the behaviours of front-line staff mediated through the behaviours of local leaders.

6. The "conversation of the organisation", the language used and the themes and topics discussed both formally and informally, is a critically important shaper of culture and behaviour.

7. If front-line staff are to be encouraged and enabled to effect purposeful change, the organisation has to be adept at quickly removing barriers to proposed changes and at encouraging experimentation.

8. To deliver an NHS which is genuinely customer-focussed, organisational leaders will have to become adept at shaping organisational cultures which enable and encourage customer focus.

9. To deliver an NHS which is genuinely customer-focussed, front-line leaders must have the authority they need to organise the resources of the health and social care system around the needs and aspirations of individual service users.

10. Transformation of the NHS and the wider health and social care system requires the development of new leadership practices at both organisational and local level and the close integration of leadership development and organisational development.

LEADERSHIP, TRANSFORMATIONAL CHANGE AND THE NHS IMPROVEMENT PLAN

This project is about getting from A to B. Nationally, the NHS Improvement Plan (DOH, 2004) sets out a coherent and inspiring vision of a health and social care system in which "the patient" becomes an empowered consumer and the NHS becomes a major part of a 21st Century service industry. More locally, the mental health hospital sets out to become a place which transforms people who represent a "*grave and immediate risk to the public*" (Statement of Purpose, 2003) into people who can live safely and constructively "outside the wire".

Nationally and locally, the project is concerned with ***transformation*** which the dictionary (Encarta, 2004) defines as

> **complete change:** a complete change, usually into something with an improved appearance or usefulness

Nationally and locally, the desired transformation is driven predominantly by values. The government argues that the vision set out in the NHS Improvement Plan is also driven by changing public expectations (DOH, 2004, p 3).

My professional practice over the last fifteen years has been concerned largely with how to lead transformational change in the health and social care system in the UK and, more specifically, how to lead transformational change in the NHS. During this period of practice I have, at various times, regarded the task of leading transformational change in the NHS as somewhere on a spectrum ranging from "extremely difficult" to "impossible". Emotionally, I have oscillated between hope and despair.

In the course of my practice, I have endeavoured to learn, through reflective practice, through formal study and through reading to become a more competent practitioner. Although I have probably over the years become more skilful, I continue to experience the challenge of bringing about worthwhile and enduring transformational change in the NHS as, at least, very difficult.

Over the period 1997 to 2004, there has, of course been significant change in the NHS in terms of increased investment[21], increased staffing[22] and a drive, led by central government, to achieve reductions in waiting times for treatment. To a large extent, this drive to improve the ***efficiency*** of the system has been successful although it is not clear that the ***productivity*** [23]of the system has actually improved. I believe that this change in efficiency, whilst important, beneficial and necessary, does not constitute ***transformational change***. The system does what it has always done with greater efficiency if not with greater productivity. Most of the interventions of the Modernisation Agency have been directed at efficiency improvement.

I would argue that, as with many change initiatives in complex organisations, there have been effects which are unintended, unforeseen and undesirable. Similar observations are made by Stacey et al (2000) and by Plsek and Wilson (2001). In particular, I believe that the strategy of driving efficiency improvements through targets, prescriptive solutions and sanctions (some would say fear) may have had the effect of reducing the capacity of NHS leaders to think and act creatively and strategically. A similar observation has been made by Plsek and Wilson (2001, p7) who suggest that

> "*Perhaps the biggest barrier to these approaches prompted by complexity thinking are the incumbent leaders of health systems who have risen within the hierarchy based on command and control methods.*"

Arguably, we have developed a cadre of leaders who are more or less good at "doing what they are told", pursuing objectives which are set for them and implementing policies which have been prescribed. It may not be going too far to say that we have fostered ***middle management*** capabilities and reduced ***top management*** capabilities. Similarly, although throughout this period there has been a considerable amount of rhetoric about "empowerment", the practices deployed to deliver improvements in efficiency may have had the effect of disempowering leaders at all levels in the NHS.

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[21] From £33 billion in 1996/97 to £67.4 billion in 2004/05 (DOH, 2004).
[22] A 22% increase in doctors, a 21% increase in the total number of nurses and a 27% expansion in scientific, therapeutic and technical staff (DOH, 2004)
[23] For a comprehensive discussion of productivity in the NHS see Dawson et al. (2004)

Finally, the emphasis placed on "throughput" may have served to de-emphasise concern for the individuality of the patient. There are not and never have been "nine month waiters" – there are only individuals with families and friends who are awaiting the treatment they have been told they need.

Realisation of the vision set out in "The NHS Improvement Plan" ***does*** require transformational change; what Senge (1993) would describe as a "shifting of mental models". The NHS Improvement Plan is not primarily about "efficiency", it is about effectiveness and responsiveness. As the Prime Minister in the forward to the NHS Improvement Plan says

> "*Now we can move to the next stage envisaged in the* NHS Plan *to reshape the health service around the needs and aspirations of its patients, not least because the speed of progress means waiting for treatment will soon no longer be the major problem. And this requires us to put power in the hands of patients rather than Whitehall".*
>
> *Forward to the NHS Improvement Plan, 2004, p 3*

If the search for efficiency has been driven by targets, sanctions and prescriptions, what will drive this "next stage"; the creation of a genuinely patient-centred NHS?

The answer appears to be "market forces" although the government prefers terms such as "contestability" and "choice". (DOH, 2004). The government clearly envisages a market in health and social care although one in which price will not be a significant part of the marketing mix. It is clear that new entrants including those from the private, voluntary and independent sectors will be allowed and encouraged to enter the market and, equally importantly, that NHS organisations will be allowed to "go out of business".

> "*It (*contestability*) will allow the majority of providers to grow and flourish in response to patients' needs, whilst the poorest performers will either improve their ability to satisfy patients' needs or face remedial action ultimately leading to closure."*
>
> *NHS Improvement Plan, 2004, p 72*

Although the relationship between leadership and transformational change is explored widely in the academic literature, I believe that the findings from this project help to clarify the precise leadership and organisational development implications of the NHS Improvement Plan (2004). It is possible that the findings from the project may inform the process of reform in the public services more generally and may be useful to practitioners in any sector who are engaged in organisational transformation, particularly when the goal of transformation is to create customer-centred enterprises.

In reviewing the literature, I noted that writers and researchers tended to concentrate ***either*** on organisational leadership[24] ***or*** on close-in team leadership[25]. The findings from this project suggest that it is the ***interplay*** between these two forms of leadership which may be of critical importance in securing transformational change. The project also suggests that, although both forms of leadership are equally important and valuable, the focus, competences and behaviours associated with each may be significantly different. Figure 5.1 below illustrates the relationships which I am proposing may exist.

[24] Peters, Alimo-Metcalfe, Senge, Kanter.
[25] Maslow, McGregor, Hertzberg, Hersey & Blanchard

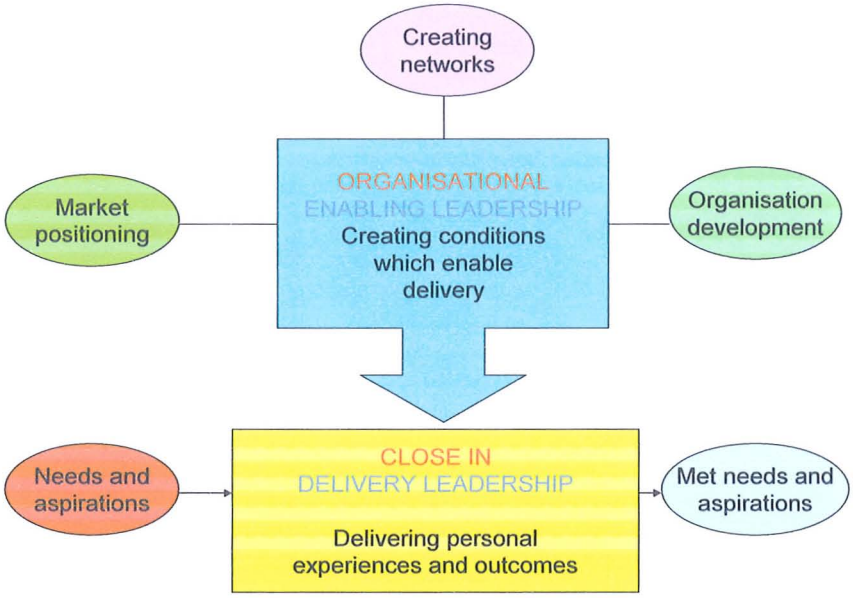

Figure 5.1 Relationship between Enabling and Delivery Leadership

I am suggesting that the primary task of organisational leaders in the NHS is to create the organisational conditions in which "close-in" leaders such as Ward Managers can deliver services which are tailored to the needs and aspirations of individual service users (customers). I have used the term ***enabling leadership*** to emphasise that the primary task of organisational leaders is to create and shape organisational conditions. I have used the term ***delivery leadership*** to describe the leadership which occurs at the interface between the organisation and its customers. The primary task of "delivery leaders" is to understand the needs and aspirations of each individual customer[26] and to mobilise the resources of the organisation (or network of organisations) to design and deliver an experience and outcomes which closely match (or exceed) those needs and aspirations.

[26] Here the term customer is used to describe the user of services together with other key stakeholders in the quality of the experience of the service user and the outcomes which are achieved. Stakeholders might include informal carers, relatives and friends of the service user.

In the context of the NHS, the ***enabling leader*** will be concerned with

- Positioning and repositioning his/her own organisation into a niche or niches in the ecology and economy of health and social care so that it can justify its continuing existence.

- Co-creating, with other organisational leaders, networks of service provision, (supply chains) capable of meeting the needs and aspirations of groups of customers such as those who may have cancer, those who are living with multiple sclerosis or those whose health could be improved by life-style changes.

- Creating the internal organisational conditions which will enable the delivery of services which meet the needs and aspirations of each individual customer.

These ideas reflect the ***future critical competences*** identified through the career development part of this project (see Appendix A).

It is also in the role of the ***enabling leader*** that the fusion between leadership and organisation development occurs – the effective organisational leader ***must be*** an effective organisation development practitioner.

Similarly, if the delivery leader is to understand the needs and aspirations of each individual customer and to mobilise the resources of the organisation (or network of organisations) to design and deliver an experience and outcomes which closely match (or exceed) those needs and aspirations, he/she ***must be*** an effective ***case manager***[27]

[27] See NHS Improvement Plan (2004), pp 37-38

In the context of the NHS, the ***delivery leader*** will be concerned with:

- Understanding the needs and aspirations of each individual customer.
- Understanding the resources which are available to meet those needs and aspirations.
- Mobilising resources appropriately to provide a satisfactory customer experience and outcome.

In practice, the person performing the role of ***delivery leader*** may change during the course of the customer's relationship with the organisation or network of organisations and the role may be shared; although it would be important to ensure that the nature of the sharing is clearly understood.

As Allen (2002) has suggested, successful case management (delivery leadership) requires both knowledge and requisite authority on the part of the case manager.

In the mental health study which forms part of this enquiry, the role of delivery leader was, in theory, vested in the Primary Nurse. The study suggested, however that Primary Nurses lacked:

- A clear understanding and acceptance of the role.
- The competences to fulfil the role.
- The authority to fill the role.
- The organisational conditions in which the role could be performed effectively.

Based on my experience in working with the NHS, I believe that there would be relatively few good examples of delivery management and that most of the factors inhibiting the performance of the role in the mental health hospital would also be found in other NHS settings.

Similarly, the data from the Development Centre suggests that the NHS is unlikely to have a sufficient supply of organisational leaders capable of fulfilling the ***enabling leadership*** role. As I have suggested earlier in this chapter, the experience of leading in a tight "command and control" environment over (at least) the last seven years may have diluted the capacity of organisational leaders to provide enabling leadership.

The NHS Improvement Plan (2004, p72) states that "*the majority of providers (will) grow and flourish in response to patients' needs*". This study suggest that, if the standard of judgement is based on the extent to which *everyone* is to experience a "*personal health service*" (2004, p 4) and to have access to "*high quality services*" (p6), few existing NHS providers would "*grow and flourish*" and many would "*face remedial action ultimately leading to closure*" (2004, p 72). If the reader considers this statement unduly pessimistic or alarmist, he or she may wish to consider that the average life expectancy of enterprises in developed economies is about 12.5 years and that of global enterprises around 40 years (de Geus and Senge, 1997). The reader will be personally familiar with the rise and fall of once great enterprises which failed to continue to live up the expectations of their customers in the face of changing expectations and/or the arrival of new entrants in their market place.

On reflection, I do not really mind if the statement is alarming. I believe, on the basis of this study and on the basis of my other work with the NHS, that the magnitude and urgency of the challenge presented to those responsible for leadership development in the NHS should not be under-estimated, if the NHS is to realise the vision set out in the NHS Improvement Plan. I also believe that it ***is*** currently being under-estimated.

Senge (Seminar, 2003) suggested that transformational change can be driven either by "aspiration" or "desperation". He also suggested that "desperation" was the driver for change in 90% of cases but observed that by the time desperation has set in, it is often too late to bring about the required transformational change.

The NHS Improvement Plan presents an opportunity to drive transformational change in the NHS by aspiration. The NHS does not have a right to exist. Other mechanisms exist for providing publicly funded access to high quality health-care. Although the NHS is regarded as being unassailable and inextricably embedded in the nation's heart and soul, I believe that the public does not really care ***who*** provides its health care provided that it is of high quality, accessible and largely free at the point of need. There is some evidence[28] that whilst those who grew up with the formation of the welfare state do have a strong sentimental attachment to the NHS, later generations do not have such an attachment. They would be relaxed about its demise or diminution provided that good alternatives were available.

[28] For a discussion of generational and life-cycle effects on satisfaction with the NHS see Appleby and Alvarez Rosete in British Social Attitudes; the 20th Report pp 36-37

In the recommendations which flow from this study, I emphasise the need to:

- Start a vigorous and wide-spread discourse about the leadership and organisational development implications of the NHS Improvement Plan and its aspiration to re-shape the NHS.

- Start to regard leadership and leadership development as something which needs to be performance managed and quality assured with the same determination as clinical practice.

- Recognise the vital importance of leadership at the interface with the service user and invest leaders at the patient interface with the knowledge, skills, authority and respect which they need to meet the needs and aspirations of patients and carers.

In my view, ***how*** this is done is important. Rightly or wrongly, the pursuit of efficiency in the NHS has been largely characterised by control, prescription and "fear" and has, in my view, created some undesirable side-effects. I do not believe that "fear" is capable of delivering an aspiration. At best, a transformation process driven by fear and coercion would be prolonged, bloody and wasteful. At worst, it will fail altogether.

I suggest that Strategic Health Authorities have a pivotal role to play in leading transformational change within the NHS. They directly performance manage Primary Care Trusts and NHS Trusts with the exception of a few Foundation Trusts. They also, through the Workforce Development Confederations, control much of the funding which is available for the development and education of staff within the NHS.

The Strategic Health Authority Chief Executives together with the NHS Chief Executive and the National Directors set the overall strategic direction of the service.

In the longer term, Primary Care Trusts, in their commissioning role, have the potential to shape the behaviour of the NHS locally, including that of Foundation

Trusts. The extent to which they currently have the capacity and capability to do so should be a matter for urgent consideration by the Strategic Health Authorities.

Again, in the longer term, the NHSU (National Health Service University) has a critical contribution to make. It is important that its efforts should be channelled into the delivery of transformational change so that it makes a coherent contribution to the aspirations set out in the NHS Improvement Plan. Unlike other Universities it is not and should not be a "free agent" – its purpose is to support the transformation of the NHS not to set its own agenda.

The proposed reduction in the number and scope of the "arms length bodies" (DOH, 2004, p 76) should lead to a greater focus on the role of Strategic Health Authorities and a reduction in the distraction and confusion which must confront NHS leaders on a daily basis.

I think that the political climate is becoming more favourable towards transformational change. There is a move away from detailed central control and target setting towards a more devolved climate underpinned by a system of national standards and quality assurance. The danger is that, without a determined effort to improve the quality of local leadership, there will simply be a "direction vacuum" in which the service will wander round aimlessly waiting for guidance and instructions which never come.

I believe that the challenge is immense but also immensely exciting. Although the transformational change envisaged in the NHS Improvement Plan (2004) appears to be driven politically, I think that it is in fact driven by deeper, more enduring and more pervasive trends in society. The citizens of an advanced consumerist society will simply not go on accepting "*a system devised for a time of rationing and shortages*" (DOH, 2004, p 3). Nor will they accept a system in which the views and priorities of "professionals" can often take precedence over the needs and aspirations of service users.

PRACTITIONER RESEARCH

Being a researcher is something of a state of mind, a selective perception, a particular form of sense-making. Usually, I do not consider myself to be a researcher; I am a practitioner who does some of the things which "researchers" do both to maintain and update my professional competence and to equip me for a particular piece of practice. For example, in preparing for a project concerned with health visiting practice for afro-Caribbean populations, I set out inform myself both about health-visiting and about afro-Caribbean populations. I read extensively and critically (a literature review?), asked questions (data collection?) and learned to dance to reggae music, albeit very badly (participant observation?). I also wrote up the project in various forms to communicate the findings and bring about change in practice (dissemination?). Throughout the process, I thought of myself as an organisation development practitioner ***not*** a researcher.

In this section of the chapter, I will explore what it is that constitutes "research", what is special or unusual about practitioner research and some of the characteristics and dilemmas which face the practitioner-researcher who is not, in a legal sense, a member of the organisation in which the research and the practice is taking place.

About research

At one level, as Senge (Seminar, 2003) suggests all human beings are "researchers" and "action researchers" at that; Senge asserts that we are all programmed to investigate the world around us by acting in it, seeing what happens and constructing theories about it which may serve to inform our future actions. At however an unsystematic level, the PDSA approach (see figure 2 below) is something which we all apply quite naturally from infancy.

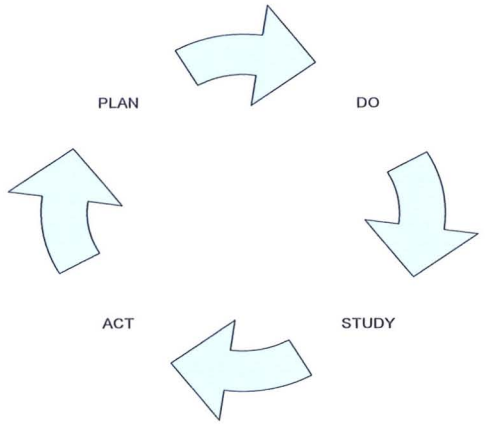

Figure 5.2 the PDSA Cycle

What may differentiate the sort of research which is exemplified in this project both from the informal research of human beings learning about their worlds and from the private research which I normally undertake in the course of my practice is the ***intent*** that this research should be ***public***.

If the research enterprise is thought of as an exploration of unknown or poorly known territory, research with a ***public intent*** requires that the explorer should provide maps and journals of the exploration in sufficient detail that others can retrace his footsteps as part of their own explorations. Research with a public intent also requires that the explorer provides enough information to enable others to make a decision about how

much ***confidence*** to place in the map which has been produced. Particularly if the "map" is to be used to inform action in the real world, the user needs to know whether the "cartographer" undertook a systematic and thoughtful exploration of the landscape or whether he/she sat in an arm-chair and dreamt about how the landscape might be. Dreaming might be good enough to suggest an expedition but not good enough to provide a reliable guide for future journeys.

It is only in the latter stages of this project and this course of study that I have come to terms with the difference between private research and public research. At first, I experienced the requirements for literature reviews, referencing, authorisations and so on as simply a burden on my practice; a rather tedious impediment to the "real work" of organisation development. It is only by reflecting on the ***purpose*** of public research, that I have come to accept that there are good reasons for most of the constraints and requirements demanded by the academic community.

The requirements of public research though are an additional ***demand*** on the practitioner; he or she should only accept the additional demand if he/she is convinced that the ***value-added*** of writing for publication exceeds the costs of doing so. It is probably helpful to give this issue careful thought ***before*** the journey starts rather than half-way through or at the end of it.

About practitioner research

Practitioner research could mean several things:

1. The Practitioner who also undertakes research but whose research activities are largely ***separated*** from his/her practice activities.

2. The Practitioner who designs and undertakes formal research projects set in his/her workplace but with the research activities taking place in ***parallel*** to the work activities.

3. The Practitioner who does his/her work in a way which generates public research – the research is firmly ***embedded*** in the practice.

In this section of the chapter, I will discuss some of the problematic aspects of this third type of practitioner research (embedded research) on the basis of my own experiences in this project.

The first problematic aspect of embedded practitioner research is that the congruence between the research goals and the practice goals may start to break down and drift apart. In my organisation development practice, I tend to adopt a heuristic[29] approach. I am exploring in and seeking to shape a landscape which is constantly shifting and which gradually reveals itself as I become more familiar with the organisation. In my practice, I am constantly twisting and turning tactically whilst, hopefully, attempting to hold on to an overall strategic direction. Whilst trying to keep in sight the strategic practice goals and navigating the immediate organisational landscape, there is a significant risk that I will not be able to keep the research goals in focus. Classical research paradigms tend to assume a more stable and predictable world than practitioners often experience. Aristotle remarked that "*Give me a lever long enough and a place to stand and I can move the world*"; all too often, the organisation development practitioner finds that he/she is standing on very shifty ground.

Although an assumption in embedded practitioner research is that the research and the practice will be congruent and the relationship between them synergistic, in reality, the practitioner will find himself/herself managing tensions and juggling priorities. In the organisation case study which informs this project, I anticipated that an action research approach would be appropriate both for research purposes and to achieve the desired organisational change goals. Some way into the project, it became apparent that action research would not be a productive way of achieving the desired organisational change goals. The fact that I had written and had approved a research plan which specifies action research as a methodology created an additional pressure to cling to the declared research strategy even it was wrong from a practice perspective. To help to address this dilemma, I evolved the principle that the research

[29] Involving trial and error: using or arrived at by a process of trial and error rather than a set of rules. Procedure for arriving at a solution but not necessarily a proof. (Encarta Dictionary, 2004).

strategy would have to bend to follow the practice requirement; the practice would drive the research not the other way round.

The world of practice-based research is hyper-rich with information, ideas and opportunities. It is extraordinarily easy for the practitioner researcher to become overloaded and/or distracted; where almost anything could be relevant, how does the practitioner researcher decide what to incorporate in his/her study and what to leave out? Again, a classical research paradigm seeks to construct high walls around the research activity to shut out "confounding" variables. In real world practitioner research, there are no variables which can safely be regarded as "confounding". Johnstone makes similar points in her discussion of using mixed methods (2004, p264).

The world of practice-based research is an opportunistic one. Unforeseen opportunities may arise to gather more data, conduct new experiments, test ideas in a new setting and so on. In the course of this project, for example, I was presented with an opportunity to investigate the implications of the NHS Improvement Plan which was, itself, only published in June, 2004 (although many of the ideas in the document had been foreshadowed). I believed that undertaking this (career development) investigation would (or might) add important new information to my research enterprise. However, it would also require substantial re-working of the project and re-writing of some of the documentation of the project. An extra level of contingency and uncertainty was added by the fact that the career development work would be open to competitive tender. There was no certainty or even any way of estimating the probability of being awarded the contract. A dilemma facing the practitioner researcher may well be that of "how open" he/she keeps the boundaries of the study. The dilemma may be more than that of maintaining open-ness. In this case, I was also faced with the question of "how actively do I pursue opportunities for new information?"

My belief is that the practitioner researcher should seek to keep his/her project open to new information and that he/she should actively look for opportunities which may enhance the value of the enquiry. However, the practitioner/researcher must then be prepared to pay the price in terms of added complexity, re-work and potential loss of focus. Again I believe, in principle, that the research has to follow the real world rather than allowing the research strategy to unduly constrain how the real world is perceived and interpreted.

Practitioner research is likely to be part of a continuing experiential narrative. The practitioner researcher is likely to draw as much upon his/her own previous experience as a practitioner as upon the published literature. The diagram below suggests how this particular project can be seen as drawing upon two specific current projects in addition to other work which I have undertaken in the past.

Figure 5.3 Overlapping areas of enquiry

There is, therefore, an issue of ***temporal boundary management*** to be understood and to be managed. How does the practitioner researcher manage the flow of information and ideas from his/her own past experience as a practitioner into the current research project? Here I believe that the professional doctorate framework is particularly helpful with its concept of an unfolding personal learning narrative rather than a research project existing in isolation from the rest of the practitioner researcher's learning and experience.

Decisions concerning methodological approach can also be problematic for the practitioner researcher perhaps in a way which is different from the methodological issues confronting the "pure" researcher. The practitioner researcher has to take into account both the requirements of the research enterprise and of the practice enterprise. He/she has to negotiate with multiple constituencies and with many stakeholders. If the practitioner researcher is undertaking work of any complexity and if the research is embedded in the work of the organisation and his/her own practice with that organisation, the practitioner researcher must develop a strategy which is itself "change adept" (Kanter, 2003). Kanter's advice about change-adept organisations needing to be characterised by the four Fs (Focussed, Flexible, Fast and Fun) can also be seen as helpful precepts for the practitioner researcher. The issue of holding focus on both the research goals and the practice goals has been discussed above as has the need for a flexible research strategy in which research activities are able to follow the twists and turns of real life organisational life. Certainly for the practitioner researcher working with the NHS there is also a "need for speed". Both internal organisational factors and the external contextual variables change at what seems like lightning speed and often unpredictably.

For the practitioner researcher, complexity science is not just an interesting academic discipline; it accurately describes how he/she ***experiences*** embedded practitioner research. Quoting Plsek and Greenhalgh (2001), Wilson, Holt and Greenhalgh (2001, p1) describe a complex adaptive system as

> *"a collection of individual agents with freedom to act in ways that are not always predictable, and whose actions are interconnected so that the action of one part changes the context for other agents"*

It is this very "slipperiness" of the practitioner researcher's work which provides the interest and excitement but which also presents real methodological challenges.

Turning to Kanter's last "F" (fun), practitioner research does offer a "buzz", a level of excitement and adventure which may not be present, but I imagine often is, in "pure" research. Fun, of course, like beauty is in the eye of the beholder. Perhaps what may really differentiate the "fun" of practitioner research from the "fun" of pure research is that the practitioner researcher aims to deliver change ***and*** knowledge; probably in that order. The "pure" researcher aims to deliver knowledge which may, of course, lead to change; but the change making will be in the hands of others.

Figure 5.4 below summarises some of the tensions which the practitioner researcher undertaking research which is embedded in practice has to manage.

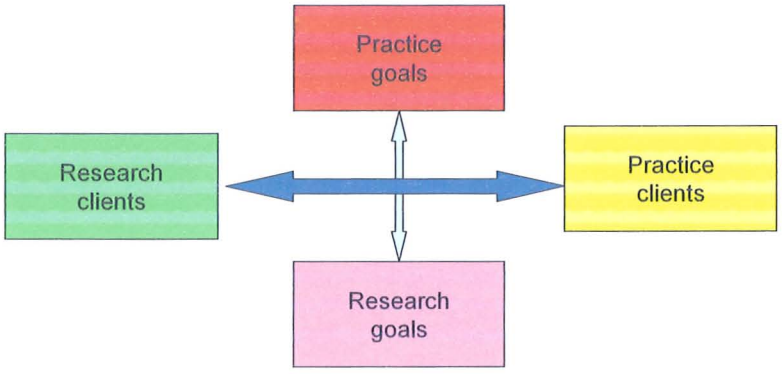

Figure 5.4 Tensions in practitioner research

Insider practitioner research

As I have suggested in Chapter 3, there is a tendency to regard practitioner researchers as being either "insiders" or "outsiders" (see Module Handbook, p33 for example). There is also a tendency to use the terms "practitioner researcher" and "insider researcher" more or less interchangeably (see, for example, Robson, p447).

In this section of the discussion I will suggest that such a clear dichotomy may not exist and that it may be more helpful to think in terms of a continuum of "insider-ness". "Insider-ness" is also a matter of perception; different perceivers may see things differently and the same perceiver may make different interpretations under different circumstances.

In both projects which inform this research, I am formally an external consultant. If one were to accept the nature of the contractual relationship between practitioner and organisation as the defining characteristic of insider-ness/externality, I would clearly be an "outsider".

However, in my experience (which may not be typical or characteristic), as the practitioner researcher engages more fully and deeply with the organisation there is a ***continuing*** and ***mutual*** renegotiation of the relationship. The organisation becomes more familiar to the practitioner researcher and the practitioner researcher becomes more familiar to the organisation. Relationships of trust, openness and intimacy start to build up. Feelings of attachment (Bowlby, 1969) can and do develop and feelings of mutual loss can be experienced on completion of a project. The growth of "insider-ness" can manifest in cultural signs and symbols such as greetings, recognition, inclusion both in "business" activities and in the social life of the organisation, the replacement of visitor's passes by staff passes, being able to make one's own coffee and so on. At times the formal outsider can behave more like an insider than do the formal insiders. The formal outsider may have been around the organisation longer than many of the formal insiders and have more extensive networks of relationship. He/she may well have more privileged access to "people and papers" than do some of the formal insiders. The trajectory towards greater insider-ness is not, of course,

confined to those who are formally external to the organisation; new members of staff (and patients) also embark on a journey of becoming insiders.

This blurring of the insider/outsider dichotomy may be of increasing importance as UK society moves to a pattern of more complex working relationships; an increasing use of temporary or locum or project-based appointments, interim management, work portfolios, job sharing, work rotations, joint appointments, the growth in consultancy and so on. Handy (1995) describes these developments extensively and clearly.

If, as I suggest, "insider-ness" is not adequately defined by formal contractual relationships, what considerations might help in thinking about insider-ness/externality? I believe that it has both affective and perceptual components. The affective component is the extent to which the practitioner researcher ***feels*** part of the organisation; it comes to matter. He/she will share emotionally in the successes and failures, celebrations and mourning of the organisation. There may be an affective component from the organisation too, it may want to know about the life of the "external" person and it may experience a sense of loss when the "external" person moves on. As well as an affective component, insider-ness may also be understood by how the practitioner researcher perceives himself/herself in relation to the organisation or to parts of the organisation and how he/she is perceived by the organisation or by parts of it. There may be a process of "incorporation" – a journey from being "them" to being "us". Although these observations are written as if they applied to the organisation as a whole, I believe that they are equally valid in relation to parts of the organisation; the practitioner researcher may feel and perceive himself/herself to be "part of the management team". Equally, he/she may have a sense of affiliation with a particular clinical team and may share their exasperation and frustration with the behaviours of the management team.

For me, this part of this discussion raises four questions:

1. How does the practitioner researcher maintain his/her ability to ***see clearly***[30] as he or she becomes invested with insider-ness? In research which is embedded in practice, I think it unlikely that the researcher will be able to sustain claims to the sort of "scientific objectivity" to which the laboratory experimenter might lay claim. Organisation development practice is essentially an inter-personal process. As the practitioner researcher starts to build relationships of mutual trust, openness and intimacy, it can become difficult to continue to "stand back" and see what is happening – the practitioner researcher has "joined the tribe". As a minimum, it is important for the practitioner researcher to understand the journey towards insider-ness and to put into place stratagems for continuing to see clearly. These might include the supervision methods which are widely applied in psychotherapy and in reflective practice.

2. How does the practitioner researcher manage his or her own ***vulnerabilities*** in the face of the organisation? In the course of the research enterprise, he/she may evoke hostility or may be sickened, saddened or ashamed by what he/she discovers. He/she may bring about or advocate organisational change which is damaging to the well-being of individuals in the organisation. The practitioner researcher will need a degree of "toughness" to undertake change and to live with the personal consequences in terms of guilt and anxiety. The closeness and intimacy which he/she may have developed in the course of his/her research and practice may now exacerbate feelings of guilt and anxiety or cause the practitioner researcher to avoid conclusions and actions which are personally uncomfortable.

3. Which part of the organisation does the practitioner researcher "join"? I have had the experience of working with groups of "front-line" staff and starting to share their feelings of hostility towards their senior management. I have come to relate closely to the group I happen to be working with and started to see the world at least partly through their eyes. Conversely, I have, in other studies, "joined" the management team and seen the world through their eyes. The "joining" decision

[30] I have borrowed this term from Binney and Williams (1997)

influences not just how the practitioner researcher experiences the organisation but also how he or she is experienced ***by*** the organisation. In the mental health study which forms part of this project, I sought to address this dilemma by "joining" several parts of the organisation in parallel and by I and my research colleague "joining" different parts of the organisation. If time and resources permit, this strategy of joining the organisation at multiple points and in multiple ways seems a sensible and pragmatic one. However, the practitioner researcher needs to be aware that he/she has only ever partly joined parts of the organisation.

4. Is it a "good thing" that the practitioner researcher starts to identify or identifies already with the well-being of the organisation? For the practitioner researcher who is already formally and psychologically an insider, the issue does not really arise. For the external "professional" practitioner researcher it is quite an important question. How much "distance" should he/she maintain or how does he/she manage the boundary between self and organisation?

   Through conversations with professional colleagues, I have come to realise that I allow or encourage a high level of affiliation and identification. Put negatively, I "join the tribe". Put more positively, I care passionately about what is going on in the organisations with which I am working.

   For me, this stance was instinctive rather than deliberative. However in the light of this work in particular and more generally, this programme of study, I have thought about the issue and concluded that for ***my*** practice the benefits of passionate involvement outweigh the risks and disadvantages. I believe that transformational change has to be driven by some strong passion particularly as transformational change projects in complex organisations are likely to be quite prolonged spreading over a period of years.

   The decision to continue to take this "high involvement" stance is accompanied by a greater awareness of the need to safeguard my ability to see clearly and to develop and maintain multiple perspectives on the life of the organisation.

Insider researcher and change agent roles

Not all practitioner researchers, whatever their level of "insiderness", will be acting as change agents. For example, an insider practitioner researcher who is concerned with developing practice in palliative care, may not be responsible for bringing about the changes in practice which are suggested by his/her research. His/her role may be limited to publishing and disseminating the results of their research.

In my own case as an organisation development practitioner, I am more frequently than not also in a change agent role; I am expected not only to say what could or should be done but I am also expected to make it happen or, at least, to play a prominent role in seeking to effect the change which I am advocating.

I believe that there are tensions between the role of the insider/researcher and that of the change agent; there are also important synergies. In my experience, particularly in the projects which inform this report, the change agent role is much more ***pragmatic*** than that of the insider/researcher. On a day to day basis, the change agent runs into the realities and uncertainties of organisational life; his/her ideas and theories are constantly challenged and plans have to be modified, delayed or even abandoned in the face of organisational reactions and internal and environmental turbulence. The contractual obligation of the change agent is likely to be rather different from that of the insider/researcher; he or she is likely to be under pressure and under a contractual or moral obligation to deliver particular real world outcomes by particular dates. As discussed earlier in this report, the change agent who is ***also*** an insider/researcher is constantly seeking to balance the priorities and direction of the research enterprise with those of the change agency project.

Rightly or wrongly, "research" is often seen as a relatively innocuous activity; there is a buffer between the research activity and implications for individual and organisational behaviour; on the whole, people do not feel threatened by "research". By contrast, change agency is "up-close and personal"; people can and do feel threatened by it. The change agent is likely to experience organisational and personal resistance and may experience strong hostility and attempts to undermine his/her work or even to remove or sideline the change agent. The change agent, in my

experience, carries an emotional burden which is rarely present for the insider/researcher who is not also in a change agent role.

I suspect that the success criteria for insider/researchers and change agents are different. The insider/researcher may be concerned with measures such as getting published, citations, invitations to speak at conferences, peer approval and so on. For the change agent, only tangible change will do – are people now behaving differently than they did beforehand? Each set of criteria has its own challenges and they may be equally difficult; but they are different.

Where the two roles can converge, as in these projects, is where action research methods are applied. Here the researcher is using change agency as a research tool; explicitly seeking to implement change and to develop theories grounded on the experience of seeking to implement change. The relative importance of the "change" as opposed to the "learning" will vary from project to project and from researcher to researcher. Where both are critically important, the action researcher will have to embrace fully and live with the delights and distresses of both roles.

I suggested that whilst there are tensions between the insider/researcher role and that of the change agent, there are also synergies. An important synergy particularly in the context of professional research, is the extent to which change agency allows theories and idea to be tested out immediately in real world situations and the results fed back in a very tight cycle. The probability of developing ideas which are likely to work in practice and to be adopted readily is, I think, rather greater when the two roles have been combined and intertwined.

Finally, in Chapter Three, I have questioned the appropriateness of traditional research governance frameworks such as the Research Governance Framework Health and Social Care (DOH, 2001) for practitioner research, particularly when the research is embedded in practice in living and working organisations. I explored, for example, the problematic nature of "informed consent", "beneficence" and confidentiality in a context where members of staff are not individually and explicitly consenting to engage in the project but are, rather, required to do so by virtue of the contractual relationship with the employer. I suggested that there may be a need to develop an ethical framework which is more realistic and appropriate for this sort of practitioner research perhaps drawing upon documents such as the Code of Conduct for NHS Managers (DOH, 2002). My concerns are twofold; firstly that by trying to fit practitioner research into a framework designed for other purposes, the researcher will actually end up behaving unethically and dishonestly and, secondly, that that by imposing unnecessary and inappropriate requirements, the development of practitioner research embedded in practice may be unduly inhibited.

SUMMARY

The NHS Improvement Plan (2004) sets out a bold and aspirational vision of a health and social care system which delivers high quality services tailored to meet the needs and aspirations of the individual citizen. I believe that the realisation of this vision will require a transformation of the NHS and its partner agencies into a modern service enterprise, competing with other providers, to satisfy the needs and aspirations of its citizen-consumers.

This study suggests that a transformation in the role and competences of organisational leaders is a prerequisite for such organisational and system-wide transformation. The study also suggests that the role and practices of leaders at the interface with the consumer is of critical importance in bringing about and maintaining transformation where it counts – in the experience of the consumer; patients, their carers and their families and friends.

Using a twin project strategy, the study has sought to explore the wider strategic context of health service leadership, leadership behaviour at the consumer interface and, most importantly, the interplay between the two. Just as the research strategy has required "parallel processing" I believe that leadership development requires simultaneous attention to the development of organisational leaders (enabling leadership) and to leaders at the consumer interface (delivery leaders) – neither is more important or urgent than the other and neither is dispensable.

The study suggests that it is in the role of organisational leader that the disciplines of leadership and organisational development need to fuse – the organisational leader must become an expert organisation development practitioner – as Catherine the Great might have put it "*c'est son metier*".[31]

[31] Moi, je serai autocrate: c'est mon metier.
Et le bon Die me perdoneera: c'est son metier.

Portwood and Thorne (2000) assert that

> *"The D.Prof is unequivocally orientated to praxis and the products of its projects are judged on the intensity and extensiveness of their impact within the candidate's professional context and circle".*

The projects on which this report is grounded were designed to bring about change in the real world. In the case of the mental health study, to implement successfully an assertive rehabilitation model which would stop people from being detained unnecessarily in conditions of high security and deprived of many of their rights as autonomous human beings. In the case of the career management study, to start to develop the leaders the NHS needs for the ***future*** rather than simply rolling forward the past.

Although in both cases, it is a little early to judge, there are encouraging signs that both the process and the products of the study are starting to make an impact on the thinking and behaviours of the professionals concerned.

CONCLUSIONS AND RECOMMENDATIONS

Introduction

The aim of this project was to derive a number of general principles and practical measures which can be applied to enable effective leadership of change within the NHS. As might be expected in a professional doctorate, many of the important outcomes take the form of real world changes (as in the case of the organisation development case study in mental health), in new processes (such as the development centres) or in documents (such as the two Career Development Guides) – all of these are the products of applied professional research at doctoral level.

In the project, I set out to:

- Achieve a clearer understanding, based on credible evidence, of the interaction between individual and organisational learning in relation to the leadership of change.

- Develop and disseminate principles and practical guidelines to inform the design and commissioning of leadership development activities in the NHS.

- Embody evolving principles and practical guidelines in the future work of Leadership London.

A requirement for the award of a Doctorate in Professional Studies is that the candidate should "*demonstrate the ability to interpret existing knowledge and to create new knowledge and new applications*" (Programme Handbook, p 13).

"Newness" can consist of creating new fragments of the picture or in putting together existing knowledge in novel ways. I am not making claims for having discovered any "bits" of new knowledge; given the extent of the literature about leadership and organisations, it is, perhaps, unlikely that I would have done so. Everything which I recommend is foreshadowed somewhere in the literature on leadership and

organisations. What is missing and what I believe I may have contributed is how to put this knowledge together in a particular way to enable the NHS to transform itself into a 21st Century public service organisation.

In proposing that organisational leaders in the NHS must take on the role of "enabling leaders" (see Chapter 5, p71) and that to do so they must have highly developed organisation development skills, I am clearly building upon Alimo-Metcalfe's work on transformational leadership (1999) but I am focussing the work on a particular type of role. By implication, I am challenging the belief that it useful for leaders operating at the interface with service users to have "transformational leadership" skills.

In proposing that leaders operating at the interface with the service user (delivery leaders) must have both the skills and the organisational permissions and power to exercise effective "case management" (Allen, 2000), I am proposing a fundamental change in the role of people like Ward Sisters and, therefore, in how they are trained, developed and performance managed. I am also suggesting that we need many more people capable of exercising this "case management" role – not just those who are currently regarded as formally being in leadership roles.

Perhaps most significantly, I am arguing that a number of things have to happen ***in parallel*** to bring about the sort of organisational transformation which is envisaged in the NHS Improvement Plan:

- Measuring system performance primarily by the extent to which the whole system meets the needs and aspirations of ***each*** service user.

- Changing institutional and cross-institutional policies, procedures and practices, so that system resources can be mobilised to address the needs and aspirations of ***individual*** service users.

- Developing "enabling" organisational leaders who are primarily concerned about and skilled in shaping organisational culture and competence in complex organisations and across institutional boundaries.

- Developing "delivery" leaders (and recognising that we need very many of them) who have the skills, responsibility and authority to mobilise whole system resources to address the needs and aspirations of each individual service user.

I am suggesting that if we continue to cling to mental models (Senge) in which we see organisation development and individual development as quite separate things, we will continue to invest heavily but gain little.

In terms of new applications, I am suggesting that Development Centre technologies can usefully be applied to help people to envisage and understand the future in concrete ways and, by so doing, to start to equip themselves for future roles. I am also suggesting a systematic approach to career management and succession planning again building on existing knowledge about coaching[32], mentoring[33] and work-based learning[34] but linking these to a future vision of the NHS, to differentiated leadership roles and to organisation development.

The conclusions and recommendations which follow, taken together with the products of the project, demonstrate how the objectives of this project have been addressed. The project also set out to address a number of specific research questions. To demonstrate the extent to which each of these has been addressed in the project, I have grouped the conclusions and recommendations from the project under the relevant research question headings.

[32] Parsloe and Wray, 2000
[33] Lewis, 2000
[34] Cunningham et al. 2004

CONCLUSIONS

Research question 1

In what ways do leadership behaviours and practices influence change in clinical practice and, therefore, in the experiences of patients and the outcomes which are achieved?

1. The day to day behaviours and practices of local "near" leaders such as Clinical Nurse Managers and team leaders are of critical importance in shaping the behaviours of staff actually delivering patient care. The mental health study, in particular, demonstrated clearly that changing either the individuals in leadership positions or their practices brought about a relatively rapid change in the behaviours of many of the staff delivering care. Critically important behaviours included:

    - Role modelling good practice.
    - Giving praise and recognition for good practice.
    - Showing disapproval of poor or mediocre practice.
    - Establishing or making effective work systems which support good practice (such as care planning).
    - Addressing working practices (such as Primary Nurses on long-term night duty) which inhibit good clinical practice.
    - Securing the resources necessary to enable good practice by influencing "upwards" and by demanding satisfactory services from other parts of the organisation.

2. The critical importance of effective leadership at local "team" level does not seem always to be fully recognised in terms of:

    - Articulating the standards of leadership practice required and expected.
    - The performance management of leadership practices.
    - The training and development of local leaders.
    - The care taken over selection of local leaders.
    - The authority which is invested in local leaders.

Research Question 2

What organisational factors encourage and enable front-line staff to innovate in their practice and what factors inhibit innovation?

3. A pressing demand for unsolved problems to be solved is an indispensable driver for innovation. If the *status quo* is regarded as acceptable or if problems are defined as "intractable", there is no stimulus or rationale for innovation. In the mental health study, for example, only when the failure of patients to "move on" to less restrictive settings in a timely fashion became of concern did innovation occur to address long-standing problems.

4. Re-conceptualising or refreshing organisational (or team) purpose is potentially an important driver for innovation. The introduction of the term "assertive rehabilitation" in the mental health study elicited innovative behaviours as staff re-conceptualised their task from "warehousing" to "rehabilitation". The organisation development team made specific use of "new" vocabulary such as "rehabilitation plan" rather than "care plan" to reinforce the re-conceptualisation of purpose.

5. The effort required to introduce innovations or experiments must not be too great otherwise many staff will be discouraged from seeking to innovate. The concept of the "Dynorod" group was introduced into the mental health organisation development programme specifically to reduce the "burden of innovation" by providing a fast and effective way of removing organisational blockages to innovation.

6. How "failed" innovations are responded to and seen to be responded to is an important factor in determining the extent to which front-line staff are likely to innovate. Local and organisational leaders need to understand the mechanism of "shaping behaviours" so that they reinforce *attempts* to innovate, whether successful or not. This conclusion supports the work of the Expert Group on Learning from Adverse Events in the NHS (DOH, 2000).

Research Question 3

To what extent is it necessary or desirable to blend individual development and organisational development to achieve the best return on investment in these activities?

7. The evidence from this project confirms that investments made in individual development often fail to deliver a commensurate benefit to the organisation because the conditions do not exist which facilitate the application of new learning. Specific examples from this project include substantial investments having been made in both leadership development and clinical development but with little or no discernible change in practice.

8. Where opportunities for individual learning and development are created *in response* to clear organisational need, the probability of securing an acceptable return on the development investment is increased. Specific examples from this project include re-defining the role of Primary Nurses as Rehabilitation Managers before providing training and development to enable them to carry out the role successfully.

Research Question 4

What new leadership challenges will be presented in meeting key policy objectives for the NHS in England?

9. Competence in organisational development will be a requirement for success in organisational leadership roles in an NHS and social care system which aspires to respond to the needs and aspirations of individual "customers" and in which institutions are exposed to contestability.

10. Organisational leaders will increasingly be engaging in collaborative leadership across networks of service provision rather than focussing exclusively on the leadership of their own "stand-alone" institutions.

11. Organisational leaders will require competence in strategic marketing as they continuously re-position and re-invent their organisations to adapt to a constantly changing ecology and economy of health and social care provision characterised by contestability, payment by results, consumer choice and new entrants.

12. In an increasingly competitive labour market, organisational leaders will have to demonstrate high level skills in attracting, developing and retaining skilled staff. Their ability to do so is likely to become a critical success factor for their organisations.

13. Local leaders such as Ward Sisters/Charge Nurses will be responsible for orchestrating the totality of the customer experience and for mobilising the resources of the system to meet the needs and aspirations of individual customers. To do this they will require:

    a. Enhanced skills and knowledge particularly in terms of case management.
    b. A fundamental re-conceptualisation of their role.
    c. Enlargement of their authority to command and mobilise resources on behalf of their customers.

14. Many more clinical practitioners than at present will need to conceptualise their role as having a significant leadership component as they take responsibility for orchestrating system resources to meet the needs and aspirations of the individual customers for whom they have responsibility. This will have implications for how clinical practitioners from all disciplines are prepared for their roles and how their performance is managed.

Research Question 5

What approaches to leadership development are likely to help to meet these challenges?

15. Approaches which closely integrate organisation development and individual development are likely to be more successful than approaches which separate these two sets of activities.

16. Approaches which require demonstrable changes in practice in the work-place are likely to be more successful than those which do not have a demonstration of practice requirement.

17. Approaches which are designed to contribute to the solution of acknowledged specific organisational problems and priorities are likely to be more successful than those where the link is more tenuous.

18. Approaches which help learners to achieve and sustain clearly defined standards of practice are likely to be more successful than approaches which are not clearly linked to required standards of practice.

19. Approaches which are embedded in a continuing discourse about organisational purpose and consequential role requirements are likely to be more successful than approaches which are not so embedded.

20. Approaches to leadership and leadership development which mirror ideas about clinical competence are likely to be more successful than those which do not mirror the core clinical competences of the NHS. In practice, this might mean:

    a. Clear standards of competence.
    b. Qualifications based on demonstrated knowledge and skills.
    c. A significant work-based "apprenticeship" component.
    d. A requirement for continuing professional development.
    e. A requirement for re-validation.

f. Sanctions for misconduct or incompetence.

21. Approaches which are embedded in a systematic approach to career development and succession planning are likely to be more successful than approaches which exist in isolation. The products from this project include a draft policy on career management and succession planning and a Guide for Chief Executives and Directors on career management and succession planning.

22. Technologies such as Development Centres can play a useful part in promoting understanding of future role, organisational and whole system requirements and in communicating about future standards of practice and competences. Approaches like Development Centres become particularly important when future demands are thought to be significantly different to past demands.

RECOMMENDATIONS

1. That the implications for leaders working at the interface between the system and the consumer should be thoroughly explored and debated in the context of the aspirations set out in the NHS Improvement Plan (2004).

2. That local NHS organisations should identify the roles within their organisations which will require significant leadership competences if they are to deliver the aspirations set out in the NHS Improvement Plan and they should design and implement development programmes to ensure that people in such roles are adequately skilled.

3. That local NHS organisations should evaluate the extent to which local leaders have the decision-making scope to deliver satisfactory experiences and outcomes for individual consumers and should take whatever action is necessary to provide the required decision-making scope.

4. That nationally and locally, performance management systems are developed and implemented which focus on the extent to which each consumer has a satisfactory experience and has their needs and aspirations met.

5. That local NHS organisations should ensure that quality of leadership practice forms part of their performance appraisal and personal development systems.

6. That the implications for organisational leaders of the NHS Improvement Plan should be thoroughly debated with a view to recognising the qualitative difference between the role of organisational leaders in the future and those which currently prevail. The products from this project provide a useful starting point for this debate. In particular, organisational leaders should understand their role in organisation development and should be adequately skilled to perform this aspect of the organisational leadership role. Technologies such as Development Centres should be deployed as they have a useful contribution to make in the implementation of this recommendation.

7. That Strategic Health Authorities, supported by the NHSU and the Modernisation Agency, should develop and implement strategies to equip organisational leaders with the competences which they will require to deliver the aspirations of the NHS Improvement Plan.

8. That locally and nationally systems are developed and implemented which actively manage the identification, development and retention of people with potential for leadership roles. Some of the products from this study should support the implementation of this recommendation.

COMMENTARY ON RECOMMENDATIONS

As this is a professional doctorate concerned with practice, it may be worth noting how the research findings have been translated through into practice in the context of the two projects which inform this report.

The Case Study

Work has been undertaken to clarify the role of and standards expected of local leaders, particularly Clinical Nurse Managers, Team Leaders and Primary Nurses.

Work has been undertaken to help people in these roles to develop the competences required to perform them to an acceptable standard.

Work has been undertaken to build patient experiences and clinical outcomes more clearly and prominently into the performance management systems of the organisation.

Work has started to re-balance the need for security with the need for rehabilitation – nudging simple systems into the zone of complexity.

Work has started to nudge clinical practice out of chaos and into complexity through more robust care planning processes and through better use of evidence-based practice.

Career development

Guides and workbooks have been developed to provide a framework for more consistent leadership development.

Development centres have been developed and are being applied as a way of preparing people for future leadership roles in the NHS. In London, agreement has been reached to establish an infrastructure to support the use of development centres across the five Strategic Health Authorities.

The conclusions and recommendations from this project are being fed into national policy through the NHS Leadership Centre and the network of Directors of Development.

SUGGESTIONS FOR FURTHER RESEARCH AND DEVELOPMENT

In some ways, this project set out to paint a big picture; dictated by the scope and magnitude of the research questions. I believe that such a big picture is necessary before more detailed work is undertaken. However, whilst I have tried to propose some very concrete next steps and to develop some useful tools, I am also conscious of having created an agenda for further work. I am told that this is not at all unusual in any research enterprise!

Although I am fairly confident that my assertion that the behaviours observed in local clinical leaders in the mental health hospital are not completely atypical, this is based solely on my own observations in the course of my practice over the years. I would like to see a systematic review of the literature on leadership behaviours at the interface between the system and the citizen and, if necessary, formal research studies to help to understand the nature and scale of the problem across a range of NHS and health and social care settings.

There is more detailed work to do on defining the roles and competences of organisational leaders and on how such competences might be developed. A particular question in my mind is how work-based learning approaches can be employed if the current work-place is indeed very different from that in which we expect people to practice in the future.

There is more work to do on defining the roles of leaders at the interface, in defining the competences which are required to perform these roles and in deciding what sorts of people would require "case management" competences.

I would like to see a demonstration project to create an organisational setting in which leaders at the interface would have the authorities and permissions to carry out the role. The nearest example of which I am aware is the practice of one of my colleagues as an Independent Nurse Case Manager in which role she is able to put into practice many of the findings from her own M.Phil dissertation on Transdisciplinary practice. It may be significant that she has not been able to do this within the NHS.

The products from this project tend to focus on the development of organisational leaders; I am currently arguing for complementary work to be undertaken with a focus on leaders at the interface.

The conclusions drawn about the application of Development Centres is based on very limited data and on feedback gather almost immediately after the event. There is a need for a more detailed study of the application of development centre technologies in helping to prepare people for the future NHS.

MY PERSONAL LEARNING

The work of which this is a report highlights the need to put together strands of thought and activity which are often considered to be quite separate; leadership and organisation development, organisational leadership and "front-line" leadership, institutional success and individual patient success.

My own learning has mirrored this process of synthesis; putting together my practice as a teacher, as a change agent and as a researcher and hoping to generate some useful synergy from the process of synthesis.

Learning about organisation development

For me there have been two major strands of learning in connection with my own professional discipline and practice both of which represent departures from, perhaps, an overly rational way of thinking about organisations and the people living and working within them.

I have been strongly influenced by some of my reading around psychodynamic approaches to thinking about organisations; needing to understand more about the irrational and subconscious components of individual, group and organisational behaviour. In looking particularly at the case study organisation, I feel that I have observed organisational life through a somewhat different lens; a lens which has enabled me to understand rather better what has previously seemed to be simply perverse or senseless behaviour. Translating this through into my practice has proved more difficult and this remains one of my goals for future continuing professional development.

The other approach which I have found both helpful and persuasive is relatively recent work on complexity theory; understanding organisations as complex adaptive systems in which the outcomes of interventions may not be as predictable as I would like them to be and as I have perhaps fondly imagined them to be. Again, in the case study in particular, being able to see the impact of shadow systems and the networks of influence running through the organisation have been very helpful. In particular, I

was able to conceptualise the behaviours of the custodial aspect of the organisation and the behaviours of the therapeutic part of the organisation as exhibiting respectively the characteristics of simple systems and chaotic systems and to suggest that both might need to be "nudged" or re-conceptualised as having the properties of complex systems.

The link between the psychodynamic approaches and the complexity systems approaches seems to me to be both in acknowledging and respecting the autonomy of agents within organisations and the interactions between autonomous agents and in accepting and coming to terms with the inherent unpredictability of my practice. As with the psychodynamic approach, I am still working on how to use the insights from complexity theory in developing new models for my own practice.

Learning about leadership

In my review of the literature on leadership, I detected "fashions"; in particular a focus on organisational leadership alternating with a focus on close-in leadership. Something which became clear to me in the course of this study was that both forms of leadership are critical to organisational success but that they are different from each other and may require quite different forms of selection and development.

I am instinctively drawn to the "leader as servant" model and to leadership as a value-adding process. At an emotional level, I tend to find the leader as "commander and controller" unhelpful and inappropriate.

Both my reading and the work I have been undertaking within this project reinforce this basic view. In the context of the case study, the need to deliver individually tailored rehabilitation and to shape the behaviours of patients suggest that local leaders, particularly Primary Nurses and Ward Managers, must have the competences and the freedoms to mobilise organisational resources around patient need, if the organisation is to achieve its therapeutic purpose. Similarly, in the wider strategic context of the NHS as a whole, leaders at the interface with patients must have the competences and the authorities necessary to orchestrate care throughout the patient journey.

The effectiveness of leaders working at the interface is, however, determined as much by the organisational context in which they work as by individual skills and attitudes. In practical terms, unless organisational leaders create the appropriate conditions for holistic and patient-centred care to be delivered, the best efforts of local leaders will be thwarted. Correspondingly, the aspirations of organisational leaders will not be met without the development of effective local leaders. The two roles are complementary but different.

I have also postulated that there may be a third distinctive leadership role, that of the leader/educator; who ensures that the organisation has appropriately trained staff at its disposal.

In terms of my own learning, I am now much clearer about the different roles of different kinds of leaders, about the relationships between them and, crucially for my practice, about how their development might be supported. I am also convinced about the need to find ways of blending organisation development and individual development. Through the projects and the associated background reading, I believe that my instinctive position can be supported by sound evidence. I feel that I am, therefore, in a much stronger position to advocate for what I believe in.

I have also come to recognise that my own role as an organisation development practitioner is to exercise organisational leadership and that, in doing so I have both an opportunity and an obligation to exemplify that which I am advocating.

Learning about policy development

One of the personal learning goals set out in my Programme Planning and Rationale was to extend and deepen my knowledge of public policy development and implementation. My involvement with the case study has exposed me to an area of public policy, criminal justice and its interaction with health, of which I had little knowledge. I have had to grapple with ethical issues which are quite different from those with which I am familiar in the NHS (coercive care and treatment).

My involvement with the career development and succession planning project has made me engage with the wide landscape of health and social care policy and to reflect both on what drives policy making and how it feeds through into practice "on the ground".

I have learned a good deal about the political aspects of policy making through working closely with the Strategic Health Authorities in London and with the NHS Leadership Centre.

In the context of policy-making, I had a particular goal to become more adept at balancing or reconciling policy and pragmatism. In both the case study and the career development and succession planning project, I had to negotiate solutions which were pragmatically acceptable to and possible for the people with whom I was working whilst holding onto the policy objectives which I was seeking to achieve. I feel that I have made some progress towards my aspiration of becoming a "tempered radical".

Learning about research

Quite specifically, I have learned to understand the difference between research for private use and research for private consumption. At the start of the programme of study, I believe I was sufficiently competent to carry out research to inform my own practice and teaching. Although I had carried out some applied research projects on behalf of the Department of Health, these were designed and written up only for internal consumption and would not, for example, have met the requirements of peer-reviewed journals. It is probably fair to say that I was somewhat disdainful of "academic research", its style of writing, its preoccupation with methodology and references.

I believe that I now could plan, execute and write up a piece of research which would pass muster for a peer-reviewed journal. Equally importantly, I think I understand why academic researchers work within the framework which they do. I could, therefore, now make an informed choice as to whether I wished to undertake research with a view to publication or whether I wished to undertake work solely as a change agent or teacher.

I have some unresolved issues about research ethics in the context of practice-based research and I am slightly gratified to note that some of my concerns about the Research Governance Framework for Health and Social Care are shared by researchers in a the Royal Colleges for Nursing and Midwifery. It is a salutary reminder to me and others about the "law of unintended consequences" and the need for policies to be living documents which are constantly challenged and reviewed. It is a further powerful example of how policy and practice can become uncoupled from purpose – how easy it is to lose one's way on a journey through confusing terrain.

Learning about purpose

If I had to select only one insight from a learning-rich few years, it would be how easy it is for organisations and for practitioners to forget what they are there for. An enduringly important role of leaders at any level in any organisation is to keep articulating and reinforcing the purpose of the organisation. Organisations, and their leaders, do have lives of their own and it is frighteningly easy for the imperatives of these internal lives to distract us completely from a sense of external purpose; we do what is right for us rather than what is right for our patients or customers.

I have embedded this insight into my own practice as a change agent and as a teacher to the extent that it has become a central theme of my teaching and my practice.

I think that I also have a clearer sense of purpose in my own work; a sharper sense of what I am trying to help the NHS to become.

APPENDICES

APPENDIX A

CAREER DEVELOPMENT BACKGROUND DOCUMENTS

Tender for the project

Invitation letter for focus groups

Focus group briefing paper

Composition of focus groups

Report on outcomes from focus groups

Health-od.net Ltd.

Tender to develop a Career Management and Succession Planning pilot with London Health Trusts.

Michael Faulkner
13th October, 2003.

28, St. John's Road, Isleworth, Middlesex, TW7 6NW
Telephone/fax 020 8847 4490
Mobile 07885 132574 email Michael@health-od.net

OUR APPROACH

Our role will be to work as integral members of a project team led by Annabel Scarfe and accountable to Julie Dent.

Within the team, our role will be to:

Contribute to the thinking of the team.

Contribute particular expertise in, for example, development centre design.

Undertake particular tasks on behalf of the team as agreed within the team.

We recognise that we will probably be able to commit more time to the project than the other team members and would, therefore, expect to undertake a significant amount of the work which takes place between project team meetings.

We will agree with the project team a detailed project plan which sets out deliverables, milestones, timescales and responsibilities and work with colleagues in the project team to ensure on-time delivery of high quality products.

PHILOSOPHY OF CAREER DEVELOPMENT

We believe that career development must be primarily self-directed but enabled and encouraged by employing organisations.

We share the view set out in the background documents that performance in a particular role is not necessarily a good predictor of potential for future roles.

METHODOLOGIES

The project is best considered as a number of linked sub-projects each of which requires its own methodology.

Developing Indicators of Potential

We would recommend a number of focus groups to elicit likely indicators of potential which are owned by the NHS leadership community. The table below shows the focus groups which we would suggest.

FOCUS	MEMBERSHIP
Aspiring Chief Executives	Chief Executives who are considered to be close to the model of the future Chief Executive (transformational). Annabel Scarfe and Julie Dent.
Aspiring Chief Executives	Thoughtful Directors and senior clinicians to elicit early indicators of potential demonstrated by peers.
Directors seeking more challenging roles.	Chief Executives who are considered to be close to the model of the future Chief Executive (transformational).
Directors seeking more challenging roles	Thoughtful Directors and senior clinicians to elicit early indicators of potential demonstrated by peers.

Each focus group discussion would require about 90 minutes and would involve six to eight people.

The outputs from each focus group would be fed back to its members for clarification and comment.

Should it not be possible to arrange focus groups because of diary pressures, an alternative methodology would be semi-structured interviews. We would prefer focus groups because the interaction between participants often helps to form a richer and more rounded view than a series of interviews.

Development Centre for Aspiring Chief Executives

A development centre fulfils three roles:

> It elicits evidence about potential which cannot readily be obtained through other processes. In particular, it elicits evidence through the simulation of situations associated with future roles.
>
> It identifies (and may plan how to meet) development needs in relation to the realisation of potential.
>
> It confirms or disconfirms prevailing assessments of potential drawing on the whole pattern of evidence not just that elicited during the centre.

The starting point for design is a consideration of the indicators of potential and the identification of those indicators which cannot satisfactorily be evidenced in other ways. The output from this consideration is the identification of a number of evidence gaps. A gap may reflect absence of evidence from other sources or weakness in evidence from other sources.

We then need to design a set of activities which will elicit the evidence needed to fill the identified evidence gaps.

The activities then need to be constructed into a programme which is practical and stimulating for both participants and "assessors".

In this case, following the suggestions in the supporting documents, we think there should probably be a reasonable amount of work-based activity prior to the event itself.

The other work which needs to be done is deciding how assessment will take place, thinking about who assessors will be and what training they need. We will also need to take a view on whether we want observers as well as assessors.

Finally, we will need to think through how we manage feedback to participants and where responsibility for follow-up action lies.

Development Centre Tool-kit

Essentially the design process would be similar to that for the Aspiring Chief Executive Development Centre except that we would need to have in mind from the out-set that we are preparing something for others to run.

We think we should probably try to design a flexible framework into which we could initially slot materials for directors seeking more challenging roles but with a facility to add materials for other roles once the indicators of potential for these roles have been developed.

Eventually we would end up with a tool kit consisting of the following sorts of materials:

Framework programmes.

Materials (activities and exercises) with indications of the target population.

Assessment frameworks based on indicators of potential.

Observation sheets etc.

Within the scope of this project, we should probably attempt to include a training session for people to use the tool-kit and, ideally, have it trialled at least once.

In terms of medium, the toolkit could be delivered in paper form and/or CD-ROM form.

It is possible that, when we do the project plan together, we may be able to build in the work to identify performance indicators for aspirant Directors. If this is possible, then we could take the tool-kit development a stage further and have it piloted on aspirant directors which would be very helpful.

Guide on Career Development and Succession Planning

We think this is probably two documents.

The first is a guide aimed at Chief Executives, HR Directors and other Directors which would set out the policy for career development and succession planning in the NHS in London and would contain the leadership qualities framework and the associated indicators of potential.

The guide would aim to provide practical guidance to sharpen their "talent-spotting" skills and processes and would also provide practical guidance on organisational processes for helping people to develop their potential.

The guide might make specific reference to identifying and developing potential in under-represented groups such as people from minority ethnic groups, people living with disabilities and older people.

The second document is probably something like a career development work book (or a CD-ROM or Web equivalent).

It would again set out clearly the policy on career development and succession planning for the NHS in London and the indicators of potential.

We think that it could then contain the following sorts of tools and materials:

A framework for analysing strengths, weaknesses and development needs in relation to the indicators of potential.

A framework for investigating life work values and preferred work content and context.

A framework for life and career trajectories.

A framework for constructing an account of learning and experience related to the preferred experience concept.

Perhaps some accounts or analyses of the challenges and opportunities provided by different leadership roles in the NHS and its partner agencies.

A framework for maintaining a learning and development diary.

Practical guidance on accessing learning opportunities within and outside the workplace.

Perhaps a framework for constructing a Continuing Professional Development (CPD) portfolio in relation to leadership.

Our initial thought is to produce this on paper but with a view to it being subsequently developed into an interactive medium.

Part of the development process for this document would be a quick search to find out what materials, tools and techniques are in use by the Leadership Centre and others which could be incorporated into this guide. The 360^0 appraisal document might be a case in point.

Web-enabled system

We note that you do not envisage developing this as part of the project but that you may seek to use a scaled-down version of the national database. As part of the project, we are happy to work with you in thinking through what is needed and the extent to which the national system can be used or adapted and used.

OUR TEAM

Our lead consultant will be Michael Faulkner who will work as a full member of the project team for the duration of the project. We may wish to involve another colleague, Alan Dods, in thinking through web-based applications and in putting materials developed into CD-ROM or web-based formats.

Michael is a graduate in psychology and philosophy and holds post-graduate qualifications in computer science and in research in professional practice. He is a Member of the Chartered Management Institute and an Honorary Fellow of the Royal College of Speech and Language Therapists.

As Head of Personnel Research and Planning for J. Sainsbury, he developed and implemented organisation wide systems for career development and succession planning including the use of development centres. He has extensive experience in the design and use of development centres both within the NHS for organisations such Great Ormond Street and the (then) London Regional Office and for private sector organisations such as Marks and Spencer and National Westminster Bank.

He also has extensive experience in leadership development within the NHS and its partner agencies including acting as professional adviser to Leadership London and developing and leading the Facilitator Development Programme and the Clinical Leadership Programme.

Alan is a computer specialist with experience in the development of web-based systems. He has also been involved in the design and development of development centres.

DELIVERABLES, TIMESCALES AND COSTS

Output	When	Days	Cost
Project plan	Nov 2003	1	£750
Focus group notes	Dec 2003	4	£3000
Indicators of potential.	Dec 2003	2	£1500
Outline design for DC for ACEs.	Dec 2003	2	£1500
Agree date and venue for pilot DC	Dec 2003	0	0
Materials for DC for ACEs	Jan 2004	5	£3750
Assessor training for DC for ACEs.	Feb 2004	2	£1500
Pilot DC for ACE's	Feb 2004	2	£1500
Evaluation of pilot DC for ACEs.	March 2004	2	£1500
First draft guide for CEs etc.	March 2004	3	£2250
Second draft guide for CEs etc.	April 2004	1	£750
First draft guide on career development	March 2004	3	£2250
Second draft guide on career development	April 2004	1	£750
Strategy for web-enabled system.	April 2004	2	£1500
Outline design for DC toolkit.	Feb 2004	2	£1500
Detailed design for DC toolkit.	March 2004	5	£3750
Training for DC toolkit users.	March 2004	2	£1500
Pilot DC toolkit.	April 2004	2	£1500
Workshop to capture learning	April 2004	1	£750
Project Learning Report	Early May, 2004	3	£2250
TOTAL		**45**	**£33,750.00**

Costs include travel, equipment, materials and other incidentals. Please note that VAT will be added to the total of all invoices.

Invoicing schedule to be agreed against deliverables.

Dear Colleague,

The London Career Management and Succession Planning Pilot

We are leading, on behalf of the NHS in London, a pilot study to develop a comprehensive and systematic approach to career management and succession planning in the NHS and, where appropriate, with our partner agencies.

The attached background brief describes the scope of the pilot study and its intended outcomes in more detail.

As part of the project, we will be holding a number of focus groups to help us to understand better what future leadership roles may be like and to understand what indicators people use to identify potential for future roles.

I am writing to invite you to participate in one of these focus groups which will take up about two hours of your time. I would particularly welcome your involvement as someone whom I know has given a great deal of thought to the direction in which the NHS is developing and the implications for those who will be undertaking leadership roles in the future. The focus groups will take place in Central London.

I would be grateful if you could let me know by email whether you would be willing to take part and, if so, which of the following sessions would be convenient for you. Although you would only need to take part in one group, it would be helpful if you could give me as many possibilities as you can so that I can balance up groups.

If you can get back to me by xxxxxx then I will confirm dates, times and venue no later than xxxxxxx.

I have attached for your information the briefs for the focus groups one of which is concerned with aspiring Chief Executives and the other with Directors and equivalents seeking more challenging roles.

Thank you in anticipation for your help. If there is anything you would like to ask, please feel free to call me or email me.

Best wishes

Yours sincerely,

Annabel Scarfe

The London Career Management and Succession Planning Pilot

Background Briefing

The project is a pilot study funded by the NHS Leadership Centre and be carried out on behalf of the NHS in London by South West London Strategic Health Authority.

The pilot study aims to inform the development of a comprehensive and integrated approach to career management and succession planning within the NHS and involving our partners in health and social care as appropriate.

The specific objectives which we aim to achieve through the pilot which will run through to May, 2004 are as follows:

To identify indicators of potential for aspiring Chief Executives and for Directors seeking more challenging roles.

To design and run a pilot Development Centre for aspiring Chief Executives.

To develop a "tool-kit" which will enable NHS organisations in London to design and run their own development centres drawing on a range of materials.

To produce a guide for organisational leaders to assist them in identifying and developing people with potential.

To produce a guide for people working within the NHS and its partner agencies in London to assist them in managing their own career development.

As part of the pilot we will also be doing some design work on the sort of web-site and database facilities which would support and enable career management and succession planning.

We wish to engage the NHS leadership community in London in the project. To enable this, we will be posting draft materials for comment on a special section of the Leadership London Website www.llweb.co.uk. If you wish to be notified about new materials placed on the website for comment, please go to the website and click on the ***Include Me*** link. For further information about the project, please contact Annie Roy – Project Manager on 02085456019 or email her at annie.roy@swlha.nhs.uk.
Annabel Scarfe

FOCUS GROUP COMPOSITION

Chief Executives	Acute	13
Chief Executives	Primary Care Trusts	6
StHA Directors		9
Other		2
Total		30
Male		9
Female		21
Total		30

OVERALL INTRODUCTION

This paper contains four separate but inter-related sections:

- Early Indicators of Potential for Organisational Leadership.
- Additional Indicators of Potential for Chief Executive roles.
- Future-critical competences for Chief Executives.
- Future-critical competences for Directors.

The content is based on a series of focus groups involving Chief Executives and other organisational leaders from health and social-care in London.

The focus groups were invited to discuss the future context of leadership in health and social care in London and to identify the behaviours which they used in identifying individuals with potential to perform effectively as Chief Executives and as Directors.

In reflecting on the future context of leadership, participants were particularly mindful of:

- Patient Choice and its implications.
- Changes to the flow of funds within the NHS and social care.
- The increasing importance of non-statutory providers in the delivery of health and social care.
- A trend away from tight central control and direction towards community accountability.

They were also mindful of wider social trends in the direction of increased "consumerism" and of a continuingly competitive labour market in London.

In terms of the leadership context, they believed that:

- There would be a shift of focus away from autonomous leadership of institutions (e.g. NHS Trusts) towards shared or collaborative leadership of whole systems of care.
- There would be an increasing focus on the quality of the whole patient experience and on the outcomes achieved by the health and social care system with measures such as waiting times being seen as a means to an end rather than as end in themselves.
- The role of NHS bodies as employers, purchasers and controllers of physical and intellectual resources in their communities would gain increasing prominence.

An important goal of this project is to enable us to "spot talent" early in people's careers and then to foster the development of that talent assertively and intelligently.

It is difficult to separate out potential, performance and competence. However, the groups were able to identify a number of early indicators of potential which they see as largely innate or at least formed by the time people come into their first leadership roles. Many of these will be observable in first leadership roles although in some situations in may be necessary to create the conditions in which particular individuals are given opportunities to demonstrate their potential.

The groups considered that future corporate leadership roles would present significantly different challenges to those which currently apply. They believed that future corporate leaders would require both ***wider*** experience and ***deeper*** experience.

In developing corporate leaders for the future, we will need to:

> Encourage and enable movement and learning across several domains of health and social care. This need not always be achieved by job changes – greater use could be made of secondments, projects and so on to widen experience.
>
> People may stay longer in one post than they do at present, but the post will provide wider, deeper and more explicit opportunities for learning and development. There was a view that sometimes people move on so quickly that there is not an adequate opportunity for them to learn properly or to demonstrate their achievements fully.
>
> Recognise that being an effective head of function is a necessary but not sufficient requirement of people working at Director level.

The focus group members stressed that selecting and developing the right leadership ***team*** for a particular organisational context was as important in determining organisational success as the competences of individuals. A Chief Executive may not personally possess all the competences required for organisational success but he/she must ensure that the required competences are available within the team and that team members are enabled to apply their competences effectively.

The findings from these focus groups and subsequent debate and comment , together with other data, will be used to:

> Design the pilot Development Centre for aspiring Chief Executives in London.
>
> Design the Guides on "talent spotting" and "managing your own career" which are two of the deliverables from this project.
>
> Influence thinking within London and nationally on career management and succession planning in health and social care.

EARLY INDICATORS OF POTENTIAL
for
ORGANISATIONAL LEADERSHIP

INTRODUCTION

The indicators of early potential set out below describe behaviours which we would expect to see in individuals who, with appropriate development, are likely to become effective organisational leaders operating at least at Director level and potentially at Chief Executive level in complex health and/or social care organisations.

We have sought to differentiate clearly between performance and potential. Thus the indicators of potential will often be evidenced by attempts to do x or y, even if the individual concerned did not have, at that time, all the competences which they might have needed to succeed. In a sense, the indicators of potential are largely innate whereas performance can be improved through variables such as development, leadership and organisational context. For example, we would regard enjoying relating to people and seeing relationships as important as largely innate whereas interpersonal skills can be learned and developed.

We were unable to identify ***early*** indicators of potential which discriminated between Director level roles and Chief Executive roles. A set of indicators of potential to identify people in Director level roles who have the potential to develop into successful Chief Executives is published separately.

It is also important to note that success in organisational leadership may be as much influenced by the composition of the leadership ***team*** as by the abilities of the individuals who constitute that team, including the Chief Executive. For example, it may not be important for a Chief Executive to be creative or innovative as long as he/she incorporates creative and innovative individuals into the leadership team and enables and encourages them to think and act creatively.

Some of the indicators of potential may be readily observable in all or almost all leadership roles. Others may require an individual to be placed in a position in which he/she is able to demonstrate a particular indicator of potential.

THE INDICATORS

Breadth of experience

Evidence that they have sought to gain experience in and understanding of several domains of health and social care.

Empathetic understanding

Evidence of attempting to gain insight into the perceptions of others involved in a given situation and to value and respect their perceptions, values and opinions.

Interpersonal relationships

Evidence that they enjoy developing constructive relationships with other people in a work context and see interpersonal relationships as important to success.

Intellectual curiosity

Evidence that they are curious about a wide range of health and social care issues and eager to understand them.

Search for improvement.

Evidence that they look for scope for improving how work is done, particularly how things could be made better for service users and staff.

Initiating action

Evidence that when they identify an opportunity to improve things, they try to do something constructive about it.

Reflexiveness and self-monitoring

Evidence that they monitor their own beliefs and actions and seek to form an accurate view of their own effectiveness.

Drawing on other people

Evidence that they seek out support and guidance from other people to help them to become more effective at work.

Passion for patients

Evidence that they are strongly motivated by a desire to improve the experiences of people using health and social services.

Risk taking

Evidence that they attempt to assess the risks associated with possible courses of action and to make reasoned judgements about the balance between potential risks and potential benefits.

ADDITIONAL INDICATORS OF POTENTIAL
for
CHIEF EXECUTIVE ROLES

INTRODUCTION

Individuals who have the potential to develop into successful Chief Executives are likely to evidence the Early Indicators of Potential for Organisational Leadership ***AND*** the following additional indicators. It is unlikely that individuals will have had an opportunity to demonstrate these ***additional*** indicators of potential until they are working at Director level or at comparable levels of responsibility and breadth.

As with the early indicators of potential, it is important to differentiate between potential and performance. Potential is concerned with attitudes and ability to learn whereas performance is influenced by competences, leadership and organisational context. The purpose of these additional indicators is to help to identify individuals currently working in corporate leadership roles who, with appropriate development and leadership could learn to become successful Chief Executives.

THE ADDITIONAL INDICATORS

Freedom from function

Evidence that they have sought to understand and become involved in matters outside their functional specialism.

Attitude to the unfamiliar

Evidence that they are willing to grapple with unfamiliar problems and to undertake the learning necessary to understand and tackle unfamiliar problems.

Attitude to uncertainty

Evidence that they are able to function in conditions of uncertainty and ambiguity.

Decision-taking

Evidence that they are willing to take difficult and problematic decisions even under conditions of high uncertainty.

Speed of learning

Evidence that they can master complex and intellectually demanding material speedily.

Independence

Evidence that they are not excessively reliant on close intellectual and/or emotional support at work to be able to function effectively.

FUTURE-CRITICAL COMPETENCES

CHIEF EXECUTIVES

INTRODUCTION

We believe that the combined effect of policies such as Patient Choice and Flow of Funds will make the role of Chief Executives in three to five years significantly different from the current role. The nature of the change can be summarised as a move away from an emphasis on institutional leadership (my Trust) to shared system leadership (our Health Community). In the future we see success being defined in terms of the complete patient experience and the outcomes for the patient from the whole health and social care system as opposed to process measures such as waiting times; short-term measures will no doubt continue to be important but only as part of an overall quality of experience measure. An important implication of the shift from a purely institutional focus to a system-wide focus is that Chief Executives will have to accept being held accountable – sometimes jointly with other Chief Executives - for outcomes and processes which they do not directly control.

We do not envisage the Chief Executive role as requiring any absolutely new competences but some which are not critical in the current role will become critically important in the future. This document sets out the competences which we believe will become critically important for success in Chief Executive roles in the future.

Implicit in these future-critical competences is the belief that Chief Executives will also have to demonstrate:

- Excellence in communication.
- Excellent interpersonal skills.
- Excellent skills in the development of people.

Under each of the top level future-critical competences we have indicated some of the more specific competences which might be required.

FUTURE CRITICAL COMPETENCES

Collaborative leadership.

Recognition that the focus of the Chief Executive role moves away from primarily leading individual institutions towards contributing to the leadership of complex networks of organisations to deliver constantly improving experiences and outcomes for service users.

Whole system knowledge and understanding.

Cultural and political sensitivity.

Sophisticated influencing and negotiating skills.

Performance management on a whole system basis.

Entrepreneurial skills.

Recognition that Chief Executives will have to position their organisations to make particular contributions to local and national systems of health and social care and to "compete" against other actual and potential providers in terms of the quality and cost effectiveness of their contribution.

Identifying emergent "niches" in the system of health and social care.

Understanding the changing needs and aspirations of actual and potential "consumers" (both individual and institutional).

Constantly developing and re-developing services which match or exceed the needs and aspirations of "consumers".

Re-engineering services to improve quality and cost-effectiveness.

Promoting the services of their organisations to actual and potential "consumers".

Cultural transformation.

Recognition that Chief Executives will have to transform existing organisational cultures and practices to create organisations which are responsive to the needs and aspirations of individual patients, which can function effectively within collaborative networks and which are constantly striving to improve the quality and cost-effectiveness of their services.

Preparing their organisations to function successfully in identified (but often contested) niches – ensuring fitness for purpose.

Creating and sustaining organisational cultures which are:

Responsive to the needs and aspirations of individual "consumers".

Focussed on continual improvement in quality and cost-effectiveness.

Focussed on the whole patient experience and outcome rather than on particular "bits" of the process.

Focuses on both the short-term and the longer-term.

Developing and sustaining organisational cultures which attract, retain and develop excellent staff in the context of extremely competitive labour markets.

Corporate citizenship.

Recognition that Chief Executives will have to use the power of their organisations as employers, as purchasers, as owners of facilities and as sources of expertise to contribute fully to the well-being and enrichment of their local communities.

Identifying existing and emergent community networks to which the organisation could contribute.

Identifying the issues, problems and opportunities which are of concern or interest to the local community or to parts of that community.

Identifying the physical, economic and intellectual resources which the organisation has available to contribute to its local community.

Working successfully with local organisations and groups to apply the resources of the organisation effectively.

Promoting the corporate citizenship ***value*** internally and externally.

FUTURE-CRITICAL COMPETENCES

DIRECTORS

INTRODUCTION

The political and social leadership context which we have described for Chief Executives will apply equally to Directors and other corporate leaders. We believe that, in the future, there will be a greater emphasis on the role of Director as member of a corporate leadership team and rather less on the role of the Director as Head of a particular function; effective functional leadership will be a necessary but not sufficient measure of success in Director roles.

Given the increasingly complex nature of corporate leadership, we believe that most Directors will have to be able to carry out many of the role requirements of Chief Executives. In particular, they will have to be able to develop and manage some of the collaborative relationships which will characterise organisational leadership in the future. In doing so they must have the same authority, competence and credibility as the Chief Executive. In some ways, they must be seen as "alternative Chief Executives" otherwise the time of the Chief Executive will become an unacceptable "bottleneck" which prevents the organisation from developing and functioning effectively.

An implication of this proposition is that the "gap" between the role and competences of Directors and Chief Executives narrows.

In practice, the appointment and development of Directors will be influenced as much by the need to create a balanced corporate leadership team in a particular organisational context as by individual competences. At a particular point in time, some Directors will more closely approximate the "alternative Chief Executive" model than others.

APPOINTING DIRECTORS

In appointing Directors for the future, we should expect:

- Excellence in communication.
- Excellent interpersonal skills.
- Excellent skills in the development of people.

Competence in at least one of the future critical competences applicable to future Chief Executives.

Potential to become competent in at least one additional future-critical competences.

Evidence that they regard effective functional leadership as a necessary but not sufficient requirement of Director roles.

APPENDIX B

DEVELOPMENT CENTRE BACKGROUND DOCUMENTS

Briefing for participants

Briefing for development advisers

Outline programme

Analysis of Development Centre feed-back.

London CM&SP Project

Pilot Development Centre for Aspiring Chief Executives

Briefing note for potential participants

Background

As part of the London Career Management and Succession Planning Project, we will be piloting a Development Centre for aspiring Chief Executives on 17th and 18th of March, 2004 at a venue in or around London.

The pilot Development Centre is designed for 20 volunteer participants drawn from across London to enable us to test the design of the Centre. It is important to stress that this pilot event is purely to test the ***process*** rather than the participants. We believe that participants will, however, find the experience of value for their own learning and development. We will be selecting "guinea pigs" from volunteers to give us a representative sample in terms of professional backgrounds, experience and so on. Volunteers will be people who have expressed an interest in becoming Chief Executives and who are currently in positions from which they might reasonably apply for a Chief Executive role in the next two to three years.

What is involved?

The two day event is designed to simulate important aspects of the role of the Chief Executive in the future NHS. Activities will include:

A "day in the life of" which will present you with the sorts of issues which Chief Executives are expected to deal with. During this simulation, you will have meetings to attend, people bringing you problems and ideas and, perhaps, the odd crisis to manage.

A visit with another participant to an NHS organisation with which you are not familiar to evaluate its leadership practices by studying its front line services.

Feedback will be available from your fellow participants and from a team of Development Advisors most of whom will be experienced Chief Executives with a particular interest in leadership development.

A follow-up visit from your Development Advisor about six weeks after the event to help you to put together and negotiate your own personal development programme informed by the Development Centre.

As this is a pilot study, we will also want to get your feedback and comments on the design either through questionnaires, group discussions or individual interview some time after the event.

Benefits to you

Mostly this pilot is about asking you to help us to develop an important element of the career management and succession planning process for the future NHS. However, we think you will get some personal benefits from your participation:

An interesting and challenging experience.

An opportunity to identify your own development needs in relation to becoming a successful Chief Executive.

Useful feedback on your performance during the centre.

Help and support in identifying and addressing your own learning and development needs.

Confidentiality

As this is a pilot activity, no information about you will be fed-back to your own organisation or to anyone else other than what you choose to feed-back. Participants and Development Advisors will undertake not to discuss or disclose anything about any of the participants although you are free to talk generally about the Centre and your own experience of it.

Selecting participants

Strategic Health Authorities in London have been asked to identify a number of possible volunteer participants. We will then be selecting randomly from suitable volunteers to make up a reasonable sample to test the development centre process.

London CM&SP Project

Pilot Development Centre for Aspiring Chief Executives

Briefing note for Development Advisors

Background

As part of the London Career Management and Succession Planning Project, we will be piloting a Development Centre for aspiring Chief Executives on 17th and 18th of March, 2004 at a venue in or around London.

The pilot Development Centre is designed for 20 volunteer participants drawn from across London.

We need to recruit 10 Development Advisors to observe, evaluate and advise the participants during the Centre and in a follow-up visit.

The role

During the Centre:

To observe the behaviour of participants as they undertake a range of activities designed to simulate key aspects of the future Chief Executive role. Likely activities include an interactive in-tray, group discussions, handling difficult conversations and so on.

To take part in a Development Adviser Conference to share observations and to reach a consensus about each participant's potential and development needs.

To give immediate feedback and advice to two assigned participants.

After the Centre

To visit the two assigned participants in their work-place to help them to firm up their individual development plans and to facilitate drawing up a learning contract between the participant and his/her Chief Executive. We anticipate these discussions taking place four to six weeks after the Centre and requiring two to three hours each.

Preparation

Development Advisers will be expected to attend a half day briefing session to be held on ..... at ..... The materials for the Development Centre will be distributed at the briefing session.

CEO DEVELOPMENT CENTRE

OUTLINE PROGRAMME

	Participants	Development advisers
09.00 – 09.30	Arrival, coffee, registration.	
09.30 – 10.00	Welcome, briefing and questions	
10.00 – 17.00	Day in the life of	Day in the life of
17.00 – 18.30	Unobserved learning set	Writing up notes etc.
DAY TWO		
09.00 – 12.30	Learning visits	First DA Conference
13.00 – 13.45	Lunch and farewells so that people can leave after their development discussions.	
13.45 – 15.00	Observed learning set sharing learning from visits.	Observing learning sets.
15.00 – 16.00	Individual preparation for development discussion.	Second DA Conference. (Perhaps in two halves)
16.00 – 17.00	Development discussions	
17.00 – 18.00	Development discussions	
18.30 – 21.00		Working dinner and debrief.

DEVELOPMENT CENTRE FOR ASPIRING CHIEF EXECUTIVES

REVIEW NOTES

In general, the event was seen as a successful pilot from which useful lessons could be learned to improve the approach.

Feedback suggests that:

> The process elicits valuable new evidence which is beneficial for most participants.
>
> Development advisers regard the DA conference as a systematic methodology for analysing and interpreting evidence so that robust conclusions can be drawn and fed-back to participants.

What worked well?

- The event was well organised and managed.
- The venue was appropriate.
- The overall design was about right although some fine-tuning is required.
- Although one or two participants did not find the "Day in the Life" activity particularly useful, the overall view was that seeing performance over a relatively long time period provided insights which would not have been available with shorter activities.
- The Learning Visits were valuable although they were not implemented quite as intended.

What we should do differently

- The multi-agency meeting did not work well because of the number of people playing the same role. The "emergency" during the meeting was, however, useful.
- Some of the roles in the "Day in the Life of" need to be modified or played by people with an NHS background rather than by actors.
- The work programmes in "Day in the Life of" need to be balanced better. However, it could be argued that where participants "did not have enough to do early on", this reflects a preference for reactive work rather than proactive work.
- The timing (and possibly the process) of the DA Conference needs to be adjusted. It took longer than planned as a result of which Das did not have an opportunity to observe the discussions from the Learning Visits as intended.

- Learning Visits did not always take place as intended.

Recommendations

This event should be repeated once or twice a year according to demand on a pan-London basis.

The role of Development Centre techniques in other areas of career management and succession planning should be considered carefully. Although the process is costly and time-consuming, it does seem to add significant value for both the participants and the commissioning organisation.

Minor adjustments need to be made to the design in the light of the feed-back received.

We should consider designing a multi-role interactive simulation to address some of the design issues highlighted in the feed-back on "Day in the Life Of".

Other observations

A number of Development Advisers expressed disquiet that some of the feed-back given should already have been known to participants had effective career development discussions taken place in their own organisations.

A number of Development Advisers believed that the robustness of the conference process highlighted weaknesses in the decision-making processes which are used in other settings in relation to career development and selection decisions.

APPENDIX C

Organisation development in mental health – background documents

Statement of purpose

First Report (Diagnostic)

Supporting the OD Strategy

Programme for Launch Workshop

What would better look like?

Moving and Speeding Up

Managing Rehabilitation

Gill's role

Current work programme

X HOSPITAL STATEMENT OF PURPOSE

X Hospital is an integral part of a system of care and treatment for people with mental disorders. This statement of purpose seeks to define its particular role within that wider system.

X Hospital is a high security hospital providing care and treatment for patients with a mental disorder who represent a grave and immediate danger to the public. It is accepted good practice that patients should not be detained in conditions of security greater than those necessary to protect the public. Hence, the provision of care at X Hospital should.

- Ensure that only patients who meet our admission criteria are admitted.

- Be delivered in a patient centred manner to ensure that patient needs are assessed and reviewed regularly by multidisciplinary teams taking into account patient's views; that there is rapid, planned access to all appropriate therapeutic interventions; that therapeutic interventions are planned to prepare the patient to cope with the demands of the setting to which they will be transferred; that interventions designed to reduce risk are properly prioritised to enable patients to transfer as quickly as possible; that there is as much continuity of care as possible; and that ensures transfers or discharge are achieved quickly when agreed to ensure patients are detained in high security for as short a time as possible.

- Provide high quality continuing care for those patients whose discharge or transfer cannot be envisaged in the foreseeable future.

- Ensure obstacles to achieving goals for patients are addressed proactively and concertedly to minimise the adverse effect on patients.

- Be organised in a way which enables the organisation to judge the effectiveness of its work and to continuously improve its practice.

- X Hospital also exists to provide first class training in the treatment and care of patients in a high security environment.

- X Hospital also exists to undertake research and development designed to improve our understanding of and practice with people who have severe mental disorders, particularly those who present a grave and immediate danger to the public.

X Hospital

Towards an Organisation Development Strategy

Preliminary Report

Michael Faulkner

25th July, 2002

INTRODUCTION AND CONTEXT

The Independent Review into the safety of women patients at X Hospital in March, 2002 identified a number of wider issues which the Board and Chief Executive were invited to note. As a consequence, I was commissioned to work with the Chief Executive and her colleagues in developing a comprehensive organisation development strategy for the hospital as an integral part of the West London Mental Health NHS Trust.

Effective action has already been taken by the Trust to identify the specific safety issues which led to the Independent Review and these do not, therefore, form a focus for my work.

This report is to advise you of my preliminary conclusions and to suggest a general approach to the continuing development of the organisation. It is based on confidential one to one conversations with senior clinical and managerial staff involved with X.

THE CURRENT SITUATION

X has a culture which is quite different to that found in the majority of NHS hospitals although it no doubt has features in common with the other high security hospitals. Although much less institutionalised than it has been in the past, it is inevitably influenced by the very long lengths of stay of its patients and by relatively low staff turnover. On the positive side, this does create a real sense of community but it remains a somewhat isolated and defensive community. The culture also reflects the need to provide treatment and care with a high security environment and reflects too the challenging nature of the client group with which it works. Perhaps more importantly it has been isolated, under-resourced and ignored unless a high profile incident occurred.

Over the last five years or so, the senior leadership team have been very successful in starting to transform a dysfunctional organisation into one of which the NHS can become proud. It is a tribute to that team and to all of the staff at X that a significant level of change has been achieved in the face of difficult circumstances.

The integration with mainstream mental health services in West London provides an excellent opportunity to carry this transformational work forward. Particular achievements which are worthy of note and which, taken together, create a sound base from which to move forward include:

Stabilisation of the nursing workforce and a reduction in vacancies to a level which many other London NHS Trust would envy.

Successful implementation of new shift patterns for nursing staff.

The award of Investors in People status marking the implementation of effective workforce policies such as appraisal.

The development of business cases to re-provide old, unsuitable and, in some cases, dangerous physical facilities.

Implementation of new arrangements for clinical management.

It is worth noting that these achievements have been realised despite a significant amount of top management time having necessarily been diverted into managing a difficult merger process.

In summary, the organisation has been stabilised, there are islands of excellent practice, morale is reasonably good, organisational leadership commands respect and there is willingness to embrace a positive and productive organisation development programme.

THE ISSUES WE NEED TO ADDRESS

Clarity of purpose

Unlike most NHS Trusts, X has to reconcile the demands of providing a tightly secure environment with the demands of providing a therapeutic environment. Political pressures can cause undue emphasis to be placed on one of these dimensions at particular points in time at the expense of the other. The tension between security and therapeutic efficacy is not just a challenge for top management, it is a daily balancing act for all staff who are directly concerned in providing patient care. It should also be recognised that the combination of "custodial" work and "therapeutic" work can be a real source of role conflict and dissonance for nursing staff in particular.

We believe, therefore that there is a need to engage staff in re-examining the therapeutic purpose of the organisation and in developing models of care which are likely to be clinically effective. We would expect such a re-examination to lead to changes in how people practice within the hospital and in how outcomes are measured and evaluated.

We recognise that the Clinical Improvement Groups are an important step in the right direction. We would advocate building on this initiative, broadening its scope, including more people and embedding it in a wider organisation development strategy.

The urgent and the important

Inevitably, ensuring the safety of patients, staff and the wider community always seems a more immediate and visible concern than providing an active therapeutic environment. The extremely long length of stay tends to militate against any sense of urgency in ensuring effective therapy. Security is a "right now" problem, delays in therapy may not seem important given that patients are likely to be around for some time. Security considerations are always in the foreground and therapy in the background. An effective organisation development strategy needs to reverse this positioning so that high security is seen as a background context within which the hospital pursues its real goals of caring for people and changing their lives.

Internally driven change.

There is a tendency in some respects for the organisation to be reactive. It has a history of "being left alone" unless something goes critically wrong. In this, it is just a slightly more extreme example of the prevailing culture in many NHS Trusts. The need for cultural transformation throughout the NHS is highlighted in the NHS Plan and, in this respect, X simply lies towards one extreme on a proactivity scale rather than being qualitatively different from other NHS organisations.

In terms of organisation development, the organisation and its staff need support in learning how to take charge of their own developmental agenda and in gaining confidence in leading innovation in the care and treatment of the patient group in which they have unrivalled expertise.

Continuity of care

Within the organisation, thought is being given to providing a better sense of continuity of care both within the hospital and between the hospital and other settings. In the current structure, patients tend to move between teams in a rather sudden and bumpy fashion. There is also rather poor integration with other services which may provide care when a patient leaves X. The lack of continuity of care leads to unnecessarily prolonged lengths of stay and may lead to patients regressing rather than progressing.

Consistency of care

As with most NHS Trusts, if the quality of care throughout the organisation could be brought up to the level of the best, there would be little to complain about. An important strand of the Organisation Development process would, therefore, be to engage staff in thinking through what constitutes excellent care, what factors impede the delivery of such care and in how identified impediments can best be overcome.

Clinical leadership

The quality of clinical leadership is again variable. Where it is very good, the patient experience and the experience of staff also tend to be very good and vice versa. An organisation development strategy would have to address this issue and ensure through appropriate development work that the hospital's staff and patients have uniformly excellent standards of clinical and managerial leadership.

Investment in facilities

There are limits to what the hospital can achieve within its existing facilities. The design and configuration of buildings leads to inefficiency, poses avoidable security and safety problems and inhibits staff in engaging as effectively as they might in the therapeutic process. Although much can be achieved through organisational development, staff cannot reasonably be expected to deliver 21st century care in 19th century buildings.

HOW THE ORGANISATION MIGHT PROCEED

As a general model, we are suggesting the use of action research groups throughout the hospital (and more widely the Trust) to lead the transformation process.

An action research group, as the name implies, seeks to draw together research, learning and effective action. It seeks to create a virtuous spiral in which groups identify issues and problems, take action, evaluate the outcomes, generalise the learning and then act again.

We would suggest that some of the organisational leaders, clinical and managerial, should form such a group to orchestrate and implement the organisation development strategy as a whole.

We would also suggest that action research groups should exist at Service and Ward level to drive forward the developmental agenda more locally.

The overall focus of the work of the action research groups would be on the development and implementation of a more effective therapeutic environment within the constraints of the need to provide a safe and secure environment.

We would expect the action research groups to identify the need for and to commission supporting work such as staff training, policy development and so on. As groups identify issues and solutions which are of wider relevance, we would expect these to be shared with the service wide or organisation-wide groups so that a continuous ***learning and action conversation*** is taking place throughout the organisation.

Where appropriate, action research groups would involve clinician and managers from other parts of the Trust.

To enable the action research process on a sustainable basis, the organisation would need to ensure that it is able to release staff, sometimes as whole teams, to engage in this activity. The organisation also needs to ensure that a budget is available to respond to identified training and development needs. This should be a priority for the Strategic Health Authority and for the Workforce Development Confederation.

Initially, the process would need to be supported by some external facilitation and some additional investment in the resources of the training and development team. Over time, the aim should be to build up sufficient internal capacity to enable the process to be self-sustaining.

SUPPORTING THE OD STRATEGY

WHAT WE ARE TRYING TO ACHIEVE

We want to ensure that how we practice on a day to day basis delivers the purpose of the organisation as a hospital.

We also want front-line staff to learn to take responsibility for and to feel "empowered" to maintain and improve the quality and purposefulness of practice throughout the organisation.

HOW

We are proposing a pilot study in one part of the organisation. We will build on the Clinical Improvement Group model but:

Extend participation.

Increase intensity.

Sharpen focus and measurement of outcomes.

Explicitly learn and act on organisation-wide lessons.

If the pilot is successful, we will learn the lessons from it and then extend it to other parts of the hospital and eventually the Trust.

DESIRABLE EXTERNAL SUPPORT

Define the pilot project as running over six months.

Michael Faulkner will:

Lead facilitate team meetings and discussions.

Work with the Executive/Steering Group to knock down barriers to effective practice and to elicit organisational lessons.

In addition, I would like to place one of my colleagues, Gill Allen, on-site for two half-days each week to help to facilitate change in practice in clinical settings. Gill is an experienced Nurse Practitioner. She is not mental health trained but she worked with ward staff in Oxford Mental Health Trust with some success. She is a good coach and facilitator with a passion for good care and an intolerance for what you described as "the small cruelties of organisational life".

This is fairly heavy support but I think it might be necessary to break out of where we are and bring about highly visible change.

BUDGET

Over the six months this would cost about £30,000.

If it works, we will:

> Find out how to make the organisation work better.
>
> Improve things significantly in one area.
>
> Learn how to replicate it with fewer external resources and more internal resources – mainstreaming the process.

It might be possible to do it for less or to use more internal resources but I would be less confident.

Clearly, if it needs less investment that I think at the moment, then we will only incur the costs we actually incur.

PROGRAMME FOR LAUNCH WORKSHOP

WEDNESDAY 12TH MARCH 2003

CENTRAL HALL - X HOSPITAL

12.30-1.00	Lunch	
1.00-1.15	Welcome and introductions	
1.15-1.45	Background and context	Julie Hollyman and Michael Faulkner
1.45-2.15	What would "better" look like? – identifying success criteria.	Small group work.
2.15-2.30	Feedback from small groups.	
2.30-2.45	Coffee	
2.45-3.30	What gets in the way – a first look at barriers.	Small group work.
3.30-4.00	Feedback and discussion of barriers.	Open discussion.
4.00-4.30	An opportunity to digest.	Small group time for people to digest what we have been talking about and to think about the questions they want to ask.
4.30-5.00	Question time.	

WHAT WOULD BETTER LOOK LIKE?

From the patient perspective

Different disciplines and professional groups would be working together rather than competing.

Better communication between disciplines – multidisciplinary notes.

Lots of things free – drugs.

Move through hospital quicker.

More structure to day.

Clear, firm boundaries without it being too regimented.

To not be bored.

Rehabilitation geared to their needs.

There would be clear pathways from admission onwards.

The responsibilities of patients would be set out clearly in the care plan.

Patients would be fully engaged in treatment.

There would be a better quality of life in X – particularly social opportunities and functions.

From the staff perspective

Happier.

Clear expectations backed by supervision.

Feel safe.

Working well and communicating with others in the team.

Progress (understanding, achieving, moving forward)

Linking day and night shifts – (e.g. for care plans and supervision).

Promoting forward thinking/training.

Less number crunching.

Security – blanket coverage.

More off-ward activity.

More individual care based on patient need.

More 1:1 time.

More facilities on ward – e.g. interview room/group room not store rooms.

Accommodation – space for staff and patients.

Full time consultant.

Improved environment on wards.

Improved communication between wards and departments.

Staff not being taken away.

Better deployment of staff – health and safety issues.

Cleaner environment.

"Proper" CPA.

Patient voice to be heard.

More ward-based activities.

Activity nurse and long-term projects.

In and out referral system.

Communication for patients.

Sense of ownership.

Sense of pride.

Clear philosophy.

Objective4s and plan.

Good leadership.

Good communication.

Feeling valued.

Empowered.

Supported.

Friendly.

Respect.

Programme of activity.

Flexibility in working arrangements.

Training on and off wards.

Tasks taking staff away from working with patients – security/searching and escorting.

Objective measures of improvement

Better multidisciplinary team notes.

Reduced psychology waiting list.

Attendance at case conference CPA and external MSU.

Clarity about the purpose of wards.

Patients to be transferred/discharged appropriately.

Patients meet the admission criteria.

Clearer outcome measures.

Evidence-based practice.

Recruitment/retention of staff.

Reduction in staff sickness.

Continuity of care – auditable clinical pathway.

CPA as a live document.

Short waiting times for treatment.

Reduced waiting times for referrals.

Blanket responses

Staffing levels.

Delivery of clinical supervision.

Happier:

Staff attitudes.
Staff turnover.
Sickness record.

Fewer assaults/safer environment.

Transfers (forward/back/sideways/out) but carefully judged.

Nursing process=team working – not passing the buck.

Patients off ward.

Patient mix.

ORGANISATION DEVELOPMENT PROGRAMME

Moving on and Speeding up.

24th September, 2003.

Venue

INTRODUCTION

We launched the organisation development strategy on 12th March, 2003. The aim of the organisation development strategy is to create an organisation which is clearly focussed on providing excellent care and treatment for patients with a mental disorder who represent a grave and immediate danger to the public.

We have made a certain amount of progress and learned a great deal about why progress is sometimes slow, difficult and frustrating. This workshop is about how move on and speed up the development of our organisation.

THIS WORKSHOP

In this workshop we aim to:

- Acknowledge what we have achieved and thank the people who have been responsible.
- Set clear goals for what we still have to achieve.
- Plan how we are going to achieve those goals.

A programme is attached

ORGANISATION DEVELOPMENT PROGRAMME

Moving on and Speeding up.

24th September, 2003.

Venue

PROGRAMME

09.30 – 09.45	Welcome and aims for the day	Michael Faulkner
09.45 – 10.15	Celebrating success – what we have achieved.	Short presentations
10.15 – 10.45	Concrete goals for the future and how we measure success.	Julie Hollyman
10.45 – 11.00	Coffee	
11.00 – 11.45	What we need to do differently Task groups. • What leaders should do? • What we want from our leaders. • Delivering rehabilitation. • Removing obstacles.	
11.45 – 12.15	Feedback from task groups.	Michael Faulkner
12.15 – 12.30	Summary and next steps	Julie and Michael
12.30 – 13.00	LUNCH	
13.00 – 14.30	Planning meetings in Clinical Teams	Service Directors and Service Managers.

Managing Rehabilitation

Workshop for Primary Nurses

Aim

To equip primary nurses with the skills and knowledge to lead rehabilitation programmes for the patients for whom they have primary responsibility.

Objectives

On completion of the programme, participants will:

- Understand clearly the meaning of rehabilitation in the context of high security forensic mental health.
- Understand functional models of rehabilitation and be able to relate them to their own practice and its context.
- Understand the components of rehabilitation management:-
    - Assessment of needs.
    - Planning of rehabilitation.
    - Monitoring and review of rehabilitation plans.
    - Opportunistic rehabilitation.
    - Problem-solving in rehabilitation.
- Understand the role of the Primary Nurse as rehabilitation manager.
- Understand clinical governance in relation to rehabilitation.

Style of the workshop

As participants are already experienced practitioners, the style of the workshop will be one of joint problem-solving supplemented by teaching and discussion leading.

Follow-up

The workshop will be complemented by ward-based coaching.

Managing Rehabilitation

Workshop for Primary Nurses

PROGRAMME

09.30 – 09.45	Welcome, introductions and objectives.	
09.45 – 10.30	A functional approach to rehabilitation.	Presentation and discussion.
10.30 – 11.00	Measuring success in rehabilitation.	Small group work.
11.00 – 11.15	Coffee	
11.15 – 12.00	Rehabilitation management and the role of the Primary Nurse.	Presentation and discussion.
12.00 – 12.45	Needs assessment and rehabilitation planning.	Presentation and discussion.
12.45 – 13.30	Lunch	
13.30 – 14.15	Creating a climate for rehabilitation.	Small group work.
14.15 – 15.00	Exercise in rehabilitation planning.	Working with a partner.
15.00 – 15.30	Feedback from rehabilitation planning activity.	Feedback and discussion.
15.30 – 15.45	Tea	
15.45 – 16.30	Implementing, monitoring and reviewing rehabilitation plans. Clinical governance and the role of the Primary Nurse.	Presentation and discussion.
16.30 – 17.00	Summary and follow-up.	Discussion.

ORGANISATION DEVELOPMENT PROJECT

Role of Gill Allen

The overall project will be introduced to staff at the launch meeting on 12th March which I will be attending. I hope to be able to meet informally with the Clinical Nurse Managers before the workshop if the timing of appointments allow this to happen.

I have had a conversation with Michael following our meeting. How he sees the process and my involvement is as follows:

> At the Launch meeting and subsequent action learning set meetings, we seek to agree with staff:
>
> > What we are all trying to achieve.
> > What good clinical practice would look like.
> > What's wrong at the moment.
> > What needs to change.
> > How we make change happen.
>
> I would then work with the ward staff to support them in implementing the changes which they have collectively agreed.
>
> In practical terms, the sorts of things which I would do are:
>
> > Talk informally with staff on a one to one basis to encourage them to raise issues and concerns which they may not have raised in larger groups.
> >
> > Provide some coaching and training – particularly in relation to rehabilitation and, perhaps, physical health care.
> >
> > Be available to listen to staff and help them think through how to make things happen.
> >
> > Observe what is really happening on the ward, challenge it if that is appropriate or feed my concerns back to you, to the Clinical Manager or to the Project Steering Group. Obviously this needs to be handled with some sensitivity – I don't want to become the spy in the cab but I do need to do reality checking.
> >
> > I will also report back if something outside the ward environment is constraining progress.
>
> At the risk of anticipating the problems which staff will surface, I should also be able to contribute in helping to extend people's scope of practice and change professional boundaries. As I explained, I have done a lot of work in

this area and it is likely to be one of the keys to progress given the waiting times for therapies etc.

We all need to see this as a purposeful exploration – I will keep talking with you and your colleagues so that we can shape things as we go along.

Michael and I are both acutely aware of the sensitivities of the situation and of the need to make progress at a pace which people can accommodate. Essentially, Michael and I will be working for you and your teams as an extra resource and will always be guided by what you think is appropriate.

I very much enjoyed meeting with you and look forward to seeing you soon.

If there is anything else you would like to discuss before the March meeting, please do get in touch. My contact details are:

Short-term goals and activities (2004/05)

As the new Clinical Nurse Managers come into place, we should:

Develop with the Service Directors and Clinical Nurse Managers a development programme for Team Leaders in assertive rehabilitation wards.

Continue ward-based coaching to reach a position in which care planning and care co-ordination are routinely led by primary nurses and implemented to a uniformly high standard in all assertive rehabilitation wards.

Develop with the Associate Director of Nursing and the Service Directors a continuing development programme designed to upgrade the competences of Primary Nurses.

Establish a monthly learning set for Clinical Nurse Managers in assertive rehabilitation across Directorates to encourage a shared approach to learning and problem solving.

Develop and implement a policy which will prevent nurses who are engaged in planned specific therapeutic interventions from being counted on the available nursing workforce when short notice re-direction decisions are being made.

Medium Term (2005/06)

Align Service Directorates with Houses and appoint senior clinical nurses (modern matrons) to each House.

Develop with the Associate Director of Nursing, Service Directors and Clinical Nurse Managers, a training programme to develop the role of Rehabilitation Assistant from existing HCAs. The role would combine nursing and other rehabilitation skills, would be competency-based and would provide opportunities for career progression within the Agenda for Change framework.

Remove absence control and staff re-direction from Nursing Administration making it the responsibility of line management.

Long-term (2004/07)

Develop a work-based and competency-based Master's Programme in Forensic Rehabilitation open to all qualified professionals. The aims of the programme would be to:

Extend the scope of practice of clinicians to smooth out the patient journey.

Raise standards of clinical practice and under-pinning knowledge.

Create a centre of excellence in forensic rehabilitation at X.

In addition, we should continue opportunistically to challenge practices which interfere with the organisation's ability to treat its patients and support innovations which are likely to improve patient care.

We should re-constitute the Organisation Development Steering Group meeting perhaps twice a year and chaired by the Trust Chief Executive.

An Implementation Group will be established meeting every two months to co-ordinate the organisation development programme with other initiatives and with the line management agenda. The Implementation Group will be chaired by the Director of Forensic Services and will include the Service Directors and Clinical Directors and the Associate Director of Nursing.

APPENDIX D

Analysis of themes

.

Illustrative Field Notes
and
Reflective Diary entries
from
Mental Health Project

HOSPITAL X

Themes from analysis of field notes and documents

THEME	Number of mentions in field notes	Number of mentions in documents
SECURITY AND NURSING		
Security policies and procedures are imposed.	37	2
Tilt report recommendations set us back.	12	0
Time spent on security duties	42	1
Conflict between nursing role and security role.	18	1
Performing security duties therapeutically.	3	0
EXPRESSION OF SEXUAL NEEDS		
Gender segregation	18	4
Identification of sexual needs	4	8
Inappropriate sexual conduct by staff	1	0
NURSING STAFF AVAILABILITY AND CONTINUITY		
Short-notice redirections	127	22
Extended periods of annual leave	32	3
Failure to return from annual leave	15	0
Sickness absence	59	2
Overtime restrictions	6	2
Role of Nursing Administration	38	7
Internal rotation (five years)	11	1
Long-term night duty.	43	0
Escort duties	28	0
Inadequate staffing establishment	23	0
PROBLEMS WITH ACCESS TO/PRESENCE OF OTHER CLINICIANS		
Occupational therapy	27	6
Vocational services	13	2
Education	10	1
Clinical psychology	23	8
Medicine	3	0
Psychotherapy	6	0
Social work	2	1
QUALITY OF PRACTICE		
Failure to engage proactively with patients.	194	6
Failure to respond to patient needs.	111	2
Problematic attitudes to patients (because of index offence)	28	0
Patient seen in isolation from family and society	15	0
Incompetent/dangerous practice	10	0
Exemplary practice	64	3

THEME	Number of mentions in field notes	Number of mentions in documents
PROBLEMS WITH CARE MANAGEMENT		
Quality of care plans.	32	3
Currency of care plans	34	3
Quality of CPA Meetings	19	2
Quality of CPA documents	25	2
Role of Primary Nurses in CPA	91	8
Problems with Nursing input to CPA	80	2
PATIENT MIX AND REFERRAL CRITERIA		
Problems mixing mental health and personality disorder.	39	2
Patients not sufficiently stable for rehabilitation	14	2
Lack of consultation about admissions	8	1
EXTERNAL PROBLEMS AFFECTING PATIENT JOURNEY		
Home Office interference	2	1
Behaviour of RSUs	9	1
Funding problems	7	1
Placement problems	3	0
FACILITIES		
Clinical space	22	3
Seclusion facilities	11	1
Access to fresh air	9	2
Visibility of patients	5	1
Cleanliness	18	3
Access to stores and supplies	6	1
Health and safety issues	15	2
CLINICAL SKILLS AND KNOWLEDGE		
Skills and knowledge not used	22	0
Deficits in clinical skills	31	1
Deficits in clinical knowledge	14	1
Deficits in interpersonal skills	8	0
Impact of dual training	14	1
EDUCATION AND TRAINING FOR STAFF		
Personal development plans	6	1
Clinical supervision	19	1
Role of Clinical Practice Facilitators	7	2
Provision of education and training	16	5
Practical problems with access to E&T	34	0
Quality of training	4	0
Induction programme	7	1

THEME	Number of mentions in field notes	Number of mentions in documents
CORPORATE AND DIRECTORATE LEADERSHIP		
Role and behaviours of Chief Executive (J)	18	16
Role and behaviours of Chief Executive (S)	3	1
Role and behaviours of Director of Forensic Services	21	7
Quality of Directorate meetings	6	3
Quality of BOM meetings	2	1
Corporate Medical leadership	4	1
Corporate Nursing leadership	21	3
SERVICE MANAGER LEADERSHIP		
Role of Service Managers	6	1
Quality of service management	8	1
Presence of service manager on wards	14	0
Acting up for service manager	3	0
CLINICAL TEAM LEADERSHIP		
Acting roles	31	3
Impact of changing person	22	0
Re-configuring the role	18	3
Selecting into the role	6	2
Examples of good leadership practice	34	0
Examples of poor leadership practice	87	0
Conceptions of the role	21	3
Role of Team Leader	35	1
Performance of team leaders	35	0
Problems with team leaders.	6	0
ROLE OF PRIMARY NURSES		
Current conceptions of role.	52	1
Re-defining the role.	52	2
Nursing attitudes to re-definition	40	1
Medical attitudes to re-definition	7	1
Competences to undertake new role	30	2
Confidence to undertake new role	21	2
Organisational factors inhibiting satisfactory role performance	14	1

FIELD OBSERVATION RECORD			Nr.13
Date 18/07/03	Start 09.00	End 13.00	Location Ward F

Themes

Tilt Report recommendations set us back
Security policies imposed.
Access to fresh air
Gender segregation

Notes

Many of the 'old school' members of nursing staff mentioned in an almost reminiscent kind of way – how they remembered 'better times' for the patients pre 'Tilt'. They pointed out of the window to me to a neglected, overgrown area that I could just about still recognise as a 400m field track, with remnants of a seating area just like any usual sports track site, albeit with a 30' high wall surrounding it – as the crow flies, about 100m away from the ward areas. 'Tilt' put a stop to all that, was the message I was told – too unsafe – after all a helicopter could fly overhead and drop a ladder down to aid an escape – the fact that this had never happened at any of the three high secure hospitals. This particular group of staff could see the negative effects of patients being prevented from engaging in such outdoor sports activities/exercise – the exposure to fresh air, the freedom of running, the competitive spirit , useful usage of energy etc. The patients do have access to an amazingly well equipped brand new sports centre, gym and large indoor heated swimming pool – sadly this is seriously underused – for safe staffing reasons – and the patients do not enjoy being 'indoors'!
The 'Central Hall' used to be frequently used for 'mixed' social events, - Ward/House Quiz Nights, various parties and discos, (not just at Christmas time), pantomimes, Plays, Musical Concerts and other shows – where male and female patients could if they so wished socialise together. Another thing 'banned' by Tilt. So now at Christmas time for example they only have 'all male' or 'all female' discos – hardly conducive to social re-integration and addressing 'normal' sexual needs all in the name of rehabilitation....albeit heavily supervised and observed!

Fortunately, as the nursing staff inform me, 'Tilt' was not able to prevent male and female patients worshipping together. So attendance at all denominational services is apparently higher than average. Apart from a smaller number of female staff compared to male, working as 'frontline staff', these are the only 'females' that the male patients see and have the opportunity of talking with, during the course of their stay in hospital – which for some is up to 25 years and more.
Nursing staff were able to quickly identify to me how certain aspects of nursing care/rehabilitation care were unable to be achieved, as the patients were being forced to live in a very false sense of the real world. How could they ever hope to successfully achieve being able to communicate appropriately with female members of society, when they were not exposed to any in a social environment. How difficult a problem this could pose for a male patient when transferred to an RSU?

Observer GA

FIELD OBSERVATION RECORD			Nr.14
Date 18/07/03	Start 15.00	End 16.00	Location SLN office

Themes

Security policies and procedures are imposed
Conflict between nursing role and security role
Performing security duties therapeutically

Notes

After a very short period of time of working on the Assertive Rehabilitation (AR) Wards, I soon realised that the nursing staff (of all levels grades A-H) do experience difficulty in getting the balance right between providing a therapeutic environment and the necessary security needs of the complex and vulnerable group of patients within their care.
Care being the very word most difficult to define – many of the nursing staff express difficulty in articulating and expressing 'what it is they do for patients as nurses – what is their nursing practice?'...and 'what is it that is 'security focussed' – they found it relatively easy to list the 'tasks' such as levels of 'searches', of patients and the environment, and all the various 'checks'. One ward in particular has numerous clip boards for different 'checks' – cutlery check, razor check, lighter check etc etc. However no clip boards to sign and tick off when any nursing care has been completed.

The teaching of 'level searches is delivered by the Security Liaison Nurses (SLNs) – a meeting was arranged with M and myself and four of the six appointed SLNs attended

A discussion took place about how the teaching of this could perhaps be changed – to appear to be less punitive and mistrusting, to more meaningful and even positive. AR could after all be more opportunistic, and the boundaries of nursing and security become more blurred .The SLNs also agreed that the Dedicated Search Team (DST) could be included in their teaching. This meeting ended on a positive and encouraging note

Personal reflections:

Promoting safety and positive risk taking is one of the ten identified essential shared staff capabilities (as documented by the National Institute for Mental Health in England, the NHSU and the Sainsbury Centre for Mental Health) – staff seem unaware/unwilling to take any positive risk taking. There appears a notion of 'it doesn't matter if I don't carry out any nursing, whereas I'll be in trouble if I don't 'tick the boxes' on the clip board for security checks'. How sad.
One Health Care Assistant (HCA) told me that he knew the nurses were not actively trying to encourage certain patients to 'move on'...as they never knew who they might get in that bed next – so 'better the devil you know, sort of thing'

Observer GA

FIELD OBSERVATION RECORD			Nr.43
Date 07/11/03	Start 10.00	End 12.00	Location Ward D

Themes

Impact of changing person
Quality of care plans
Quality of CPA documents
Examples of good leadership practice
Impact of dual training

Notes

Ward D- received a replacement CNM on secondment from the admission ward in October 2003. The previous CNM (in post for 4 years) had left, and it was felt that neither Team Leader (TL) was suitable to be acting up.
I had had the opportunity of meeting A on his permanent ward some months earlier – he appeared mature and well experienced in his then role as TL.
A gently, although fairly swiftly, introduced many positive changes to the routine of the running of the ward as well as to some important clinical practices – which were obviously commonplace and second nature to him on his former ward area. My observations were that the staff on the whole welcomed his directive style of leadership. He was actively motivating, encouraging and praising his staff for the hard work he witnessed from the Nursing Care Plans (NCPs) which he found to be out of date on his appointment to the ward – he turned this situation around in six weeks. He carried out an audit on the patients notes, the CPAs and the NCPs. Staff seemed to admire him as a role model, even though they knew he was 'meaning business'.He introduced each Primary Nurse in rotation to the weekly Clinical Team Meetings (CTM), and gradually encouraged them to present the weekly review on their named patients. This was a new experience for the Primary Nurses, likewise presenting their nursing reports at the CPA meeting – however it is common practice on the ward now, and the system is working well.
A soon became aware of some 'identified training needs' amongst his staff (at all levels) and helped develop some 'teaching templates' as 'Guides' for his staff – ie the nursing care of a patient suffering with : chronic schizophrenia, acute anxiety, panic attacks, personality disorder
A is a 'fitness fanatic' himself and is trying hard to introduce a sense of 'health promotion' amongst his staff and patients, particularly around the area of weight reduction. He is trying his best to encourage staff that by introducing meaningful activity for the AR of the patients, the amount of time patients are able to smoke and sit and watch TV is reduced – that this has to be a healthier way forward for all concerned.

FIELD OBSERVATION RECORD			Nr.43
Date 07/11/03	Start 10.00	End 12.00	Location Ward D

Personal Reflections

As it happens, A is qualified as an RGN and RMN – and what a difference I see, not that I think this essential, but certainly helpful.
A was able to help support his staff in taking decisions, working across some boundaries – mainly I believe because he had worked outside Hospital X in a community setting. I remain surprised at how little some of the nursing staff are aware of 'the structure of the NHS'. A is ensuring that his staff are aware of the role of the PCT and commissioning/funding RSU places.
I am encouraged by the difference I have witnessed since A has been in post – slowly he is beginning to articulate the vision of the clinical areas, both patients and staff are showing respect – some creativity is being observed and people are feeling valued.
Members of staff have told me how helpful the templates prepared by A have been when completing the NCPs and CPAs.. I have fed this information back to A, and encouraged the staff to do so likewise.

Observer GA

FIELD OBSERVATION RECORD			Nr.57
Date 24/12/03	Start 15.00	End 17.00	Location CEO office

Themes

Role and behaviours of Chief Executive (J)
Medicine
Exemplary practice
Examples of good leadership practice

Notes

The CEO was most supportive and influential at the Launch Day 12/03/03 and Follow Up Day six months later. She promised when we met together again in the October (having announced her intended resignation at Christmas time) that she would visit three of the AR Wards before she left the organisation, to view for herself progress made to the CPA and NCP documentation.
Some staff I believe thought that this would not happen – but happen it did. She fed back some very honest, fair and helpful feedback, within 24 hours. Some of her observations were encouraging and praise was given accordingly – other areas, well she did not hide her concerns that improvements needed to be made, and soon.

In another clinical area I had the opportunity to visit, there are some 'flats', where patients thought appropriate to be moving to a less secure environment in the not too distant future, live as independently as the clinical setting allows. Cooking all their own meals, cleaning the flat – their rooms, kitchen, communal lounge area, bathroom and toilet etc.
The three patients living in this flat invited me to 'tea' and whilst chatting they told me in great detail of the previous Christmas time when they decided (without informing the ward staff) to write a letter inviting Dr J (CEO) to the flat for an evening 'Christmas' meal. Much to their surprise they received a reply and an acceptance to their invitation. In minute detail I heard of their planning of the menu (three courses), the purchasing of all the ingredients, and who was responsible for cooking which dishes, the cleaning up (and decorating) of the flat before and after the event. They showed me the menu that they had made in the Printing Shop, and proudly showed me her letter of acceptance and 'thankyou' letter. This had never been known to happen before – a Doctor and CEO coming to spend an evening in the flat having a meal! The effect this had on these three patients was clearly amazing, and touching. They were talking to me about it as if it all happened yesterday – not a year ago.

FIELD OBSERVATION RECORD			Nr.57
Date 24/12/03	Start 15.00	End 17.00	Location CEO office

Personal Reflections:

One little act of kindness goes such a long way, is what is coming into my mind just now. Having spoken to the CEO about this story since, I of course realise the depth of her clinical decision making in accepting this invitation from the patients. However, I'm not entirely sure that she is aware of the total impact and lasting impression she had made....may be she saw it as all part of her clinical work and chronic disease management. Whatever, I hope that staff who witnessed her being alone in the flat with three patients have been inspired by her leadership and have realised that she saw them as people – patients who had almost recovered and were self managing not only their chronic illness, but their lives. She was seeing them as people and not 'index offences'.

Her style of clinical leadership I believe has left its mark. As I've said earlier – whilst not essential to be trained as a General and Mental Health Nurse, it is helpful. Equally I am beginning to feel that is certainly helpful and a bonus point to be a CEO and have a clinical background. She certainly exhibited a truly 'patient centred manner' and focussed on aspirations of the Trust to hold high - patient comfort, privacy, dignity, autonomy as much as a high secure setting allows – respecting diversity, challenging inequalities, identifying peoples/patients needs and strengths, promoting recovery (and not just containment), providing user-centred care where possible, and encouraging patients to be moved on to a less secure environment as soon as is safely deemed to do so.

Observer GA

FIELD OBSERVATION RECORD			Nr.60
Date08/01/04	Start 09.30	End 16.30	Location TEC

Themes

Nursing attitudes to re-definition of role
Failure to engage proactively with patients
Problematic attitudes to patients (because of index offence)
Organisational factors inhibiting satisfactory role performance

Notes

Second in series of Primary Nurse Workshops:
Whilst in discussion with the Primary Nurses about their changing role as Care Coordinator within the Care Programme Approach (CPA) – and actively encouraging and supporting the two patients for whom they were specifically responsible for in their ward area – promoting 'assertive rehabilitation', and supporting the associate nurse and HCA within the team.....it became the topic of conversation between several of them, that they felt so strongly that their patients should never be 'moved on' to a less secure environment or given any hope of ever leaving the hospital. 'What they have done (index offence) appals me and disgusts me'. The nurses were mainly referring to patients whom had committed paedophile and sex offences. 'They should never be let out' – 'I wouldn't want one living next door to me and my children'. Many of these nurses admitted to preferring to keep the patients indefinitely at Hospital X regardless of any progress and reduced level of risk they may pose, at a cost to the tax payer of approximately £100,000.00 per year.

Personal reflections:

These nurses are obviously entitled to their opinions, but perhaps at recruitment/ selection, this sort of thing should be identified at interview. It is unfair to both the nurse and patient to be together in such a working environment. Inappropriate staffing I am thinking to myself – yet staffing levels for security reasons will take priority – any member of staff is better than none?!
The first Primary Nurses Workshop wasn't like this, so perhaps the next one won't be either. Have we just got unlucky, or is this a theme amongst some of the nurses? I need to carry out some further investigation.

Observer GA

FIELD OBSERVATION RECORD			Nr.64
Date 10/01/04	Start 10.00	End 12.00	Location RMO office

Themes

Problems with nursing input to CPA
Quality of care plans
Quality of CPA documents
Role of Clinical Practice Facilitators

Notes

In the months leading up to Christmas 2003, Dr D (RMO and relatively new in post) spent much time helping to improve the CPAs – that is the document part of the CPA – unfortunately this work, although not wasted, was having little to no effect on improving or impacting on the NCPs. During a discussion with him in January 2004, he told me how he had realised and acknowledged that clinical practice would not improve until there was some good, strong, and influential leadership at CNM level. In January 2004, a Professional Development Nurse/Facilitator was appointed to each of the Directorates. Dr D was hopeful that this appointment might help to address some of the poor clinical practice on his two wards.

Personal Reflections:

I admire the determination of Dr D – he is not giving up…and maybe this style in itself – 'if at first you don't succeed' sort of thing will still eventually rub off on the nursing staff. There is not a 'one size fits all' approach to leadership – one needs to keep tweaking it until it works. Fundamentally though – it is going to take a serious cultural shift to change the attitudes of some of the nurses on this particular ward. The content and quality of the paperwork/documents might change with a new keen Doctor – but it won't be enough to change the nurses, unfortunately.

Observer GA

FIELD OBSERVATION RECORD			Nr.70
Date 16/01/04	Start 09.30	End 16.30	Location TEC

Themes

Role of Team Leader
Performance of Team Leader
Problems with Team Leaders
Examples of poor leadership practice
Personal Development Plans

Notes

Team Leaders Away Day

Six TLs from three AR Wards attended this day. We found out by accident that whilst working in grade F roles, they were in fact on protected G grade salaries as they had previously worked as CNMs at G grade level. The oldest had been employed at Hospital X since 1966 and the youngest since 1985. They highlighted their previous experiences and training opportunities – some to a very high level of specific group work and interventions, cognitive behavioural therapy. However this was all in the past tense ' I haven't run a group mow for at least 10 years.' ' I used to do regular 1:1 work, but don't have the time any more'.'Can't do group work now, too much paperwork and staff re-directions'.

Personal Reflections

What is happening here? What are CNMs doing with these TLs? Their Personal Development Plans for example, these valuable members of highly qualified staff are being wasted – to the staff, patients and the organisation. So much has been invested in them over the years and yet 'if you don't use it, you lose it' – and these TLs have definitely lost it – and lost the plot. M and I both feeling despondent after todays Away day

Observer GA

FIELD OBSERVATION RECORD			Nr.71
Date 17/01/04	Start 09.00	End 17.00	Location Wards G & M & T

Themes

Identification of sexual needs
Deficits in clinical knowledge
Current conceptions of role
Problematic attitudes to patients (because of index offence)

Notes

Whilst talking with 'older' members of nursing staff about their involvement in assisting patients in this area of nursing/rehabilitation – I met a variety of responses.

Some nurses felt that the male patients who had committed sexual offences could/should only be helped by ensuring that they took the prescribed medication to help reduce libido and testosterone levels. Psychological interventions may help (but of course that was in the domain of Psychologists only)...quite why there could be no 'skills transfer' from Psychologist to Nurse to aid on going/continuity of care...no one was able to tell me.

Some nurses could not/did not identify with the fact that scarring or excessive weight gain, could be factors affecting self image, self worth, self projection. Many nurses thought that 'expressing sexuality' was just to do with sexual intercourse, and seemed surprised when I mentioned factors of appearance, general behaviour and communication, perhaps playing a part due to the long term nature/expectation of the 'patient journey', they expressed the 'waste of time' element in approaching such subjects as :1) resuming/restricting sexual activity after a long period of hospitalisation.2) Sexual difficulties arising from mental health problems & medication or physical disease problems (ie diabetes) 3)Helping patients with anxiety/embarrassment about sexual activity 4) Helping patients to understand, develop and enjoy their sexuality.
Sadly I found that the nurses did not see this as part of their role – or indeed relevant/important as part of the AR of the patients for whom they were caring. If anything – any subject related to 'sex' was best avoided, on the grounds of reducing stimulation and arousal. Staff gave me examples of the 'page 3' type of pictures in certain tabloid newspapers – but was this 'evidenced based' I asked myself?

Observer GA

FIELD OBSERVATION RECORD			Nr.93
Date 17/04/04	Start 10.00	End 14.00	Location Ward F

Themes

Competences to undertake new role
Access to vocational services
Access to occupational therapy
Access to education
Failure to respond to patient needs.
Quality of CPA Documents
Role of Primary Nurse in CPA
Poor clinical team leadership practice

Notes

Attended a CPA for patient W, my role to support a Primary Nurse who had previously attended one of the Primary Nurse Workshops:
I wish to highlight one experience that is sadly still a frequent experience for me. Primary Nurse reported the following in his Nursing Report:

- W had been referred to attend a Violent Offenders Group a year ago – but nothing has happened to date. (Primary Nurse had not seen it either clinically important, urgent or his role to investigate and chase up this referral)
- W needs to be encouraged to participate in more therapeutic interventions on and off the ward. He needs to be educated in eradicating his anti-social traits (Primary Nurse had not been able to provide any evidence on what he had personally implemented to address these needs)
- W needs to be introduced to further educational studies and vocational work to help equip him for the future (Once again no evidence on what interventions had been put into practice to date)
- W spends most of every morning in bed, perhaps this can be rectified by the OT providing more activities on the ward (Primary Nurse did not feel it was part of his responsibility to either engage with or actively encourage his patient as part of his AR to change – or what incentives could be at least tried)

When I looked at the CPAs six months ago and a year ago – the recording was disappointingly very nearly the same.

Other observations have been – witnessing a patient approaching a nurse and asking if he 'could please have a chat?'. On many occasions the reply I have heard has been – not now, I'm too busy – some other time, maybe tomorrow. Even if the nurse had been busy, a response such as 'I'm really sorry, but I can't just at the moment, but I promise to come back to you in 5-10 minutes, unless you would like to talk to x instead?...surely other options are always available? Patients have looked despondent, distressed, upset, rejected.

FIELD OBSERVATION RECORD			Nr.93
Date 17/04/04	Start 10.00	End 14.00	Location Ward F

Meetings with the CNMs

Four out of the six CNMs I have found to be defensive and negative – blaming everyone else for the problems except themselves. Quality improvement/Clinical Governance issues is not seen as important. 'Just maintaining good custodial care is about all I can be expected to achieve'.

Personal Reflections:

I remain saddened and at times depressed by my findings on the six wards. Not enough to make me give up trying to make a difference though, however small. Perhaps the evidence of what I am seeing, hearing, and experiencing is all to be blamed at inadequate leadership 'from the top' – only where do I call 'the top'? Such transformational leadership should be injected at various levels of 'the top'. There remains much work to be done before it is common practice for AR to really matter – regardless of the patient's index offence, or the anticipated length of stay, or their clinical diagnosis.

Small changes, positive changes are beginning to show, and I remain hopeful that 'things will change more quickly' as soon as the other new CNMs (H grade) are in post in the Autumn. Plans to work with and support them in Action Learning Sets should hopefully help to drive through some sustainable changes

Observer GA

FIELD OBSERVATION RECORD			Nr.103
Date 06/07/04	Start 12.00	End 14.00	Location Ward T

Themes

Impact of changing person
Incompetent/dangerous practice
Quality of care plans
Quality of CPA documents
Deficits in clinical skills
Deficits in clinical knowledge
Examples of good leadership practice
Impact of dual training

Notes

Ward T – received a replacement CNM in April 2004. The previous Acting CNM had been in post for 18 months – 'trying to keep the show on the road'. The ward morale was low. At a 'Team Away Day' several months earlier, it was evident to M and me that they had no shared vision, no common agenda, or much sense of team or joint working. However J said she was ready for a challenge, but not quite the level of challenge she found herself faced with! She told me how she was horrified to find that very few of the nursing staff (TLs included) had any understanding of their responsibilities under the legislation of the Nursing & Midwifery Council (NMC), knowledge of the National Service Framework (NSF) for Mental Health (DoH 1999) or in deed the CPA process or AR.
In a very short space of time she was 'on top' of all the CPAs and NCPs. She was manipulating the so called inflexible off duty rosters so that Primary Nurses were free to be preparing for and attending CTMs and CPAs – and no excuses for being on night duty. Her next plan she tells me is to be encouraging/supporting Primary Nurses as part of their CPD to be attending Tribunals with their named patients.

Personal Reflections
J is also doubly qualified (RGN & RMN) – again the difference shows! J identified some serious areas of unacceptable clinical practice – intramuscular injections for example, were not being administered safely or correctly.
Several patients who had developed Type 11 diabetes were not being monitored with either their weight being recorded, urinalysis checked, or BM stix (blood sugar) monitoring. J mentioned to me that on her questioning of her staff, their clinical knowledge of diabetes was 'shameful and appalling'.
A nurse of a different sexual persuasion was being bullied by fellow nursing staff – this had been evident for the last 18 months, but sadly not addressed, until now.
I hold out hope for J to go on 'making the changes happen' – in the mean time I only hope that she doesn't give up with frustration!

Observer GA

FIELD OBSERVATION RECORD			Nr.104
Date 06/07/04	Start 13.45	End 14.00	Location SLN office

Themes

Conflict between nursing role and security role

Notes

Unfortunately, when talking with one of the SLNs , he informed me that as their number of six has now been reduced to five, and one of those five has been seconded to work with the 'Agenda for Change' (AfC) group – any change of practice in their teaching has gone on 'the back burner' for the time being. He admitted that this was still very important, but just not possible for it to be a priority at the present time

Personal reflections:

Prioritising I ask myself? – highlighting yet again that security is taking preference to improving patient care, when all I am seeking is that nursing and security are seen, believed, and carried out in a manner of equal importance.

Observer GA

FIELD OBSERVATION RECORD			Nr.110
Date 10/07/04	Start 10.00	End 12.00	Location RMO office

Themes

Problems with Nursing input to CPA
Role of Clinical Practice Facilitator
Skills and knowledge not used
Examples of poor leadership practice
Role of the Team Leader
Performance of the Team Leader

Notes

At a recent meeting in July 2004 – Dr D reports to sadly not seeing any significant difference since the Practice Development Nurse/ Facilitator has been in post (6 months now).
Dr D has carried out several audits on the CPAs, and has tried to encourage a Primary Nurse to become interested in auditing – but the one TL whom he did manage to get on board, has since said that he doesn't have any time for this – the CNM has even supported his TL in this decision.
Dr D has tried to introduce several 'new ideas' – like encouraging patients to be taking some ownership for their weekly activity records – to be working in partnership with their Primary Nurse – addressing the variances as part of the NCP – ie why they did not attend a work area, education session, treatment session etc.
However he found no support from the CNM or nursing staff, and this along with other ideas for improving practice have fallen by the wayside.

Observer GA

FIELD OBSERVATION RECORD			Nr.111
Date 12/07/04	Start 14.00	End 16.00	Location Dir of Forensic Services Office

Themes

Quality of Directorate Meetings
Role of Service Managers
Quality of service management
Occupational Therapy
Short- notice redirections
Role of Nursing Administration
Inadequate staffing establishment
Provision of education and training
Practical problems with access to E&T
Quality of training

Notes

The London Directorate started off with a good Service Director, and after he sadly moved on, another excellent Director was appointed – both have been encouraging and supportive to work with in the project.
The two Service Managers are 'middle of the road', but pleasant enough and certainly not obstructive.
Several Directorate and Ward Team Away Days over the last 18 months have been supported by the Service Directors and Managers.
Following on from the OD Launch Day in March 2003 when 'barriers' to being able to practice in a meaningful way were highlighted by the frontline staff present – the Service Director did take these on board and tried to address many of them. He was particularly influential in facilitating the employment of 'ward based Occupational Therapists with OT Aides for support'. It had been highlighted in March that there were not enough staff to escort patients to and from the OT area – so hence this was delaying their progress in AR. This practice has been sustained in spite of OT staff pregnancies and sickness/injury problems.
The London Directorate staff are fully aware of – although to date not able to implement some of the following issues:

- The need to help change/expand/develop the role of the HCA
- The need to focus on the highlighted points from the Training Needs Analysis – training & development requirements of the staff in order to enable them to be 'fit for practice'. A Competency Framework for all grades of staff is on the 'back burner' – although hopefully through the job evaluations through the AfC – this might soon come back onto the 'front burner'!
- An awareness that the chronological age of a nurse in terms of years of service since qualifying, does not necessarily equate to the assumed level of skill, knowledge or clinical expertise
- An awareness of long delays in waiting for Clinical Psychology in put to commence following referral (some times several years wait)
- An awareness of the lack of consultation about admissions especially since the closure of an 'intermediate ward between admissions, high dependency and AR wards

FIELD OBSERVATION RECORD			Nr.111
Date 12/07/04	Start 14.00	End 16.00	Location Dir of Forensic Services Office

- An awareness of nursing staff not being entirely comfortable/competent managing the mixing of patients with mental health and personality disorder problems
- An acknowledgment that not all patients being transferred to the AR wards were sufficiently stable to engage in AR
- An awareness of a historical disparity in budgets between the same sized wards – for no apparent reason. Likewise an awareness that it has been some considerable time since any workload measuring tool was used to help determine staffing levels.
- Aware that ward staff find the short notice re-directions of staff to other wards by Nursing Administration – most unsatisfactory – and are a factor in sickness and absence
- Training days at the 'Training & Education Centre' (TEC) are often cancelled at short notice – or staff attending study days at the TEC are sometimes pulled back to help 'cover' the ward areas.
- Off Duty restrictions do not allow the flexibility required to safely cover the wards with any degree of continuity of care – but hopefully the European Working Time Directive & AfC might have some benefits – you never know!

Personal Reflections:

Having worked more closely with this Directorate than the other one – it has certainly helped, although I still feel that 'meeting-itis' is endemic, preventing real work and changes being able to take place. I believe the Directorate know of our presence though. Just a bit more 'partnership working' and together we could achieve a lot more!

Observer GA

Reflective diary extract

30th October, 2003.

Yesterday I went to a meeting with the Service Director (T) and Nurse Consultant (J) for the London Directorate with Gill. The purpose of the meeting was to review the action plans for the three clinical teams undertaking rehabilitation within the Directorate.

We discussed the opportunities created by having vacancies for Clinical Nurse Managers in each of the teams and also touched briefly on the leadership structure "above" the CNMs. I outlined my conversation with the Chief Exec. Which had led to me withdrawing a first version of one of the action plans and replacing it with an updated version. T will not circulate the notes and action plans within the Directorate.

T commented on the clarity of role and structure in the new job which he will be moving to in the private prison sector. He contrasted it with the confusing and fragmented structure which he experiences in the NHS.

.....

T was uneasy about our plans to develop HCA/OT Assistant roles. He has just secured funding to recruit OT Assistants for each of the wards and has set up job descriptions in such a way that there is clear demarcation between the role of the HCA and the OTA. He wants to do this so that OTAs are not diverted into other duties such as escorting and searching. I understand his rationale although I think it sends out some of the wrong messages about rehabilitation being everyone's business and being a continuous process. J and Gill share my view but none of us choose to confront the issue. We agree to have a discussion with the OT leads and the CNMs about how best to deploy the new resources.

.....

We go to J's office for coffee – and go over some of our concerns about T's plans for OT assistants.

Gill has arranged for us to meet the Security Liaison Nurses to discuss how we might address the perceived tension between security duties and caring duties. I am not convinced about the value of this meeting partly because of pre-conceptions which I hold about Security Liaison Nurses – as we wonder over, J fills us in on the backgrounds and his opinions of the Security Liaison Nurses – he regards them quite highly.

I am not sure that Gill understands (places the same meaning on) my point about how we make security feel like care – she keeps giving me the impression that she thinks it is about "searching nicely" like the reception staff. I think it is much more than this.

The Liaison Nurses are (to me surprisingly) open, thoughtful and reflective.

Reflective diary extract
From mid-term review November 2003

The next five months

During the next five months (April to August) we persevered with the action research model. The facilitators found it very difficult to get reasonable or consistent attendance at their groups and found it difficult to get those who did attend to engage. Where groups did manage to come up with ideas, there was extreme difficulty in getting these implemented – ostensibly either for financial reasons or because what they wanted to do was "part of some other strategy".

I met with the Care Champions who were uncertain about their role. Only two had the time or organisational position to have a significant presence on the pilot wards and one of them left the organisation after three months. They became a sort of reference group/thinking group.

Gill was getting to know staff and patients on the pilot wards and establishing rapport with them. This was extremely useful and her reports on "how things really were" were invaluable.

I became aware that the Service Managers were "out of the loop" and took action to ensure that they were adequately briefed about how the OD programme was going.

In parallel with the organisation development programme, there were many other initiatives under way in the organisation. Probably the most germane to our project were:

Reflective Diary Extract 11/12/03

I think the formal ethical issues have now been sorted or are close to being sorted. However, I do want to explore further the issues around ethics in professional practice as opposed to "research ethics" perhaps building on the paper which I have drafted.

There are many other ethical issues implicit in this project and I do want to capture and think about those – for example, the balance between the "rights" of staff and the "rights" of patients. My own duties if I come across abusive practice.

I have started writing up the case study (Hospital X) from the perspective of complexity theory. I propose to outline complexity theory and then to illustrate it with observations/stories from the project. Conceptually I am going to suggest that the "security" behaviours of the organisation need to be nudged out of "simplicity" into complexity to enable rehabilitation and that the "therapeutic" aspects of the organisation need to nudged out of chaos into complexity.

In terms of the case study informing my understanding of leadership and the interplay between leadership and organisation development there is what I think of as the "A to B" question – how do you use formal hierarchical power to bring about an empowered organisation? I think I can conceptualise the OD interventions which I have been making in the context of this question and in the wider context of complexity theory.

APPENDIX E

Ethical considerations

Supporting Documents

Letter from Chief Executive

Working paper on ethical framework for work-based research

West London Mental Health NHS
NHS Trust

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BY EMAIL

Dr Hemda Garelick
School of Health and Social Sciences
Middlesex University
The Queensway
Enfield
Middlesex
EN3 4SF

9th December 2003

Dear Dr Garelick

ETHICS CLEARANCE FOR IPH5180-PROJECT MODULE-DPROF

Michael Faulkner, currently one of Middlesex University's doctoral students, is contracted to provide an Organisational Development Service to part of this Trust. I understand from him that he wishes to write up the work that he is undertaking for this Trust as a research dissertation in respect of his studies at the university. He has also shared with me your email of the 25th November in which you ask him to obtain formal confirmation that the project does not need, or possibly already has, ethical approval and a communication from me saying that the project is allowed to progress.

I have thought about this request and I don't think its appropriate for the Chairman of our local Research Ethics Committee to be approached in respect of this project for the following reasons.

Michael is undertaking a piece of work organisational development for this organisation which has been specified by the Trust and where any amendments to it are discussed and agreed with the Trust. The nature of the work does not require Michael (or his associate) to have any personal contact with patients or with their medical records. None of the organisational development interventions are made with patients. The work that Michael does in working with staff is designed to assist them to do their jobs more effectively and does not require staff to do anything other than they would be required to do in the course of their normal day to day employment. As such this work does not qualify in our terms as research work and hence it was launched with no reference to the local Research Ethics Committee some 18 months ago.

I recognise that with the nature of Michael's studies doing this work gives him a fortuitous opportunity to write up the project for his doctoral studies. This does not require him to undertake any additional activities beyond those that he is already commissioned to do by the Trust. We very much value the work Michael is doing and would not wish to impede his studies and hence I have agreed that he may use the project to support his work in this way.

I recognise that your request that this should go to a local Research Ethics Committee will be based around your need to be satisfied that the project is covered by appropriate governance arrangements. To this end perhaps I should explain that the work was commissioned following a discussion at the Trust Board in 2002. Michael produced a preliminary report which was again considered by the Trust Board and the work programme endorsed. The work is overseen by a Steering Group in the Trust which is chaired by me, the Chief Executive. As you will be aware the NHS is undertaking work generally to modernise services and for this Trust the work that Michael is undertaking comes under that umbrella. In addition to being managed through a Steering Group progress reports are taken to the Board from time to time.

I hope this letter gives you the reassurance you are seeking about the governance arrangements for the project and the fact that it has the Board's approval. Please don't hesitate to come back to me if you require further detail.

Yours sincerely

Dr Julie Hollyman
Chief Executive

DRAFT GUIDANCE FOR PROSPECTIVE PROJECT LEADERS

October, 2003.

INTRODUCTION

The NHS is engaged in an unprecedented programme of learning, improvement and transformation as it seeks to become a 21st century organisation. It can not achieve these goals without taking some measured risks and without making mistakes.

The government and NHS leaders are seeking to foster a spirit and culture of enquiry, of innovation and of entrepreneurship so that we become the kind of organisation which is responsive to the needs and aspirations of patients and of the wider community an organisation which is constantly finding new and better ways of meeting their needs and aspirations.

It is important that the efforts and energies of people in the service who are striving to transform it are not constrained by uncertainty about the ethical and policy context in which they are carrying out their work. The purpose of this document is to clarify the distinction between "research", which is governed by the Research Governance framework for health and social care ( ) and activities such as service improvement projects, public and patient involvement and work-based learning which may share some tools and techniques with the world of research but which require a different governance framework.

The document suggests guidelines which should be followed in carrying out such activities and advocates a process for ensuring that the Research Governance framework is applied when appropriate but not applied when it is clear that the proposed activity does not fall within the remit of research.

WHAT IS RESEARCH?

The Research Governance framework defines research in the following terms:

> "Research can be defined as the attempt to derive generalisable new knowledge by addressing clearly defined questions with systematic and rigorous methods." (para 1.9).

The same paragraph points out that "other documents on clinical governance and on quality in the NHS and social care set out standards and systems for ensuring the quality of innovative work in non-research contexts".

Paragraph1.4 of the framework emphasises the need "to reach agreements on arrangements that are proportionate to risk".

NON-RESEARCH ACTIVITIES

In seeking to improve services, to learn, to engage the public and service users, to develop staff and to transform organisations we may well apply tools and techniques such as interviews and focus groups which are also used in research contexts. The fact that we use some of the same tools and techniques does not mean that we are doing the same thing any more than using a thermometer in the kitchen implies that we are engaging in clinical practice when we are baking an apple pie!

Activities which apply some of the tools and techniques of research in a non-research context might include:

Service improvement projects and programmes.

Engaging the public and service users in shaping services.

Engaging in work-based learning.

Undertaking organisation development programmes.

Using 360^0 appraisals for staff development.

Identifying learning and development needs.

These activities are concerned with applying existing knowledge and approaches to address particular problems rather than with deriving "generalisable new knowledge".

The "shared use" tools and techniques might include:

Focus groups.

Interviews.

Surveys.

Pilots of new ways of working.

DUAL PURPOSE ACTIVITIES

Some initiatives, projects and programmes combine research and non-research intentions. For example, there might be an intention to generate "generalisable new knowledge" ***and*** to bring about a particular service improvement. In this case, the requirements of the research governance framework must apply fully.

ASSESSING YOUR PROJECT

The purpose of this checklist is to help you to assess whether your project or piece of work falls entirely or partially within the definition of research and whether it should, therefore, be referred for approval by the relevant Research Ethics Committee.

If you answer **YES** or **UNSURE** to ***any*** of the questions on this checklist, you should seek guidance from your local Research Ethics Committee or the person responsible for Research Governance in your organisation. ***If you are in any doubt whatsoever, you should seek such advice.***

		Referral required	
	NO	**YES**	**UNSURE**
Is your project designed to derive generalisable new knowledge?			
Do you envisage publishing the results of your project in any peer-reviewed journal?			
Is there any risk to the dignity and rights of ***any*** of the people who will be engaged in or providing information for your project?			
Is there any risk to the safety or well-being of ***any*** of the people who will be engaged in or providing information for your project?			

EVALUATION AND SHARING OF LEARNING

Although non-research projects will not normally be written up for publication in peer-reviewed journals, it will always be good practice to determine as part of the project design how the project will be evaluated and how learning from the project will be shared within the organisation and more widely within the NHS and amongst its partner agencies.

PRINCIPLES FOR NON-RESEARCH ACTIVITIES

Although your project may not be research, it is still governed by a number of ethical principles and by policies and legal requirements in relation to matters such as data protection, equality, confidentiality, corporate governance, clinical governance and so on. A list of relevant sources of information is attached as Appendix A. The following principles should be adhered to:

Intention

Your intention is to inform or bring about improvements in your organisation which will be beneficial to service users and/or the community and/or members of staff.

Openness

Everyone who is involved with your project and/or who has been asked to provide information in the course of your project has been informed about the goals of the project, the process and their own role and has had an opportunity to have their questions answered.

Consent

Unless what people are being asked to do in the course of your project falls clearly within the scope of their contract of employment, you must obtain their consent to participate and they must demonstrably have the opportunity to decline to participate without any fear of adverse consequences. Such consent should be obtained in writing using a document such as the example attached as Appendix B.

Confidentiality

Clear ground rules for safeguarding information must be agreed with everyone involved in your project or anyone who might be asked to provide information in the course of your project. Such ground rules must comply with legal and policy guidelines such as those set out in the Data Protection Act and in the Caldicott Rules.

Corporate Governance

The design and conduct of your project must comply in all respects with the principles of good Corporate Governance as set out in local policies and procedures including Standing Financial Instructions.

Equality and diversity

The design and conduct of your project must promote equality of opportunity and the promotion of diversity.

NHS Management Code of Conduct

The design and conduct of your project must fully reflect the principles set out in the Code of Conduct for NHS Managers ( ).

RECOMMENDED POLICY

To ensure that your project follows the appropriate governance requirements and represents best practice, we recommend the following:

The Project Leader should complete the Project Assessment Checklist to determine whether the proposed project falls wholly and exclusively within the non-research domain. *Unless it is clear that the project does fall within the non-research domain, advice should be sought from the Local Research Ethics Committee (LERC) or the person with responsibility for research governance in his/her organisation.*

The Project Leader should consult as necessary with their Caldicott Guardian, The Director of Human Resources and the Director of Finance to ensure that the proposed project is compliant with national and local policies in relation to Corporate Governance, Employment, Data Protection and Confidentiality.

The Project Leader should prepare a short Project Protocol outlining the project and demonstrating how the proposed project complies with each of Principles for Non-Research Activities.

The Project Leader should ask a Director of his/her Trust or other employing organisation to review the protocol and the assessment and to certify that the proposed project

Is a non-research project and does not require scrutiny by the Local Research Ethics Committee.

and

That it is compliant with the Principles for Non-Research Activities.

and

That it is likely to be of benefit to the NHS and to represent a good use of public resources.

If the Director declines to certify the project, advice must be sought from the Local Research Governance Committee before the project goes ahead.

Copies of the protocol and its certification document must be retained by the Project Leader and the Certifying Director. A copy should be sent to the Chair of the Local Research Ethics Committee and to the Chief Executive of the sponsoring organisation either of whom may challenge the certification and require the project to be referred to the Local Research Ethics Committee. Where such a referral is required, the project must be suspended until the Chief Executive and/or the Chair of the Local Research Ethics Committee have given their approval.

An illustrative certification document is attached as Appendix C.

APPENDIX A

SOURCES OF INFORMATION RELEVANT TO NON-RESEARCH ACTIVITIES

Code of Conduct for NHS Managers.

Research Governance Framework for health and social care.

PCT Corporate Governance Framework

This list needs to be filled out, references given and download details provided where possible.

APPENDIX B

EXAMPLE OF A CONSENT DOCUMENT

APPENDIX C

ASSESSMENT AND CERTIFICATION OF A NON-RESEARCH PROJECT OR ACTIVITY.

Project Title	
Project Leader	
Planned start date	Planned completion date
Sponsoring organisation	

ASSESSMENT CHECKLIST

	NO	YES	UNSURE
Is your project designed to derive generalisable new knowledge?			
Do you envisage publishing the results of your project in any peer-reviewed journal?			
Is there any risk to the dignity and rights of ***any*** of the people who will be engaged in or providing information for your project?			
Is there any risk to the safety or well-being of ***any*** of the people who will be engaged in or providing information for your project?			

Self certification

I have reviewed the proposed project against the above criteria and determined that it is a non-research activity and does not, therefore, need to be referred to the Research Ethics Committee. I confirm that I have studied the principles governing non-research activities, consulted with the relevant Directors and others and ensured that the proposed project is fully compliant with those principles. Should there be any change in the circumstances which led me to these conclusions I will immediately bring my concerns to the attention of the Chief Executive.

---------- ----------

Project Leader Date

Certification

I have reviewed the proposed project with the project leader and confirm that, in my opinion

- It is a non-research project and does not require scrutiny by the Local Research Ethics Committee.

  and

- That it is compliant with the Principles for Non-Research Activities.

  and

- That it is likely to be of benefit to the NHS and to represent a good use of public resources.

Name of Certifying Director	
Job title	
Signature	Date

APPENDIX F

DESCRIPTIONS OF PRODUCTS FROM THE STUDY

Copies of the actual products are available on request

Project Report to NHS Leadership Centre (September 2004).

This document summarises the key findings from the Career Management and Succession Planning Pilot Study and presents a number of recommendations for consideration by the Leadership Centre and the NHS Board. The report is authored by the Chief Executive and Director of Development for South West London Strategic Health Authority and myself.

Taking Charge of your Career (September 2004)

This Guide and Workbook is designed to help people with potential for development into organisational leadership roles to assess their own career aspirations and strengths and weaknesses in relation to those aspirations and to draw up personal development plans and learning contracts. The Guide will also be available in interactive electronic format through the Leadership London website. It will be piloted in London during October/November, 2004 and will then be available nationally.

Identifying and developing leadership potential: A Guide for Chief Executives and senior clinical and managerial leaders. (September 2004).

This Guide is intended to help organisational leaders to identify and develop people with (organisational) leadership potential. It sets out the indicators of potential from this study and the future-oriented competences and provides guidance on creating a development culture and designing and implementing a career management system. It will be piloted in London during October/November, 2004 and will then be available nationally.

Development Centres

The five Strategic Health Authorities in London have decided to "mainstream" development centres and have agreed to fund a project manager to support implementation of development centres across London. Development Centres for aspiring chief executives will continue to be run annually on a pan-London basis.

Development Centre Tool-kit

This provides guidance, frameworks and illustrative activities for designing and implementing development centres locally. It is complemented by a training programme for designers, administrators and development advisers. Additional materials will be shared over the Leadership London website. After piloting in London, it will be available nationally.

Development Programme for Primary Nurses in Assertive Rehabilitation.

A one year professional development programme which has started in Hospital X designed to equip Primary Nurses with the competences and confidence to perform the case management role effectively.

Development Programme for Clinical Nurse Managers and Team Leaders.

A one year professional development programme which has started in Hospital X designed to equip Clinical Nurse Managers and Team Leaders with the competences and confidence to perform their clinical leadership roles effectively.

Rehabilitation Practitioner Programme

Proposal to develop, with an academic partner, an accredited inter-professional programme at Masters level, to create a new sort of practitioner in forensic mental health.

APPENDIX G

Summaries of formative projects
(Copies of the original work are available on request)

HEALTH VISITING PRACTICE FOR AFRO-CARIBBEAN POPULATIONS (IPH 4040)

This study was commissioned by the Department of Health and was hosted by Greenwich Community NHS Trust. The study involved an action research enquiry in which I was project leading and facilitating a group of local Health Visitors. The aims of the study were to evaluate the extent to which current Health Visiting Practices met the needs and aspirations of people from Afro-Caribbean backgrounds and to develop new practices to better meet their needs.

In the course of the study it became apparent that there were significant differences between the rhetoric of health visiting practice and the reality (the final report was entitled Rhetoric and Reality) and a number of major changes in practice were implemented as an outcome of the study.

Products from the study included:

A weaning booklet for Afro-Caribbean populations making use of ethnically appropriate foods and recipes. This was developed by members of the community with advice and support from the project team and local dietitians.

A development programme for (primarily) women to enable them to acquire NVQ level qualifications in "Taking Charge of Family Health".

An "Understand Us" Day organised by the local community to educate professionals about Afro-Caribbean culture.

A revised record keeping system in which families wrote and kept their own child development records and gave copies to the Health Visitors.

TRANSDISCIPLINARY PRACTICE (IPH 4060)

This study was commissioned by a consortium of NHS Trusts in West London. The purpose of the study was to evaluate current practices in the care of people with long-term chronic conditions such as multiple sclerosis. The study took the form of an action research enquiry involving a multidisciplinary team led and facilitated by myself. The starting point for the enquiry was the capture of patient stories through discovery interviews.

As a consequence of the patient stories, an innovative model of practice (Transdisciplinary Practice) was developed with the aim of developing practitioners who would have the clinical skills to meet 90% of the needs of patients without referral to other practitioners or agencies.

A development programme was designed for Transdisciplinary Practitioners and was validated at Masters level by Brunel University.

This project also formed the subject of a dissertation for which one of my colleagues was awarded an M.Phil. by the University of Southampton in July, 2004.

EXPLORING CLINICAL PRACTICE (IPH 5140)

This study was commissioned by a consortium of NHS Trusts and Social Service organisations in West London. The aim of the study was to evaluate the extent to which current models of clinical education and training prepared practitioners for future models of practice. I led and facilitated a project team consisting of two other organisation development practitioners and some 30 clinical practitioners from a range of disciplines.

The study took an action research approach and was carried out by small inter-professional teams each of which focussed on a particular client group. Complementary studies were included with a focus on the transition from education into practice and on retention of learners.

Products from the study included:

A new good practice guide for clinicians working with children showing faltering growth.

A Project Report which was widely disseminated in the health and social care and higher education communities in West London and used to inform the commissioning of clinical education.

A series of conferences and workshops to disseminate the findings from the study.

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