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# **Possibilities and Pitfalls for Clinical Leadership in Improving Service Quality, Innovation and Productivity**

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# Contents

Contents.....	4
List of tables .....	7
List of figures .....	7
Glossary of terms/abbreviations.....	8
Acknowledgements .....	10
Executive Summary .....	11
1 Introduction and background .....	15
1.1 Background, key themes and issues .....	15
1.2 Aims and objectives .....	18
1.3 Organisation of the report .....	19
2 Project Design and methodology.....	20
2.1 The four cases and their settings.....	21
2.2 The interview programme .....	22
2.3 The series of observations.....	23
2.4 Data Analysis .....	23
2.5 Patients, service-users and carers .....	24
2.6 Workshops.....	24
2.7 Research Ethics .....	24
3 Clinical leadership and cross-boundary service redesign in the literature....	25
3.1 The idea of clinical leadership .....	25
3.2 Functions of clinical leadership.....	27
3.3 Distributed leadership and change agency .....	28
3.4 Cross-boundary care pathway redesign.....	30
4 Sexual Health: issues, services and user perspectives.....	33
4.1 Issues in sexual health .....	33
4.2 Users and Carer perspectives on Sexual Health Services.....	35
5 Dementia: issues, services and user perspectives .....	37
5.1 Issues in Dementia .....	37
5.2 Users and Carers Perspectives on Dementia Services .....	38

---

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6	Clinical Leadership in Sexual Health .....	45
6.1	The Greater Manchester Sexual Health Services Case.....	45
6.1.1	Background conditions and the prompts for change.....	45
6.1.2	The nature and extent of the changes and the achievements .....	48
6.1.3	Change processes, pitfalls and barriers.....	51
6.1.4	Lessons about Clinical Leadership from the Manchester Sexual Health Case: Possibilities and Pitfalls.....	56
6.2	The London Sexual Health Services Case.....	64
6.2.1	Background conditions and the prompts for change.....	64
6.2.2	The nature and extent of the changes and the achievements .....	65
6.2.3	Change processes, pitfalls and barriers.....	68
6.2.4	Lessons about Clinical Leadership from the London Sexual Health Case: Possibilities and Pitfalls.....	72
7	Clinical Leadership in Dementia Services.....	83
7.1	The Greater Manchester Dementia Services Case .....	83
7.1.1	Background conditions and the prompts for change.....	83
7.1.2	The nature and extent of the changes and the achievements .....	87
7.1.3	Change processes, pitfalls and barriers.....	89
7.1.4	Lessons about Clinical Leadership from the Greater Manchester Dementia Services Case: Possibilities and Pitfalls .....	93
7.2	The London Dementia Services Case.....	102
7.2.1	Background conditions and the prompts for change.....	102
7.2.2	The nature and extent of the challenges and the achievements.....	103
7.2.3	Change processes, pitfalls and barriers.....	104
7.2.4	Lessons about Clinical Leadership from the London Dementia Services Case: Possibilities and Pitfalls.....	106
8	Cross Case Comparisons.....	114
8.1	Cross Boundary Agendas.....	117
8.2	Local leadership arenas.....	118
8.3	Reworked clinical and organisational practices.....	120
8.4	Professional roles and relationships .....	121
8.5	Patterns of sentience .....	125
8.6	Performance achievements.....	126

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8.7	Summary.....	127
9	Conclusions .....	128
9.1	Introduction .....	128
9.2	Answers to the research questions .....	128
9.3	Types of clinical leadership .....	136
9.4	Limitations of the research .....	138
9.5	Implications for policy.....	139
9.6	Implications for clinical and managerial practice .....	140
9.7	Implications for future research .....	141
	References.....	143
	Appendix 1: Practical Guidance Notes for Clinical Leadership .....	148
	Appendix 2: NVivo Coding Analysis Methodology and Procedure .....	171
	Appendix 3: Examples of emergent descriptive codes used in NVivo analysis of interview data .....	172

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## List of tables

Table 1. Interviewees across the four cases..... 22

Table 2. Summary of Greater Manchester Sexual Health Services ..... 58

Table 3. Summary of Sexual Health Services London Case ..... 74

Table 4. Summary of Dementia Services Greater Manchester Case ..... 100

Table 5. Summary of Dementia Service London Case..... 112

Table 6. Cross Case ComparisonsTable 6 (contd.) ..... 115

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## List of figures

Figure 1. Clinical Leadership and types of change ..... 29

Figure 2. Framework for understanding clinical leadership for cross boundary service redesign..... 41

Figure 3. The Good Health Model ..... 54

Figure 4. Directions of Accountability ..... 134

Figure 5. Types of Clinical Leadership ..... 136

Figure 6. Modes of Clinical Leadership..... 138

Figure 7. The elements needed for clinical leadership ..... 156

Figure 8. Examples of emergent descriptive codes used in NVivo analysis of interview data ..... 172



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## Glossary of terms/abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AGUM	Association for Genitourinary Medicine
BASHH	British Association for Sexual Health and HIV
BAMM	British Association of Medical Managers
BMA	British Medical Association
BME	Black Minority and Ethnic
BHIVA	British Association of HIV
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CPN	Community Psychiatric Nurse
DCA	Dementia Care Advisor
DH	Department of Health
GP	General Practitioner
GUM	Genitourinary Medicine
GPSI	GP with Special Interests
MATS	Memory Assessment and Treatment Centre
MI	Modernisation Initiative
MLCF	Medical Leadership Competency Framework
MSSVD	Medical Society for the Study of Venereal Disease
NICE	National Institute for Health and Clinical Excellence
NRES	National Research Ethics Service
OT	Occupational Therapist
PBR	Payment by Results
PGD	Patient Group Directions
QOF	Quality and Outcomes Framework
QUIPP	Quality Innovation Productivity and Prevention
RCP	Royal College of Physicians
RSH	Reproductive and Sexual Health

SHMI	Sexual Health Modernisation Initiative
LARC	Long Acting Reversible Contraception
CMHT	Community Mental Health Team
PCT	Primary Care Trust
FT	Foundation Trust
NHS	NHS National Health Service
SHA	Strategic Health Authority
SHMI	Sexual Health Modernisation Initiative
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Disease

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# *Executive Summary*

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## Background

The idea that something called 'clinical leadership' is the favoured 'answer' to many of the huge challenges facing the NHS has been advanced with increasing intensity. *Inter alia*, Lord Darzi in the Next Stage Review emphasised the importance of clinical leadership; the Health and Social Care Act (2012) puts clinicians to the fore; and the Royal Colleges have accepted the need for Medical Leadership Competences to be defined and developed.

Despite such emphasis and expectation, the reality of clinical leadership attempts to redesign services across the extant boundaries of the NHS and which reveal how the many barriers can be overcome, has not so far been studied.

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## Aims

The overall research question was:

**What can be learned from the experience of enacting the Darzi model of clinical leadership in practice? What are the main enabling and constraining conditions for its effective realization and performance?**

Subsidiary research questions that feed-in to this main research question were:

- 1) What general lessons about its nature and its practice can be deduced from a series of examples of effective clinical leadership in introducing more integrated models of care? What variations are required when enacting the model in very different service areas?
- 2) What are the enablers and the blockers of effective clinical leadership?
- 3) How do effective clinical leaders both initiate and lead service improvements while also engaging constructively with top-down service redesign and improvements initiatives?
- 4) How do service-level clinical leaders in acute and primary care develop and implement service quality improvements through achieving greater integration between primary and acute care? How do they go about mobilising other clinicians while also engaging with commissioners and managers?

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## Methods

The nature, scope and potential for clinical leadership were explored by focusing on its practice in four 'cases'. The cases were cross-boundary service redesign attempts in two service areas: dementia and sexual health. These were studied in two different health economies: one in a part of London and one in a part of Greater Manchester. Hence, the two service areas in two geographies gave rise to 4 distinct cases. Each case contained multiple organisations including GPs and primary care trusts, acute hospital trusts, mental health trusts, local authorities and independent sector providers.

We interviewed a total of 74 informants across the 4 cases including hospital consultants, junior doctors, nurses, other clinicians, managers and commissioners. The interviews were supplemented with a series of observations of meetings and service contexts.

Feedback events were held with informants and additionally there were inter-disciplinary workshops where managers and clinicians were able to respond to our findings and to offer additional insights about their generalisability beyond the case sites. Insights from these events are included in this report.

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## Results

The main findings of the study were:

1. The obstacles to the exercise of the clinical leadership of cross-boundary service redesign within the context of the NHS are many.
2. Despite the extent and severity of the obstacles, we found some significant examples of clinical leadership of service redesign which were all the more impressive because of the challenges that had to be surmounted.
3. In general, clinical leadership was found to occur at multiple interlocking levels and the role of clinicians in shaping national policy should not be underestimated. Many of the important changes required national endorsement – and often funding – in order to put traction behind good ideas.
4. Successful clinical leadership requires the enactment of skilful practice across a number of constellations including collaborative working with a host of actors including managers, IT staff, project managers, estates and many others.
5. Clinical leaders were capable of being open to new ideas and new knowledge while also having the political wisdom to seek new reworked boundaries around which professional identity could be redefined and reformed.

6. Implementation leadership was important; it is the essential minimum for change.

7. Informal, lateral, leadership can mobilise and bring along clinical colleagues and conversely formal project planning on its own can be relatively ineffective but the most effective service redesigns were achieved when both of these processes worked in tandem.

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## Conclusions

Different types of clinical leadership were found. We identified four main types: the relatively passive; those who utilised effective interpersonal and planning skills to achieve localised and rather incremental service improvements; those who brought passion and vision to bear and rushed ahead but who lacked followers and therefore became exposed; and high-impact leaders who brought both an appropriate scale of ambition and a set of micro-political capabilities to bear so as to achieve significant cross-boundary service redesign.

A focus on patient and service user needs and wants is underscored. Likewise, the need to attend at an early stage to the identification of the public health case for service redesign proposals is reinforced. This entails a concomitant awareness and capability in calculating the resource implications and the trade-offs. This in turn means forging positive collaborative relationship with a range of critical actors.

Making the case for redesigning services across established boundaries is linked to establishing a fresh and compelling focus on patient and service user needs. Local clinical leadership of this nature stems in part from the intrinsic interest of many clinicians - doctors, nurses and allied health professionals - in understanding the wider system of care experienced by their patients. The motivation to improve interfaces and bring together the forms of care people need often finds expression in informal initiatives to link with other parts of the health service and with social care. This emergent activity form of cross-boundary improvement is an important resource for more formal and structured service redesign projects. It is often frustrated by the compartmentalised nature of NHS organisations, but continues to thrive nonetheless.

Network organisations linking clinicians and managers in similar clinical areas across a locality or region have a vital role in fostering this kind of clinical vision, and help develop a sense of belonging and commitment to a community engaged in improving a wider system of care. There is a case for extending their scope, bringing in social care and third sector organisations that have a role in the overall system of care for a particular condition.

National strategies for clinical areas can provide an important form of legitimisation for service redesign projects. Indeed, challenges emanating

from the national level which have been well forged with high quality clinical input appear to provide a vital top-down mechanism for shaking up established thinking at local and regional level as to how services should be configured, providing clinicians who have been thinking about how to improve the structure of the services with an opportunity to make their case and take it forward. Local clinical leadership is not an alternative to top-down national strategies; rather the two can productively feed off one another.

# *The Report*

## ***PART 1 POSITIONING THIS STUDY***

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### **1 Introduction and background**

#### ***1.1 Background, key themes and issues***

The idea that clinical leadership is crucial for the future viability of the National Health Service has been stated many times and with increasing frequency. Cost pressures running alongside rising demand dictate a need for both cost effectiveness and improved service quality. It is argued that clinicians, rising to the challenge of leadership, provide the solution.

This case for stronger clinical leadership is advanced by numerous authorities including policymakers and academic researchers. They point to the need to not only 'engage' clinicians in assisting with the necessary changes but also to secure their leadership. For example, the *Next Stage Review* (Darzi 2008) especially emphasised the role of clinical leaders as centrally important. Successive governments in the UK have also pointed to clinical leadership as the 'answer' – as seen, for example, in the Coalition's health reforms built around clinical commissioning.

There is a need for two definitional points to be made here. First, when we talk about 'clinical leadership' we include doctors; but the investigation is by no means restricted to doctors or to 'medical leadership'. Second, clinical 'leadership' and clinical 'engagement' can easily be confused. 'Engagement' tends to be used to refer to the process of enlisting clinicians' discretionary effort and enthusiasm into manager-led plans. The term 'clinical leadership' tends to imply rather more self-starting from the initiating clinicians or clinicians. It was leadership rather than engagement alone which was the focus of investigation in the research reported here. However, as will be made evident in the report's findings, in practice, it is simply often not possible to make such as a sharp distinction. Clinicians may start out as recruits into a manager-initiated change process but as events unfold they may migrate into a leadership role. These complex processes are at the centre of the report's findings.

Further, the nature of clinical leadership examined in this report is of a special kind. Service transformation will not occur simply through improved team or unit leadership. Rather, we are addressing the potential for cross-boundary service redesign. The need for, and the ways to achieve, disruptive solutions at system have been advanced by Clayton Christenson (Christensen 2009), and Michael Porter (Porter and Teisberg 2006).

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This idea can be seen as one part of the wider theme of 'leadership' in the NHS in general as evidenced by the various leadership initiatives such as the NHS Leadership Council and the other initiatives by the National Institute for Innovation and Improvement, the Kings Fund (Roebuck 2011) and the Royal Colleges. One crucial strand of this overall emphasis on the importance of leadership has been the specific focus on 'clinical leadership'. This emphasis has been manifested, so far, mainly in the form of exhortations, competency models, and prescriptions drawn from focus groups. For example, vision, bravery, mentoring, optimism, clinical credibility, recognition of opportunity, and developing networks have been identified by one focus group of senior clinicians as part of the NHS London Leadership Development Programme (Warren 2012).

As valid as such lists may or may not be, our purpose in the investigation reported here, was to move beyond the prescriptive, speculative and the rhetorical by exploring the actual the nature, the limits and the possibilities for clinical leadership in concrete, challenging, settings. We report here on an investigation of the factors and processes revealed by attempts to exercise leadership by clinicians in contexts where NHS power and authority structures, cultures, legacies and cross-boundary working, presented clinicians with a truly complex array of challenges. It is important to note that while the investigation is *about* the factors which enable or stymie clinical leadership the *lessons* are equally important for managers and policy makers as well as clinicians.

The emergence of the idea that clinical leadership is crucial can be traced in part to analyses made by academics and policy-oriented consultants concerning how health systems in other parts of the world have tackled issues of performance and quality improvement. Mountford and Webb (2009) draw on research conducted by McKinsey Consultants into what makes leading health care providers in the USA able to meet the quality and productivity demands placed on them by insurers and service-users.

The profound influence of these ideas on recent thinking in the NHS can also be found in Clark, Spurgeon, & Hamilton (2008). They argue that management and leadership competencies need to be recognised and developed at all stages of medical identity and competency formation.

As we shall later point out in this report, a focus on the competence of the individual as a leader is only one element in the organisation's wider improvement and capability formula. Leadership is found to be a multi-actor process that is manifested in, and enacted through, relationships with colleagues and partners. Moreover, these leadership interventions are context dependent as was discovered by the King's Fund Commission on leadership and management in the NHS (King's Fund 2011).

Despite high level advocacy for clinical leadership there remains huge uncertainty about what it would look like in practice and crucially how it would be exercised alongside the extant authority structures. Moreover, the precise reasons why clinicians per se should be assumed to be the sine qua

non of leadership have also been rarely specified or demonstrated. There is considerable scepticism about whether clinicians have the capability or even the inclination to take a lead. Hence, there is a need for a dedicated analysis of both the *possibilities* for clinical leadership (how would it be enacted, what examples exist and what lessons can be learned from them?) and the potential *pitfalls* (what obstacles would clinical leadership need to surmount, what trade-offs might be involved?).

We report here on a twelve months follow-on study to our NIHR/SDO project *Comparative Governance Arrangements and Comparative Performance* Project (08/1618/129). That project found that in both acute and primary care delivery settings, clinicians were often cautious about, and even critical of, top-down service redesign attempts (including those stemming from trust level service redesign teams and trust-sponsored management consultants). While these clinical leaders had accepted that a shift from simple improvements at the level of the individual clinician-patient-encounter, to wider, service-level innovations were necessary, they were nonetheless often sceptical about, and resistant to, centre-led interventions. They were comfortable with clinical micro-system improvements but cautious about institution-led interventions and even more so about wider scale initiatives.

But many long-term, chronic, and recurrent conditions require cross-boundary collaboration across multiple institutions such as primary and secondary care as well as across health and social care boundaries. Thus, 'within-trust leadership', while necessary, is not sufficient. Fundamental service redesign would require clinicians to take a lead on a much more far-reaching scale. Hence, the call for 'clinical leadership' in the complex context of the NHS, we will demonstrate, is tantamount to a call for whole sets of new behaviours and the exercise of new skills, some of which (as again we will show) have not so far been clarified or even identified. For whole systems change - across teams, services, institutions and professional boundaries, the implications are even more wide ranging.

To help gain insight into what clinical leadership in cross-boundary service redesigns might look like we focused on two services which place high demands across multiple institutions and agencies: dementia and sexual health. Both service areas are seeking to address significant public health needs and they both offer the potential for major improvements if the process challenges could be surmounted.

There have been few studies of what this more demanding kind of clinical leadership might look like in practice. The NHS with its notorious and ever-changing layers of complexity could easily be seen as actively discouraging cross-boundary leadership - or at least making its achievement rather difficult. While it is evident that the idea of clinical leadership is widely extolled, less clear are the nature and the size of the challenges, the limits and the obstacles to the *realisation* of the idea. From a balanced weighing of both the limits and the possibilities, this research aims to illuminate the

most promising lines of action for those clinicians and managers who wish to exercise leadership as a means of achieving radical service improvements.

## **1.2 Aims and objectives**

The **overall research question** can be stated thus:

**What can be learned from the experience of enacting the Darzi model of clinical leadership in practice? What are the main enabling and constraining conditions for its effective realization and performance?**

Subsidiary research questions that feed-in to this main research question are:

- 1) What general lessons about its nature and its practice can be educed from a series of examples of effective clinical leadership in introducing more integrated models of care? What variations are required when enacting the model in very different service areas?
- 2) What are the enablers and the blockers of effective clinical leadership?
- 3) How do effective clinical leaders both initiate and lead service improvements while also engaging constructively with top-down service redesign and improvements initiatives?
- 4) How do service-level clinical leaders in acute and primary care develop and implement service quality improvements through achieving greater integration between primary and acute care? How do they go about mobilising other clinicians while also engaging with commissioners and managers?

Most of the literature on 'clinical leadership' concerns itself with conceptual clarification of types of leadership and with delineation of requisite competences. But, other work on leadership has emphasized the importance of attending to practice in concrete situations in order to identify the dynamics at play. Our research sought to contribute to this latter task.

Before proceeding further, we need to make an important point of clarification regarding terminology. Many commentators use the terms 'medical leadership' and 'clinical leadership' interchangeably. Often, even when talking about clinical leaders people often really mean doctors. In this research however, we really do investigate the roles of other clinicians in addition to those of doctors of varying kinds. This will become plainly evident as the research methods are described and the findings presented. We accept that our reference to the Darzi report in framing the main research question may tend to suggest a doctor-focused study this is not what we intended nor is it what we did. Darzi was a useful point of reference to an agenda which placed clinicians at the forefront of service design.

In a recent article, (Howieson 2011) concluded a meta analysis of the *idea* of clinical leadership with the following observation: 'There is a considerable amount of literature on clinical leadership in the UK today. Indeed, in the NHS, several reference documents seem to appear each year. However, this literature is, on occasion, somewhat limited: there are few definitions of the subject; the approach is centred on recommended leadership behaviours/traits and competencies; there is no account of the situation; and, in most instances, the key issues or realities of leadership – as reported at the coalface – are seldom mentioned' (2011: 16).

This is an observation echoed in other places where focused attention has been paid to the problem of the *practice* of leadership and the need to locate it into concrete contexts (Hartley 2010; Storey 2011). It is this gap about the detail of the lived experience of clinical leadership in concrete circumstances that we seek to fill.

Hence, through a detailed study of extant practices, services redesign proposals and patterns of influence, we seek to identify and draw-out the nature and the contours of clinical leadership. We follow the advice of Gronn (2002:441) who argued strongly that 'leadership would be better served *by understandings more closely connected to the realities of workplace practice*' (Gronn 2002), emphasis added).

We are less concerned here with micro-leadership of teams or indeed routine leadership of, and within, relatively stable organisations by medical directors and others with formal leadership positions. Indeed, we also seek to go beyond the leadership of service changes that might be expected of the new breed of clinical directors within acute trusts (Dedman 2011). Rather, we seek to unravel the role played by clinicians in more radical, larger-scale changes which cross institutional boundaries and which also challenge traditional and prevailing service boundaries such as 'primary', 'community', 'secondary', 'mental health', and 'health and social care'.

### **1.3 Organisation of the report**

The report is organised into nine chapters. Following this introduction we describe the project design and the research methods. In the ensuing section we review a number of relevant literatures. We then present the findings from the studies made in sexual health services in London and Greater Manchester. This is followed by a description and analysis of findings from the studies of dementia services in both of these same localities. The report then makes a series of cross-case comparisons and seeks to draw out general lessons. Discussion of the meaning and implications of the finding follow and the report ends with a set of conclusions and a set of guidelines for future practice.

---

## 2 Project Design and methodology

In this section we describe the design of the study, the clinical service areas and the territories to be investigated, the research methods and the ethical issues that were taken into account.

Drawing on knowledge gained during our previous project on health governance and management, we returned to selected case study sites where examples of attempted clinical leadership of a cross-boundary nature appeared to be operating – at least to some degree and if not always smoothly. Hence, for this follow-on study, we again worked with two significant health economies – one in London and one in Greater Manchester. These both represent challenging inner-city areas with significant health issues. They allowed for comparisons and contrasts between a capital context and a Greater Manchester-city context. The collaborating institutions in these health economies included, local authorities, PCTs, acute hospitals, mental health trusts, the Alzheimer's Society and Age UK.

We were aware in advance that in both areas there had been some significant attempts to redesign services in dementia and in sexual health and that, in varying degrees, clinicians had played some part in forging these new service configurations. We also knew in broad terms, though not in detail, that these service redesigns had entailed cross-boundary leadership and that in varying degrees certain clinicians had played some part in these processes. The cases were selected on this basis. They were not the leading 'showcase' examples which the PCTs and FTs would have selected to demonstrate their most advanced forms of clinical leadership. Rather, the case areas illustrate services facing complex challenges where clinical leadership could bring significant advances in service quality, innovation and productivity.

Within these case study contexts, we interviewed the majority of the senior clinicians including hospital consultants, other medical doctors, nurses, psychiatrists, occupational therapists, health service managers, commissioners and local authority managers. We sought to illuminate the different kinds of leadership shown by clinicians at different levels and in different roles, rather than focussing on only a few people occupying formal leadership positions.

Sexual health and dementia are two less-well-studied areas of service integration. Both of these areas offer massive scope for improvement in terms of service access and availability, service quality, user-responsiveness and cost-effectiveness. There are, as yet, few established models for integrated services in these areas – in contrast, for example, to services for coronary heart disease or diabetes.

## **2.1 The four cases and their settings**

The research design allows a four-way comparison across two different service areas and in two different geographies. Of course these 'cases' are unusual in that they are not single hierarchies or institutions such as a hospital trust or a PCT. Each of the four is a rather complex array of multiple institutions which are in different kinds of relationship with each other. Each 'case' comprises at least one local authority (in the London cases there were three Boroughs involved), at least one Primary Care Trust (PCT), at least one acute hospital trust (in the London case there were two main teaching hospitals involved), a mental health trust, independent sector providers such as Brook sexual health and voluntary sector providers such as Age Concern and the Alzheimer's Society.

For each of the cases we aimed to interview an average of 20 diverse participants with a total maximum target of between 60 to 80 interviewees. These included and started with, PCT and Local Authority commissioners, consultant physicians, nurses, a range of other clinical professionals, network managers, service managers, GPs, psychologists and care assistants.

To safeguard confidentiality we label the acute hospital trust in Greater Manchester M1 and the mental health trust M2. In London we label one of the teaching hospitals L1 and the other L2; the London mental health trust we label L3 and the two Boroughs L4 and L5.

The settings for these two health economies differed in some important respects. One factor was the complex and competitive environment of London where multiple teaching hospitals (along with a number of other providers such as mental health) provided overlapping services. Another significant factor was the status and power of the provider trusts where prestige research departments with internationally renowned medics faced relatively small, weak and multiple commissioning bodies which were subject to constant reorganisation.

The health economy in Greater Manchester was notable for an entirely different reason. Here, the local authority and the PCT had a track record of partnership working. Further, they were consistently rated as above average in their respective national performance measures. For some years also, the locality had been granted additional national funding to help compensate for health inequalities in a relatively deprived area. In consequence, relatively favourable conditions for cross-boundary working and for service redesign were already in place. Moreover, this also meant that the commissioning bodies (local authority and PCT) had an influence which their counterparts in London lacked in comparison. Again, such conditions carried implications for clinical leadership.

Despite these relative differences in power structure each of the two cases comprised a complex service landscape where patients and carers have to navigate their way across institutions comprising multiple commissioners

(multiple primary care trusts, local authorities, and GPs), and multiple providers including acute trusts, mental health trusts with their various units and teams, third sector providers such as the Alzheimer’s Society and Age UK, and private sector providers of residential care homes.

This set of contextual considerations contributes to a challenging environment within which to attempt to ‘take a lead’.

## 2.2 The interview programme

We interviewed a total of 74 participants across four cases. The interviewees were doctors at various levels and specialisms, nurses also of different levels and specialisms, professions allied to medicine, and managers both from commissioning organisations and provider organisations. Each of the interviews normally lasted between one to two hours and each interview was recorded and professionally transcribed.

**Table 1. Interviewees across the four cases**

<b>Manchester dementia case</b>	<b>London dementia case</b>	<b>Manchester sexual health case</b>	<b>London sexual health case</b>
Consultants: Psychiatrists employed by the MH Trust; Geriatricians employed by the acute FT; Neurologist; MH Liaison in Acute Hospital	Consultants: Psychiatrists and neuro-psychiatrists employed by MH Trust and Geriatricians by multiple Teaching Hospitals	Consultants: specialists in genitourinary medicine and HIV and specialists in family planning employed by the PCT and the acute FT	Consultants: specialists in genitourinary medicine and HIV and specialists in family planning employed by multiple Teaching Hospitals
Senior Registrars	-	Senior Registrars	Senior Registrars
GPs	GPs	GPs	GPs
Commissioners ; Local Authority, PCT and GP commissioning group	Commissioners ; Local Authority, PCT and GP commissioning group	Commissioners ; Local Authority, PCT and GP commissioning group	Commissioners ; Local Authority, PCT and GP commissioning group
Matron, Lead Nurse; Nurses, Occupational Therapist	Psychiatric nurses, General nurses for old age medicine.	Nurses and health care assistants	Nurses and health care assistants
Community Mental Health Teams	Community Mental Health Teams		
Director of Operations Mental Health Trust	Memory Clinic Managers, old age psychiatry managers		

Clinical Psychologist Mental Health Trust	-		
Third Sector senior manager	Third Sector senior manager		

The occupational breakdown of the interviewees is shown in Table 1

This research design allowed a comparison of multiple perspectives. A semi-structured interview schedule was used and so each interviewee was asked broadly the same set of questions although these were adapted to take account of, and indeed advantage of, the diverse roles. In addition to the interviews, relevant documentation including policy documents and reports were analysed.

### **2.3 The series of observations**

We observed senior clinicians meetings for dementia in London which had consultant-level representatives from a number of different teaching hospitals.

We observed patient use and workflows in the new-style sexual health clinics which had a High Street presence and which included vending machines for basic services and triaging system with the help of Healthcare Assistants.

We made observations of the clinical environments in a number of clinics and hospitals.

### **2.4 Data Analysis**

The interview transcripts were analysed using NVivo software as a basis for analysing the dynamics of clinical leadership and cross boundary service change within each case.

Two rounds of coding were used, the first descriptive and the second explanatory. The first descriptive round was based on a set of first level codes that derived from the key phenomena under consideration in each case; the background to changes in service design, the various kinds of clinical leadership, factors that affected progress and outcomes in terms of service performance and actual reconfiguration achieved. These codes are shown in Appendix 2.

NVivo was used to develop clusters of topics, using subcodes, under each of these top level descriptive codes. A working example of these codes is shown in Figure 8 in Appendix 3. These topics were used as the basis for producing a first level of analysis of each case, which was then fed back for discussion and validation with a group of key informants from each case. Some of the sub-code topics emerged as having considerable explanatory power, and led to the development of the conceptual framework for analysing and comparing cases, which is shown in Figure 2. This framework



distinguishes different kinds of clinical leadership and different aspects of cross boundary service innovation. It provided a basis for recoding of data based on its explanatory categories and then further analysis of the cases.

Coding of data was cross checked within the research team. The individual case analyses were then compared to reveal further insights.

## **2.5 Patients, service-users and carers**

Using voluntary sector agencies and the existing user groups of the services we were investigating, we set out to tap into service user wants and expectations. It became evident that while we could gain insight into their evaluations of existing services, it was very difficult to draw upon user and carer perspectives to gain additional insights into aspects of clinical leadership. These latter processes remained hidden from view as far as users and carers were concerned. Nonetheless, user perspectives remained very important to the study because one of the guiding principles of service redesign in both areas was to respond more keenly to patient needs and wants. Accordingly, we took account of user views in two main ways. First, by investigating the service user data drawn upon by the service designers as they were re-thinking services; this included pre-change evaluations followed by monitoring of responses post-change. Second, by undertaking a thorough analysis of published studies of service user views in the selected areas of sexual health and dementia. The results from this analysis are reported in the next section.

## **2.6 Workshops**

An important component of this follow-up project was a series of feed-back events and workshops for mixed groups of clinicians and managers. At these events the research team presented their findings and then facilitated workshop-style discussion of key themes. These events served multiple purposes: they enabled our understandings and interpretations of local events to be validated and if necessary to be corrected; and they provided an opportunity for our emerging theorising about the nature of cross-boundary clinical leadership under challenging conditions to be scrutinised from a range of perspectives.

## **2.7 Research Ethics**

The study design and the research protocol were submitted for multi-site ethical approval to the National Research Ethics Service (NRES) East London REC 1. The study was approved on 5 November 2010 and the reference number 10/H0721/70 was allocated to the study. In addition, site specific approval was sought and achieved in each of the NHS institutions where staff were interviewed. This included 3 acute hospital trusts, 3 PCTs, and 2 mental health trusts. Letters of Research Access were received in each case.

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## 3 Clinical leadership and cross-boundary service redesign in the literature

### 3.1 *The idea of clinical leadership*

The idea of clinical leadership is high on the political agenda and is also a central theme in current health service policy literature (Ham and Dickinson 2008; Mountford and Webb 2009; Spurgeon 2011). On the day that the Health & Social Care Bill passed its Final Reading in the House of Commons, the Prime Minister stated: 'The point of our health reforms is to *put doctors in charge*, give patients greater choice and heal the divide between health and social care' (HoC 8 Sept 2011 emphasis added). This is but one of many restatements of the general idea that leadership by clinicians is a crucial 'answer' to the many challenges facing the National Health Service.

Under the previous Labour administration, the notion of an expanded leadership role for clinicians was also heavily pressed – most notably in the Darzi Review (Darzi 2008). It has also been promulgated by the administrations of Scotland (NHS Scotland 2009), Northern Ireland (Northern Ireland Department of Health Social Services and Public Safety 2009) and Wales (Faculty for Healthcare Improvement 2010).

Much of the literature on clinical leadership is normative and prescriptive. Influential frameworks of an essentially prescriptive nature have been advanced by leading academics at Harvard. For example, Michael Porter and Teisberg in *Redefining Healthcare* (Porter and Teisberg 2006) make a persuasive case that significant gains in the healthcare industry can only be achieved if healthcare is re-defined from the perspective of just another industry. This fresh perspective, they maintain, allows an escape from the usual limited attempts to make efficiency savings within individual segments (such as a GP practice or an emergency room) and to substitute a perspective which encourages a more radical review of the value chain. Such a perspective would, for example, involve leaders in relocating routine services from high cost specialist jobbing shops to more appropriate settings where advantages could be taken of economies of scale as patient needs are met in service areas designed for such purposes.

In *The Innovator's Prescription* Christensen (2009) similarly argues the merits of borrowing insights from other industries in order to rethink the design of healthcare. He offers a framework, or he says a 'roadmap' (2009: xviii), for those seeking a way to derive innovative solutions in this sector. His work provides a vision and a set of tools for those who might want to rise to the challenge of rethinking healthcare from first principles. It is a prescription based on formal rationality. It does not address how leaders in a complex context such as the NHS might set about making acting in such ideas.

From an operations management perspective, Bohmer (2009) argues that health-care professionals provide two very different types of care - sequential and iterative. With sequential care, a patient can be quickly diagnosed and given predictable, reliable, and low-cost care. But, in the case of iterative care, a patient's condition is unknown, and huge resources may be required for diagnosis and treatment, often with uncertain outcomes. Bohmer argues that to reduce costs and manage care effectively, sequential and iterative care situations require different management systems.

Traces of these influential sources can be found in policy documents issued by the Department of Health in the UK. For example, in *Inspiring Leaders: Leadership for Quality* (Department of Health 2009) which followed on from Lord Darzi's *Next Stage Review* which championed clinical leadership (Darzi 2008), the scale of ambition for service transformation is evident using clinical leadership as a key agent of change:

The essence of clinical leadership is to motivate, to inspire, to promote the values of the NHS, to empower and to create a consistent focus on the needs of the patients being served. Leadership is necessary not just to maintain high standards of care but *to transform services* to achieve even higher levels of excellence. (Department of Health 2009) emphasis added.

This expresses a higher level of ambition than is evident in the related idea of 'clinical engagement' which concerns the ways in which doctors and other clinicians can be 'involved' in decision making. The re-positioning of doctors and other clinicians as leaders represents a further step.

It is possible to conceive of different degrees or levels of 'clinical leadership' – represented as a journey from 'engagement' at one end through to transformational leadership at the other. The Medical Leadership Competencies Model (NHS Institute for Innovation and Improvement Academy of Royal Colleges 2010) with its levels from junior doctor to senior leader, expresses this idea in terms of career stages. This idea of 'progression' can also be used as a means to conceptualise the proposition into stages towards clinicians becoming the key leaders.

An important strand of contemporary debate concerns the distinction between 'leader' and 'leadership'. Central here is the attempt to shift the focus from the individual and individual attributes to the wider social processes involved in leadership as a verb. As Hartley notes it is often useful to distinguish between the person, the position and the processes (Hartley and Rashman 2010). The first of these tends to neglect context, it also often neglects the importance of interactions and of the degree of distributed leadership. Some influential chief executives may exercise leadership from the basis of an authority position. Other players may exercise leadership without occupancy of a formal position.

The extent to which doctors and other clinicians aspire to adopt managerial and leadership roles is an open question: it is one which is addressed in our research. If clinical leadership for service redesign is such a good idea, why has so little of it occurred so far?

Clark, Spurgeon, & Hamilton (2008) contend that the time for clinical autonomy from managerial matters is past and that nowadays doctors and other clinicians need to be at the forefront of transforming services to meet patient needs more fully. They use the findings of two reports on the changing nature of medical professionalism - a King's Fund and Royal College of Physicians report (Dewar, Levenson, & Shepherd, 2008) and an earlier Royal College of Physicians report (Royal College of Physicians, 2005). Both reports argue that organisational skills of leadership and "followership" need to become part of the medical training and medical professionalism, and even that managerial skills could become incorporated into fitness to practice requirements. Clark *et al* make the case for the medical leadership competency framework developed in collaboration between the joint Academy of Royal Medical Colleges and the NHS Institute for Innovation and Improvement. We seek to clarify what such behaviours would look like in practice.

Of course the leadership phenomenon is itself problematical (Storey 2009). There are numerous perspectives on its nature. Distinctions between leadership understood as individual practice (often translated as the charismatic or heroic leader), 'distributed leadership', and 'organisational leadership' as a more complex array of attributes (Tate 2009) are worthy of note. This last conceptualisation highlights the wider system and thus attends to organisational development elements such as identifying obstacles to the practice of leadership. In consequence of these multiple interpretations, our project attends to clinical leadership as a *process* and is as much concerned with the organisational conditions enabling or blocking the practice of leadership as it is with leadership as individual performance.

### **3.2 Functions of clinical leadership**

It seems that policy makers and others (including some chief executives) look to clinicians to 'lead' in order to serve a number of different functions. One of these is to bring on board their professional colleagues; this can be interpreted as part of a workforce strategy. One way to conceive of this is to regard clinical leadership as a form of peer regulation or 'soft governance' (Sheaff et al. 2003). This builds on Courpasson's concept of 'soft bureaucracy' (Courpasson 2000). An expression of this soft bureaucracy may be found in the mechanisms and processes of clinical governance. These preserve the essence of professional autonomy while introducing a modicum of oversight through the use of standards and their monitoring. Clinical leaders may be needed in order to bring clinicians into this regime and to sustain their engagement.

A second function and rationale driving the idea of clinical leadership is the utilisation of their unique technical expertise to ensure that change plans are feasible and beneficial from a patient safety point of view.

This leads to third rationale – to help reassure patients and public that changes are underpinned and meretricious from a clinical standpoint. The reverse side of this coin on reassurance is that as with other leadership positions, clinical leaders are being invited to risk scapegoating if things go wrong or are perceived to have gone wrong.

A fourth function becomes salient when the intention is to seek integration of care in place of fragmented, individual, clinician-to-patient encounters. It has been suggested that a shift to more concerted action requires clinical leadership (Ham 2008; Woodward and Weller 2011).

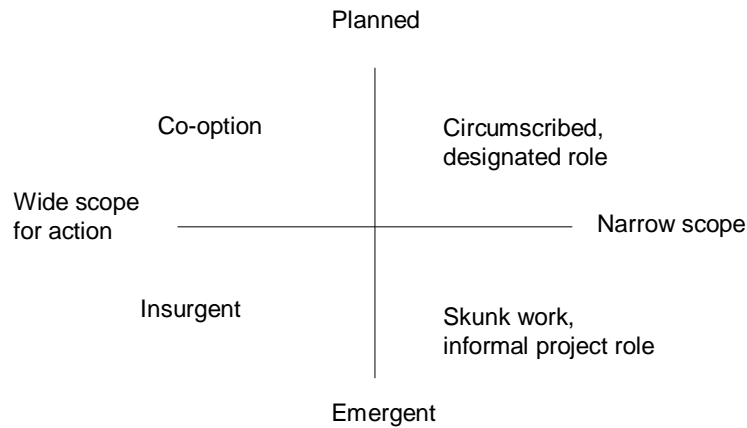
### ***3.3 Distributed leadership and change agency***

Some conceptions of clinical leadership seem to assume the enactment of a traditional heroic individualistic mode of leading. The search for clinical leadership from this perspective would amount to the search for the clinical leader or leaders. From there it is a short step into analyses which seek to reveal the unique characteristics, traits, behaviours and biographies of these leaders – a well trodden route in leadership research - see the summary and critique in Storey (2011).

A significant alternative strand in the literature attends to the idea of 'distributed', 'dispersed' or 'shared leadership' (Gronn 2000; Gronn 2002; Spillane 2004). These themes are further explored in a Special Issue of the *International Journal of Management Reviews* (Thorpe 2011). The distributed leadership research agenda attends first to issues concerning the nature and degree of alignment between different parties to the leadership process, and secondly to the extent to which distributed leadership is planned or emergent (Leithwood 2007; Thorpe 2011). Drawing on this kind of perspective, Currie and Lockett assess the concept of distributed leadership in the context of health and social care. Using existing literature they map a spectrum of variants – from individualistic leadership, through collaborative (Huxham 2000), shared leadership (Pearce 2003), collective leadership (Denis et al. 2001), team leadership (Katzenbach 1993) and 'pure distributed leadership' (Gronn 2002). An important distinction is between distributed leadership modes which depends on and may be sponsored by a managerial hierarchy, and forms which are more bottom-up and which may challenge or bypass the hierarchy.

Another dimension is worth attending to and that concerns the extent to which the leadership influence is wide or narrow. Cross cutting this dimension with the planned versus emergent dimension gives us the types of clinical leadership roles shown in Figure 1.

**Figure 1. Clinical Leadership and types of change**



This framework helps identify the variety of types of clinical leadership. It also helps to draw attention to the need to uncover the situational factors at play in explaining these types. Further, the nature of enablers and blockers can be investigated more fully if the context of planned/emergent and narrow/wide is first understood at the level of intent.

For our purposes in investigating the role of clinicians in leadership there are three important aspects relating to the space occupied along the dimension of scope for action and the dimension of planned versus emergent. These are the pattern of expectations, resources and capability. The *pattern of expectations* stem from national policy implications, trust level messages concerning clinical roles and not least the expectations of clinicians themselves. *Resources* are important in that even when expectations are high the scope for impact can be severely curtailed if resources of time, money, physical and human resources are lacking. *Capability* is important in that impactful leadership requires skilful accomplishment of change agency roles. This requires knowledge, skills and attitudes.

Processes of 'transformational leadership' have been outlined by Nadler and Tushman (1980). These include envisioning, energising and enabling. Leadership itself can also be viewed as a process of influence and mobilisation (Storey 2011). Studies which are relevant to our concerns about the exercise of influence in cross-boundary service redesigns may not necessarily use the language of leadership directly whether individual or distributed. The issue may be framed using different language such as

'organisational development', 'culture change', or 'change agency' (Pettigrew 1992; Bate 2000; Buchanan et al. 2007).

The NHS National Institute has been working on the problem of measurement of clinical engagement. This work has resulted in a 'Medical Engagement Scale' to assess clinicians engagement in leadership and management. The scale makes a distinction between an individual's desire to be engaged and an organisation's encouragement of involvement. Hence, there are two scales – one seeks to measure organisational opportunity (reflecting the cultural conditions that facilitate doctors to become more actively involved in leadership and management activities) and the other a measure of individual capacity (reflecting perceptions of enhanced personal empowerment, confidence to tackle new challenges and heightened self-efficacy) (Barwell et al 2008). Both scales are reflected in our model shown in Figure 1.

Actions by chief executives which were said to be statistically associated with higher levels of engagement were: the participation of the chief executive and/or other executives in doctors' induction programmes; regular formal meetings between doctors and the chief executive and/or other executives to discuss quality, safety and performance; and regular informal opportunities to meet with chief executive and/or other executives to discuss quality, safety and performance. We found similar associations in our previous project (Storey et al. 2010).

An emerging theme in 'service redesign' is to rethink the system around the needs of the patient and indeed to co-design with the help of patients (Bate and Robert 2006). This trend fits with the wider literature on the role of service-users in innovation (Bessant and Maher 2009). This approach can be seen as associated with the grounding of leadership and improvement activity which is known in North American health services as "improvement science". It is built around a codified body of quality improvement techniques.

Each of these ideas may help promote clinical leadership in UK health service redesign. But it is also evident that these accounts do not directly address the everyday realities of constraints and possibilities which face clinicians under prevailing conditions. Before we present our data relating to this aspect it is necessary to examine the literature that has addressed issues of cross-boundary service redesign for, while the language of leadership may not be to the fore in that segment of work, the processes are of direct relevance to our quest.

### **3.4 Cross-boundary care pathway redesign**

The rationale for service redesign stems from the joint clinical benefits and overall cost savings that are promised through reworking the boundary between primary, community based, and acute, hospital-based health services. This is argued primarily with regard to long term conditions, such

as cardiovascular disease, asthma, dementia and diabetes. The potential benefits of this approach were articulated by Feacham (2002) who compared the acute in-patient treatment focus of the NHS with the integrated chronic care model of Kaiser Permanente in California. Ham describes the Kaiser model in terms of locating specialists relevant to common long term conditions within primary care clinics, combined with risk assessment of the patient population served. This provides the basis for early diagnosis and involvement of patients in life style changes and treatment that will manage or arrest the development of more serious morbidity. The intention is to significantly reduce or even eliminate costly unplanned hospital admissions

Commentators in the UK and Canada have reported the benefits of schemes to provide integrated early intervention health and social care for the elderly within community-based teams. Such arrangements can be thought of as offering a kind of “horizontal integration” across established boundaries of health and social care. This complements the “vertical integration” between primary and acute care central to the Kaiser Permanente model .

Care pathway redesign to bring primary and acute clinicians into closer collaboration is often advocated because of its potential for saving cost, or for increasing coverage without commensurate increase in costs. Early intervention has also been advocated by clinicians independently of government - the Royal College of Physicians (RCP) has pressed for greater collaboration between specialists and general practice in ‘an integrated model of care, where multi-professional teams work in a managed network across the interfaces and manage patients in a care pathway designed by local clinicians’.

A further strand concerns the idea that health services need to be designed in close dialogue with users and potential users. The case is that it is only through their active input that effective bundles of services that deliver what patients want and need can be produced. This view has featured prominently in UK health policy under both the post 1997 Labour administrations and the subsequent Coalition. However, an authoritative analysis of national patient survey data has concluded that ‘the service as a whole is still far from patient centred. The most significant problem is the failure of clinical staff to provide active support for patient engagement’ (Richards 2007: 4)

In summary, the literature points to a number of innovative ideas for redesigning services and for the potential engagement of clinical leaders in such changes. These include ideas about the need for clinicians and managers to work in tandem, user-centred redesign, user involvement, the enablement of users through telemedicine, early intervention and personalisation. But, while all these ideas offer potentially useful ways to cut across traditional boundaries and to produce more effective modes of treatment, they do not attend to the practical matters which may inhibit



their use. We contend that it is necessary to re-think and re-conceptualise the process of clinical leadership and what would be entailed by its realisation. Such a re-conceptualisation is developed through the detailed case analyses which follow.

## ***PART 2 CLARIFYING THE CONTEXT***

Part 2 contains two chapters. The first sets the scene for understanding sexual health services; the second does the same for dementia services. In both, the user perspective is given emphasis.

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### **4 Sexual Health: issues, services and user perspectives**

In this chapter key facts and issues relating to the idea of 'sexual health' are outlined. The pattern of service offerings is described and this is followed by an outline of user perspectives.

#### ***4.1 Issues in sexual health***

Sexual health services span a range of interventions from straightforward prescribing of contraception to the treatment of highly infectious sexually transmitted infections (STIs) including HIV.

Traditionally, in the UK at least, there has been a significant divide between two sides of the service: family planning on the one hand and the diagnoses and treatment of sexually transmitted diseases on the other. The former service dealt with women and girls who required contraceptive advice and interventions. It was a service staffed mainly by female doctors and nurses, both working on a part time basis in community settings. In contrast, the services dealing with sexually transmitted diseases were, and to a large extent still are, mainly located within acute general hospital settings albeit in fringe accommodation and are led by doctors specialising in genitourinary medicine with some also specialising in HIV.

In the past, there was 'deliberate concealment of genitourinary clinics in inaccessible locations, giving them euphemistic titles [this] served to disguise their true identity and purpose. These physical and linguistic efforts to render open access difficult have reinforced public silence and ignorance of the nature of STIs, paradoxically contributing to their further stigmatisation' (Scoular 2001: 343).

There have been many far-reaching changes in some locations since this statement was made. For example, a number of clinics now offer a full range of free services and treatments for all sexually transmitted infections and some have a High Street presence. Appointments within two days and a walk-in service are now more common. These clinics may be staffed by nurses and they offer both contraceptive and sexual health services

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including free testing and treatment for sexually transmitted infections including HIV as well as chlamydia, gonorrhoea and syphilis.

One of the major drivers for change and for the national strategy was the degree of unmet demand. Demand for GUM services outstripped capacity to such an extent that internal efficiency savings by normal means could not hope to address the extent of the problem (Clarke 2006).

One of the key service innovations – and one which we focus upon in the fieldwork reports which follow - is the integration of Family Planning/Reproductive Health with GUM departments. These integrated services offer other STI diagnosis and treatments alongside, the treatment of sexual dysfunction and health promotion. Integration places new demands on staff training and, as we will see in the case studies, these needs have not as yet been fully met as national systems lag behind local leadership initiatives.

The National Strategy for Sexual Health 2001 classified services into three levels based on degrees of complexity. The idea was to align level of service provision to the capacities and capabilities of the different units to provide these services. It offered an outline vision of wholesale service redesign. Training, outreach programmes, quicker and more access, along with reassigning STI and family planning responsibilities were to the fore. Then in 2006 the Department of Health published 'Ten High Impact Changes for Genitourinary Medicine 48 hour Access'. This suggested ways to achieve access and effectiveness through better measurement of demand and capacity, processes improvement projects to inform service redesign, multi-disciplined teams, developing separate pathways to manage screening, the reorganisation of opening hours, and transparent costing.

The high demand prompted a further DH set of guidelines 2 years later in February 2008 *Genitourinary Medicine 48-hour access-Getting to target and staying there*. It recommended outreach centres to decrease the transport time of patients, centralised booking systems, telephoning for appointment booking, and marketing sexual health services. The publication included a range of examples of projects from around the nation serving to inspire and share ideas.

In July 2009, the report *Moving forward: Progress and Priorities-Working together for high-quality sexual health* reviewed progress since the National Strategy was launched. This document also provided a road map for new priorities including a redefining of strategic partnerships, improved and detailed commissioning, emphasis on prevention, and delivering modern sexual health services. Within this, cross-departmental working was encouraged with an acknowledgement, for example, that sexual health is linked to alcohol use.

## **4.2 Users and Carer perspectives on Sexual Health Services**

A useful place to start is with what people who utilise these services should be called. Would they prefer to be known as clients, users, customers or patients? A survey conducted in five UK clinics found that the majority of attendees preferred to be called 'patients' while very few preferred the term 'client' or 'user' (Loudon 2012).

Beyond the label, there are a number of studies which capture priorities among the expectations and wants held by patients/service-users. These cluster around issues relating to access to services (a high priority when in some cases access has been very difficult), the physical environment where services are delivered (often perceived as neglected and under-resourced), the need to feel respected, to have confidentiality protected and so on.

Priorities concerning confidentiality and the importance of a lack of judgemental attitudes have been identified among service-users (Morris 2001). A further factor, especially in relation to the concept of 'integration', is the attitude of patients attending GUM clinics to the idea of sharing patient records with GPs. A significant proportion (nearly half) of users were unhappy about such a prospect and a quarter said it might deter them from attending the clinic in future (Fernando 2007).

Studies of patients attending clinics tend to reveal a familiar pattern of wants: for clinics to be open in the evening and for longer hours in general, a location away from the main out-patients department; an open access, walk-in service; most patients did not want the result of the consultation to be sent to their general practitioner (GP) without their consent; and they wanted improved reception areas (Munday 1990; Evans 1996; Armitage 2004; Monteiro 1995; Munday 1990).

An important re-design has been the development of 'integrated' GUM and family planning services. This has allowed longer opening hours, provided wider access and driven productivity improvements. Patient views about these are available from two studies. Melville found that 99% of participants expressed a preference for immediate microscopy results and treatment and were willing to wait for these (Melville 2004). While Baraitser et al. describe the client experience of self-management at a High Street walk-in integrated sexual health service in London. This allowed self-registration on a touch-screen without recourse to a receptionist. Service-users reported that they valued self-management because of reduced waiting times, autonomy and privacy (Baraitser 2011).

In conclusion, user views about sexual health services have been sought by a significant number of studies over the past twenty five years. Would-be designers of reformed services in this area would seem to require attention to a set of fairly consistent pattern of user/patient views. There needs to be better knowledge of the availability of services; better access to the services once identified and people seem to prefer walk-in clinics. Attitudes

are loosening regarding one-stop shop or integrated services for FP and GUM. Patients want and expect a professional service with high regard to confidentiality, respect and a non-judgemental approach. There is increasing tolerance of service from a range of different types of professionals.

Next, we turn to an overview briefing on dementia services and user perspectives on these.

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## 5 Dementia: issues, services and user perspectives

### 5.1 Issues in Dementia

'Dementia' is an umbrella term for several diseases associated with irreversible cognitive impairment. It presents a massive challenge to health services and to society in general. It is associated closely with age. As the population in the UK and in many other countries ages, the incidence of dementia is likely to increase.

As a condition, dementia does not fit well with the current organisational arrangements and structures of the NHS and of social care. In part, it is seen as mental illness and is therefore allocated to Mental Health Trusts, in part it is seen as part of the ageing process and so is often treated by medics in 'care-for-the-elderly' wards of acute trusts and, in part, it is seen as suitable for management in the community by primary care and community teams. In addition, people with dementia may find themselves in the care of independent sector residential homes for the elderly or in part-time care of voluntary sector organisations when they visit Day Centres.

This fragmentation creates its own problems. It is also reflective of wider issues in mental health where, as a recent King's Fund report notes: 'Health and social care services in England are not currently organised in a way which supports an integrated response to the dual mental and physical health care needs of patients (Naylor and Fossey 2012: 2).

Dementia is even more expensive than the cost of cancer, stroke, and heart disease and yet receives significantly less research funding. The National Dementia Strategy (Department of Health 2009) has been influential. This strategy emphasized the need for early diagnosis, individual care plans, support for carers, psychological and alternative therapies, and specialist staffing.

With 50% of dementia care in the U.K. provided at home by partners or families and the high cost of residential homes, carers are seen as requiring greater support in a variety of community based settings. A number of alarming reports from bodies such as have the Alzheimer's Society and the NHS Confederation, in association with Age UK and the Local Government Association, have drawn attention to the neglect of elderly patients generally and those with dementia in particular (NHS Confederation 2012). These reports stress the importance of care with dignity and the need to listen to individual patients and to tailor care to their needs. 'Leadership' is

also highlighted and as means to readdress the balance in the nature of care (NHS Confederation 2012).

Dementia sufferers utilise the health care system in many ways. Patients and/or carers usually approach their GP in the first instance after becoming aware of memory deterioration or mood swings. The Alzheimer's Society voices a concern that one-third of GPs are not confident about diagnosing dementia. Current guidelines suggest GPs refer patients to the local 'memory clinic'. The April 2011 QOF (Quality Outcomes Framework) suggests testing for dementia (at the recommendation of NICE) before referral.

Memory Clinics associated with an Acute Hospital Trust offer laboratory and psychological testing and may use brain scans to confirm the location and severity of any damaged areas. Once diagnosed, patients who carry on living at home may be supported by NHS community health personnel. Charities such as the Alzheimer's Society, Age Concern, Dementia U.K., Dementia Care Trust, are also involved in offering support services.

A series of central guidelines have been issued over the past decade. The most significant was the National Dementia Strategy (Department of Health 2009). This focused on raising awareness of dementia, early diagnosis, easy access to care and peer support. It was followed by a number of further guidance notes which emphasised local delivery and accountability and reduced use of antipsychotics (Department of Health 2010). The report emphasised risk enablement, person centred decisions, and maximum independence. In the following year, *A Good Practice Compendium* featured a series of local initiatives which the Department of Health thought worthy of sharing across trusts (Department of Health 2011). These initiatives mainly focused on good practice in the areas of training, pathway design, at-home services, memory assessment and patient day-services.

## ***5.2 Users and Carers Perspectives on Dementia Services***

Here, we report on user and carer expectations, priorities and evaluations of dementia services as well as their views about perceived gaps in service provision.

There have been a number of studies of patient and carers, experiences with dementia. These cover, for example, patients' experiences with residential care homes and day care centres (Aggarwal 2003); family carer's experiences with community services (Winslow 2003); and views of dementia carers about services in general and about their own plight (Georges 2008). Gaps in services such as insufficient respite provision, home care, day care and the activities provided, and transport have been reported (Innes 2005; Hennings 2010).

Dementia sufferers in residential and day care settings have been consistently found users expressing dissatisfaction about the lack of

stimulation, the lack of choice, lack of contact with others and restrictions on independence (Aggarwal 2003) (Train 2005) (Lintern 2000).

A review of 35 papers containing empirical evidence on patient and carer experiences in the transition to dementia was undertaken by Robinson et al (2011). The vast majority of people with dementia wished to know their diagnosis. The key challenge for the person with dementia was coming to terms with losses on multiple levels. For family carers, becoming the main decision-maker and adjusting to increased responsibility were common concerns (Robinson 2011).

Of particular relevance to our study are investigations of user and family carer responses to the new breed of 'Memory Clinics'. The Croydon Memory Service Model was developed to identify and treat people in the early stages of dementia. It was a precursor to the subsequent National Dementia Strategy (Willis and Banarjee 2009). They conducted semi-structured qualitative interviews with people with dementia and with family carers to establish their opinions of the service. They found that peer support and clear communications were seen as valuable assets provided by the service allowing participants to use coping strategies.

In summary, these studies of the user perspective found they wanted attention paid to more individualisation, more communication and consultation, more respect and dignity, better relationships including an environment which legitimised and allowed complaints, more social interaction and activities. Conversely, they wanted to see less of the behaviours which led to the reduction in these valued elements.

But while many studies focus on patient and carers responses to the specific services that they are receiving in care homes, hospital wards, or day centres, far fewer studies have sought to address the kind of cross-boundary, wider system, issues that we want to examine. So, authorisation of clinicians to think about services holistically is vital, and clinical leadership that takes a partial view is not responding to what users and carers need.



## ***PART 3: EMPIRICAL FINDINGS***

In this third part we report the findings from the fieldwork drawing upon interviews and observations.

We begin with a summary of the main findings as generated from these sources.

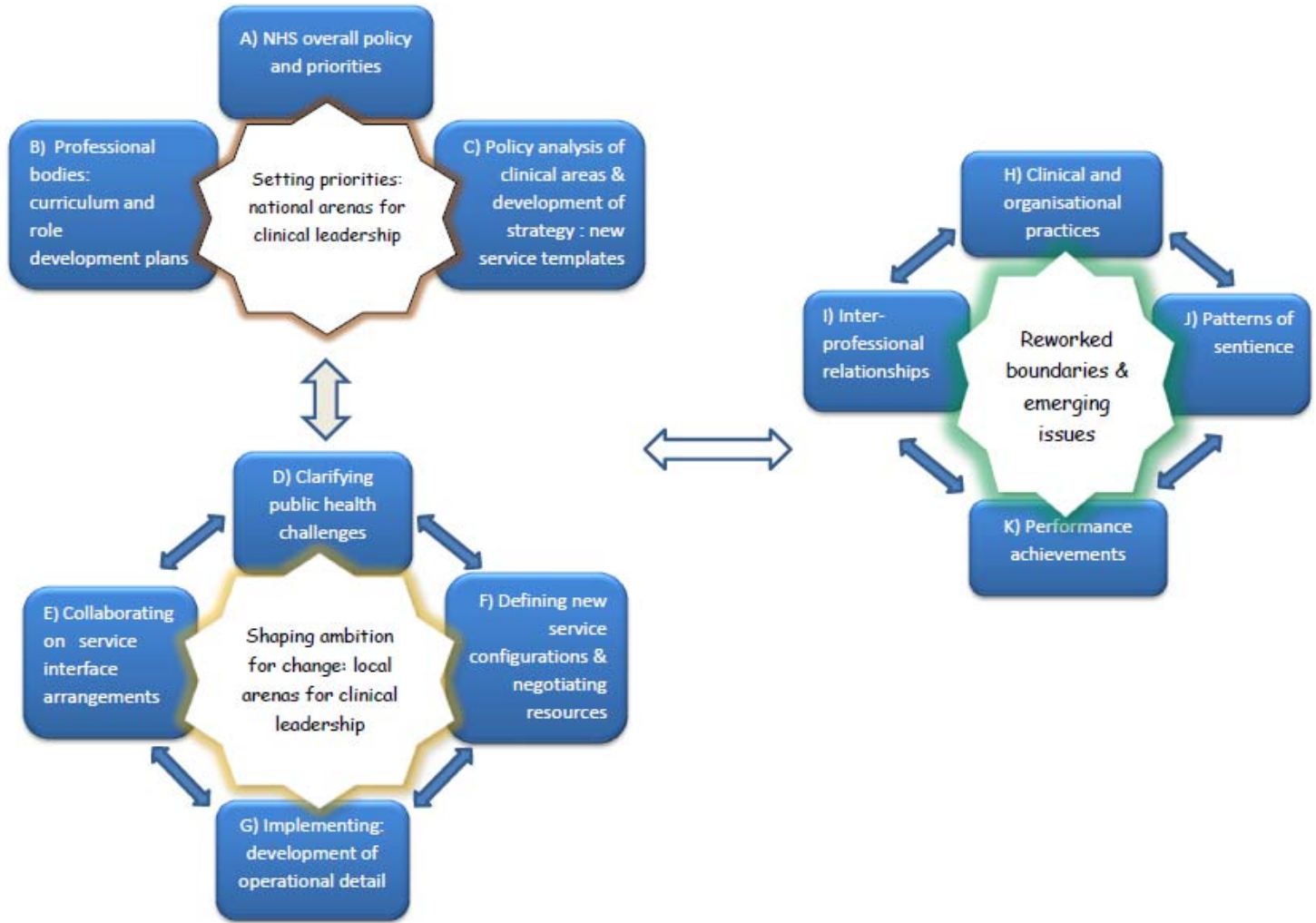
Each of the cases revealed ample evidence of the barriers to cross boundary clinical leadership and indeed to clinical leadership for service redesign in general. The case descriptions which follow will identify the nature and extent of these barriers. They will also reveal clinicians' interpretations of the difficulties they faced.

But while it is tempting to focus on the barriers (because of the sheer scale of these in most of the cases) it is important also to highlight those instances where clinical leadership was sufficient to *overcome* the barriers. The surmounting of the difficulties made the found examples of clinical leadership all the more fascinating and impressive. In each of the cases which follow we were able to find examples of clinical leadership. Our main objective was to try to identify the factors which enabled this form of leadership.

From a very detailed analysis of interview transcripts from the different service areas, we found that the operation of barriers and enablers to clinical leadership for cross-boundary service redesign can be understood in terms of the interaction between three kinds of phenomena. These are: how

- **national policy shapes the context** for attempts to redesign services; the different
- **local arenas in which clinical leadership may be practised** in some way to bring about service improvement and redesign; and the impact of all of these in terms of the
- **different kinds of boundaries that are being reshaped.** These elements are shown in Figure 2 below.

Figure 2. Framework for understanding clinical leadership for cross boundary service redesign



**The 'setting priorities' constellation** of the figure indicates that the context for local service redesign is set by national developments in three kinds of forums. Each of these forums involves clinicians with national roles, and so can be seen as sites at which clinical leadership takes place on a national stage, involving clinicians authorised to act at this level. However, as in other boxes in the diagram, clinicians can only shape developments by leading collaboratively with non-clinical leaders. Each box is characterised by its own constellation of clinical and non-clinical leaders.

Box A in Figure 2 refers to the setting of overall NHS priorities, which are reviewed and revised annually, and published in the Operating Plan. This is the responsibility of the NHS Management Board, which includes clinical input from the NHS Medical Director. Box B refers to national policies for the development of particular clinical professions. In the case of medical specialisms, nursing and allied health professions, this takes place within Royal Colleges. Although these have rather different functions in medicine, nursing and for allied health professions, Royal Colleges all have a role in reviewing the current state of their respective professional group and likely future developments in roles, and in controlling the curriculum for specialist training and admission to full membership. This work is usually carried out by committees or working parties of senior professionals. These developments may have impacts on how professionals in local services view the need for service change. Just as likely, developments in cross boundary service redesign at local level may have implications for the roles of some or all of the clinical professionals involved, which may challenge existing policies or curricula endorsed by their professional institutions.

Box C refers to strategies developed at national level for the future of particular clinical areas. We have already referred to recent national strategies for Dementia and Sexual Health, which had significant roles in shaping the course of events in the cases we studied. These strategies are usually developed by working parties with a significant representation of senior clinicians. They thus represent another national forum where a form of clinical leadership can be exercised. National strategies typically analyse how services are currently delivered, and outline new approaches and templates for improving them in the light of existing performance and emerging public health needs. As we shall see, these new templates may involve significant reworking of service boundaries at local level.

**The second constellation** of Figure 2 (*shaping ambition for change at local level*) shows four arenas in which clinicians may become involved in some kind of leadership to reshape particular services at local level. Again, in each one, clinicians typically need to work with non-clinical others in order to achieve change. However, as we shall see, it is not actually necessary for clinicians to be involved significantly in all four kinds of arenas for progress to be made. It is perfectly possible for leadership to lie firmly with non-clinicians in some of these four arenas. An important issue for consideration in each of the cases we report is therefore the extent to which

clinicians were actually involved in these four arenas and the benefits and problems that arose from this level of involvement.

Box D refers to the work of clarifying public health needs at local level, and evaluating the relevance of templates emerging from national strategies. This work may be undertaken by a combination of senior clinicians from provider services, public health professionals employed by a PCT or local authority, and senior commissioning managers. Box E refers to an emergent and continuing kind of leadership at the boundary interfaces between existing services. So, different acute services may, for example, look at how they avoid duplication in what they do, or expedite referral of appropriate patients between their services.

In contrast to such leadership work focussed on smoothing the operation of existing services, Box F refers to the leadership work of deciding on significantly new service designs or configurations in the light of public health analysis, and reconciling these new designs with available sources of NHS funding. This may mean redeploying existing funding or finding additional funds associated with national or regional initiatives. This leadership work may involve senior clinicians from provider services, working alongside commissioners and service managers. This layer of the framework is then completed by the kinds of leadership activities shown in Box G. This box refers to the leadership work of implementing new service designs once they have been resourced. As the diagram suggests, this commonly draws on the emergent collaborative leadership of Box E. It typically involves clinicians of several different professions and at different levels working together with service managers and other occupations, including estates management and information systems.

***The third constellation (reworking boundaries)*** which is shown on the right hand side of Figure 2 conceptualises what exactly needs to be acted upon when services are redesigned. It distinguishes three different kinds of boundaries that may need to be reworked. Box H refers to how clinical practices themselves may be re-organised, for example through previously distinct services being delivered together or a new referral route significant changing the patient journey. Such changes in clinical practices commonly need to be accompanied by changes in how clinics are organised, and how clinic activity is reported and funded at a detailed level. Box I refers to changes in professional roles and relationships that commonly accompany such changes in the care delivery. Box J (patterns of sentience) refers to changes in group identity that clinicians may experience as a result of these service redesign efforts. The concept of 'sentience' (Miller and Rice: 1967: 259) \* describes the ways that individuals identify themselves as 'belonging'. So, as we shall see, establishing a new network of clinics that combine functions previously carried out elsewhere may challenge established allegiances. Are they still primarily a member of their employing

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\* Miller, E. J and Rice, A.K. (1967) *Systems of Organization: the control of task and sentient boundaries*, Tavistock Publications, London

trust, of their home specialism, or is their membership of the new integrated clinic or network of clinics becoming more significant for them? Balancing and working with such issues of sentience may have major implications for the success of new arrangements and so are important factors to consider for clinical leaders engaged in shaping and implementing new service designs.

Finally, Box K in the diagram refers to the performance outcomes in terms of how effectively public health issues are being addressed by the redesigned services. In the case descriptions that follow, we use the categories of Figure 2 to bring out the key enablers and barriers that have shaped the way that clinical leadership across the four Boxes (D,E,F and G) have reshaped the boundaries described in Boxes H, I and J. These in turn produce the service performance outcomes described in Box K. We discuss how various forms of clinical leadership have led to the reworking of boundaries, showing what has been resolved and what remains unresolved.

So, in this introduction to the empirical findings we have presented an emergent conceptual framework of the factors found to be involved in the clinical leadership of service redesign. Together, these help lead towards an emergent theory of the realistic nature of clinical leadership. In each of the four case descriptions which follow (Chapter 6 and 7) this theoretical framework is used at the end of each one to help unpick and crystallise the clinical leadership lessons from each of the cases. Then, in Chapter 8, cross case comparisons are made using this same conceptual framework.

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## 6 Clinical Leadership in Sexual Health

In this section we present an analysis of the Greater Manchester sexual health case and then of the London sexual health case.

### 6.1 *The Greater Manchester Sexual Health Services Case*

For ease of access to this case – as with each of the others which follow – we organise the material under four basic headings: (i) the background conditions and prompts for change; (ii) the nature and extent of the changes and the achievements; (iii) change processes, pitfalls and barriers; (iv) the lessons to be drawn about clinical leadership.

The emergent conceptual framework shown in Figure 2 will be used to analyse the clinical leadership lessons in sub-section (iv) at the end of the case. Before that stage, in order to understand what was happening in each of the cases, it is first necessary to describe the forces and events pertinent to each by attending to the background conditions, the nature of the changes brought about and the change processes.

#### 6.1.1 Background conditions and the prompts for change

The first point to note is that service redesign in this health economy, while pioneering in many respects, essentially followed on from the National Sexual Health Strategy document first published for consultation in 2001 with a subsequent action plan for sexual health issued in June 2002. Hence, it could be said that strategic changes were driven from the top. The national sexual health strategy was constructed following consultation with a wide range of stakeholders including clinical professionals and service-users.

The context was a notable level of unmet demand. The national strategy document envisaged an integrated service which would merge family planning and GUM with access to 'one-stop shops'. This was described as part of a 'modern, comprehensive, sexual health service' (DH 2001: 22). It meant 'giving staff the education and training they need to work together and provide an integrated service' (2001:23). The drive for change was assisted by extra funding for sexual health. In Greater Manchester, the particular PCT that we studied was prompted by the funding implications and became energised to drive through the change. A number of clinicians admitted that they were initially sceptical about these 'weird' ideas although most came to accept that the changes have been beneficial. On the other hand, some nurses did not accept the service changes and the associated changes in work contracts and patterns and so they left the service.

The service transformation in this area coincided with developments in the Greater Manchester sexual health network of which it was a part. It is therefore very difficult to fully disentangle one from the other. The Network covers a population of approximately 2.5 million people. It includes 10 PCTs, 10 Acute Trusts and 10 Local Councils. It is funded by all the Primary Care Trusts in Greater Manchester. It was established to help implement the National Strategy for Sexual Health and HIV. Hence, in this case as in our other three cases, the prime drive for change derived from a national initiative. What is interesting about this case is the way that the general intent unfolded differently within local areas – in this instance despite the existence of the Greater Manchester Network umbrella. It seemed that the ease of journey towards adopting the national vision was influenced by different starting points, and was crucially influenced by different staffing arrangements, skills and relationships.

The Greater Manchester Sexual Health Network has been recognised nationally as a lead initiative. It was the UK's first comprehensive Sexual Health Network including amongst others HIV, genitourinary medicine, family planning, contraception, conception, teenage pregnancy and abortion services provided by the statutory, community and voluntary sectors.

Its elements include a comprehensive vision of the range of services including self care and health promotion, local community services including GPs, pharmacy, midwifery and hospital services such as GUM. These were arranged conceptually as a pyramid structure known as the 'Good Health Model' (see Figure 3).

The reforms of sexual health services in this case were a leading part of the achievements of this Greater Manchester wide network and are now seen as a lead model for that whole network. To appreciate the scale of these achievements it is necessary to consider the nature of the service provision prior to the changes which were first initiated in 2004.

Sexual health services in Manchester as elsewhere in the NHS were traditionally regarded as rather marginal and self contained. Before the reforms the problems reported can be summarised as:

- waiting times for appointments were far too long: as much as six to eight weeks
- access was difficult (including limited opening hours)
- premises were neglected
- the service was regarded as a poor relation
- only a fraction of the expected demand was being met
- family planning was separate from STI services
- there was awareness of considerable service user dissatisfaction

- clinicians felt constrained by a paper-based records and referral system
- GUM was located in a “corner” of the acute hospital with only 0.6 of a consultant post
- Access to clinics was limited. Family planning clinics only operated during some afternoons and a couple of hours on a few evenings a week.
- Family planning clinics were staffed by sessional clinicians and so both management and change were very difficult to accomplish

And the problems may have been intensifying: ‘There was this growing issue around the problem of chlamydia and increasing sexually transmitted infections. This was especially so because we’re situated in Manchester, quite near the gay village, so there was an increase in things like HIV and syphilis and gonorrhoea. It was massive and certainly the service that was run at [M1 Acute hospital] would never have coped with that. They just could not have kept up with that and it wasn’t accessible. People wouldn’t use it; people were frustrated with it; we had to make it more accessible to them’ (senior nurse).

The staff at all levels prior to the changes were very aware of the service shortcomings. These included the low rate (0.5%) of patients being seen per 100,000 population when national averages suggested the rate should have been above 2%. In other words, there was unmet need. It was also accepted, in retrospect, that the main response from the staff had traditionally been simply to ‘try to push all the time for more staff’ [doctor].

These were serious problems. Even the staff found it difficult to make appointments for service-users. For example, family planning staff found problems in cross-referring clients for STI tests:

‘When I talked to most of these women [who came in for pregnancy tests] I realised that they were also putting themselves at risk of sexually transmitted infections. Yet all I could say to them was “Well, you need to come in to be screened” but I also knew that there was an eight-week waiting list was just to be seen’ [nurse]

These staff were frustrated by the ‘buck-passing’ as they saw it between different parts of the fragmented service:

‘The public health director said that he felt that GPs could be picking up this kind of work. I feel very strongly about that because I’d worked in Manchester an awful long time with an awful lot of GPs and I knew that the provision of contraception was poor’ [nurse]

But what was unusual about this nurse was that she took action to try to change the system and she started, as was required, by collecting relevant data using a questionnaire:



'Frankly, the GPs are not providing this service and I needed to prove it. The results were as I expected – very poor... well, there was simply no interest there' [nurse].

The reasons that were uncovered were that some GPs felt that they were not sufficiently trained to offer these services; others reported that they were under pressure to prioritise other things like diabetes, chronic COPD, and other such conditions. Those kind of services generated income into the practice whereas contraception and STIs did not. The QOF only offered low payment for contraception.

Other difficulties were found within the then family planning service itself. A key issue was the nature of the staffing and the limits this placed on the room for manoeuvre. The reproductive health care service was staffed largely by what one nurse described as ladies who had worked in the past as midwives or school nurses and who had retired from these careers but had put themselves forward to 'do the odd session' in reproductive health because it offered part-time work with no other strings or commitments. It was sessional work and it was very difficult to persuade these staff to undertake continuing professional development. Some of them also had other jobs.

So, to keep the service coherent at that time and to keep the staff trained up to date was very difficult. Additionally, there was no investment from the PCT in reproductive health care; 'the budget was really, really small'.

Likewise, the GUM service only had a half time consultant and was a part time service. As one informant said:

'The service was limited by the fact that nobody invested in it; the hospital weren't interested in genitourinary medicine service. It was tucked away in little corners and it just managed itself, nobody was particularly interested in managing it and staff weren't particularly accountable' [doctor]

It was against this backcloth of enormous difficulties that leadership, albeit tentative and hesitant at times, did eventually emerge and make a very significant impact.

### **6.1.2 The nature and extent of the changes and the achievements**

A national STI access target of 48 hours was introduced which Manchester was able to meet, but, given the extent of the problems as described above, this required extensive changes. This required service transformation and leadership. Its elements are described below:

- An integrated service offering both reproductive health (family planning) and genitourinary medicine (STI service) was introduced. This meant that different sets of staff were brought together. They were not simply co-located they were also cross-trained so that staff could offer either service.

- The service redesign was 'built around the patient'. Tests for sexually transmitted infections and the prescribing of contraceptives were made available in one integrated service which avoided past duplication.
- The new combined sexual health service relocated out of the margins of the acute hospital grounds and were placed into more easily accessible and local community settings and high street clinics.
- A Hub and Spoke clinic system was introduced – five spokes which could offer Level 1 and 2 services and a hub which could provide Level 3 services including HIV support.
- A new IT system which allowed on-screen access to patient records across all clinics and immediate booking for someone attending a Spoke clinic who needed referral to the Hub.

As a consequence, the following benefits were reported:

- This area of Greater Manchester always had the highest rates of STIs in the region. Now it is below average for all STIs except HIV and syphilis
- A 48-hour access time for referral for STI treatment, required by the National Strategy, has been achieved for 99% of service users.
- There has been a significant increase in the number of people attending annually. Waiting times were drastically reduced. A hub and spoke system, underpinned with new IT, enabled seamless and instant referrals to more complex services thus helping to ensure quicker and surer attendance. Services were not only improved for existing patients, many more patients were able to be seen as a result of the redesign work.
- Services are now available five days week service across the system of clinics - though not in each individual clinic.

This model of provision has been held up as an example of good practice across all 10 PCTs in Greater Manchester, and recognised by the Department of Health as an exemplar of integrated care, as well as by Nursing Times. There have been numerous visitors from other services seeming to learn from what has been achieved.

It cannot be said that clinicians actually led this service redesign in the first instance. The impetus mainly came from commissioners. Though, as we will see in more detail below, a number of clinicians did help to lead the implementation of the change. Those clinicians unenthusiastic about the change tried to argue there was a lack of evidence to justify this kind of redesign. There were few proven examples – just a few isolated ones such as the Garden Clinic in Slough and one in Glasgow (the Sandyford Initiative).

But in the end, even the resisting clinicians acceded. As one said: 'we had no choice'. However, some staff – mainly nurses – did leave. There were different interpretations about whether these were resignations because of dissatisfaction with the new arrangements or, conversely, a need to leave because the new ways of working required a different level of full time commitment rather than the previous pattern of sessional attendance. Family planning and sexual health became a 'one stop shop'. To operate this in a meaningful way it was necessary to get the nurses cross-trained so they could do both FP and STIs. This was reported as stressful for some staff.

The results and achievements deriving from the leadership efforts of clinicians and managers in this case were very substantial. Diverse and inadequate services were redesigned and service levels improved significantly. The previously segmented services of genitourinary medicine and family planning were integrated and patients were, for the first time, able to access an integrated suite of services.

Health service provision rarely remains static. In this case too, there are continuing changes to priorities, to funding and to policies. These include:

- overall possibly a somewhat lower national priority for sexual health now than a few years ago
- some fragmentation of services with the introduction of competitive tendering
- The ten separate sexual health services across Greater Manchester may not survive as such; there is likely to be a need for some combining of services, and a reduction in the total number of clinics.

This last point seems especially important. Much of the current dynamic is driven at the network level. For example, the 'RU Clear' programme offers the public face of sexual health in Greater Manchester. It offers a range of free testing services and channels including postal testing kits and a free confidential help advice line for the whole of Greater Manchester.

Within Greater Manchester as a whole, other changes continue to evolve:

'Originally we had this very fixed idea of a model where there would be a hope it would deliver level three services which would include psychosexual and erectile dysfunction and then there would be spokes that would deliver sort of level 1.5 we thought, or around about that. And now the model actually looks different in that the spokes deliver up to at least level two, perhaps in some cases beyond because competencies of the staff have increased over time and demand has increased and technology has improved. 50% of the nurses can fit coils and are non-medical prescribers. That certainly wasn't the case when we first put the model together. We didn't sort of envisage that far ahead' (senior nurse).

The point here is that change has its own dynamic. Service transformation is rarely fully planned: a direction of travel is set and the first few stages of

change set out. But, once underway, new possibilities open up and are realised as the old model is unfrozen.

But, a consequence of these service changes is that patient consultations are potentially more complex and so there are implications for staff skilling. We address this issue in the next section.

### **6.1.3 Change processes, pitfalls and barriers**

Rethinking service design required changes along a number of dimensions simultaneously. These included a rethink of staffing and skills, technological support and the locus of leadership.

Moving from a set of part-time and segmented services to a full-time, integrated one-stop service required changes to staffing. This entailed a shift from 'sessional', incidental work by doctors and nurses to full time contracts for nurses which would allow multidisciplinary training and a career structure.

Managing this transition required care. 'There were a lot of people who had worked in it for years and years and we'd say, this is the way we're going to take the service, we're not going to employ people on sessional basis anymore, but you're more than welcome to apply for the job, so we had to make some people redundant' (senior nurse).

This increasingly nurse-led service is not without its difficulties. In reproductive health care some patients have complex medical histories and the standard patient group directions (PGD) are not always applicable. Yet there is an ongoing need for contraceptive cover and 'usually when they need it patients need it now'. They may have 'come in for emergency contraception and I can't make this decision because all of it is contra-indicated on my PGD, I don't feel that I can make this decision really and it's, where do you take that?' So, there is an issue here of role responsibility and appropriate support. The more skilled nurses become, the more is expected of them; and the less likelihood there is of employing doctors with similar skills.

At the time of our research, the service was seeking to recruit an additional consultant who would ideally be dual-trained in family planning and sexually transmitted diseases. As in the London case, this was at the time proving difficult. The Royal Colleges and the training system for doctors were lagging behind developments on the ground. The British Association for Sexual Health and HIV (BASHH) seeks to be the lead representative and training body for those practicing sexual health and HIV. But it does not currently embrace family planning. The Faculty of Reproductive Health tends to lead in the latter area. BASHH was founded in 2003 from a merger between the Medical Society for the Study of Venereal Disease (MSSVD) and the Association for Genitourinary Medicine (AGUM) both of which were originally founded in 1922.

Training nationally is still largely separate – this causes problems for those attempting an integrated service. Doctors are still mainly trained in either GU or reproductive health; the result is that there are not enough cross-specialist Registrars to fill posts in integrated services such as Manchester's which is ahead of the curve. But BASHH is seeking to extend its regulations over new independent providers. BASH and Faculty of Reproductive Health are not as yet working sufficiently together. A similar problem was faced with the nursing staff. Achieving dual training for nurses required bespoke arrangements with local university providers.

The services are currently provided on an integrated tariff. One contention is that it would be preferable to have some unbundling of the tariff and better allocation of funds across different types of service. The tariff pays for swabs to be taken, for diagnostic tests and for feedback to patient. But there is little time for counselling.

Respondents argued that new **information technology** was crucial in order to make the change work in practice. The two services went from an entirely paper based to an electronic system. This allowed sharing of a common database and, perhaps most importantly, instant booking for appointments – this being very important when the referral was made from a spoke clinic to the hub clinic. The incidence of non-attendance declined sharply.

There were however a number of transition problems. The most notable example was found in IT failures. Implementation needed managing and staff felt that this was initially pushed through too rapidly and this caused mistakes to occur. Nonetheless, the new IT was seen as vital to the change: 'Without a good IT system we could never have got this model off the ground' (Consultant).

Practically all persons interviewed accepted that the drive for change had come from above and that the detailed plans for implementation had largely come **from managers and commissioners with the help of some clinicians**. As elsewhere, most doctors and nurses were thought, initially at least, to want to hold-on to what they knew. The change was project managed by Public Health and a Nurse Service Lead. But it was also noted that clinicians played an important role in helping to make the changes work in practice not only through their cooperation but also by attending to important points of detail. Senior clinicians also pointed to their role in ensuring the maintenance of good clinical standards through the design of protocols and clinical guidelines.

While consultant level clinicians may not have directly led the changes and in some areas remain reluctant to depart from old ways, there have been significant developments emerging as a result of them working together at Network level:

I think we have seen a significant behaviour change. Clinicians of all kinds and other staff groups too have a much better appreciation of other people's disciplines and their positions (Network Director).

Considerable 'implementation leadership' was required. The lead nurses put together protocols that would facilitate doing sexual health screening out in the community, likewise the nurses needed to be trained. The Network Director observed that 'The Service Manager together with Public Health led the strategic aspects while the lead nurses tackled the detailed clinical redesign of how the services would operate in practice'. Governance issues tended to shift from the Consultants to the service manager. This was recognised as potentially a difficult transition but one that was accepted with very good grace. The consultant remains important for safeguarding the maintenance of clinical standards across the service as a whole.

Some interviewees also suggested that the changes were part of the wider Manchester Health Improvement for the Future (SHIFT) initiative and that the changes followed other attempts to redesign care pathways for example in diabetes. The Network Director for sexual health argued that:

The lack of profile for traditional family planning and contraceptive services was mainly due to these services not having proper clinical leadership. As a consequence, these services lacked future strategic positioning and vision. Nurse Managers, out of necessity, had focused on operational management such as "how do we staff the clinic tonight, how do we make sure we cover this week's clinics?"

Much of the big picture thinking was done at this wider, network, level. In effect, there was strategic thinking and planning being undertaken at the then Strategic Health Authority with each of the 10 PCTs devolving this kind of planning to the network which was hosted by Manchester PCT. A network board was established and this set about using peer pressure and support to drive change across each of the diverse localities. This included ideas about organisation, processes and expected performance targets.

The Network Director tried to get key players across the system engaged and involved in an initial working group which then formed the basis of the Sexual Health Network Board across Greater Manchester. He explained the reasoning as follows:

We wanted to ensure it was as inclusive as possible in terms of all the disciplines. We had to make sure we got everybody (including, for example, general practice, pathology, pharmacy, local authority and voluntary sector) to feel they were part of the arrangements. The Board was chaired by the Chief Executive for NHS Manchester which acted as host PCT and they provided executive leadership for the network.

The commissioners took a big picture approach. One said:

We used the Good Health model. The principle was to move services where clinically appropriate, that is services from tertiary into secondary and then in turn into primary care and where possible encourage self-care. For examples, we had a number of HIV patients in a specialist tertiary centre so we encouraged secondary care to develop HIV services, at the same time, we encouraged primary and community care to provide services for asymptomatic STI patients. The whole concept of the Good Health Model complemented this strategy.

The 'Good Health Model' referred to by this respondent is shown overleaf in Figure 3.

**Figure 3. The Good Health Model**



Change agents also used a wide array of tools. For example, while local persuasion was key alongside peer groups and peer pressure, if it was judged that an area wasn't moving as quickly as was expected, the National Support Team was brought into that area and used as a catalyst.

Senior clinicians emphasised their role as guardians of clinical standards and clinical governance. Hence, one view is that the clinical leadership role is to lead on implementation which means solving practical problems thus allowing the architectural vision to work. Likewise, this applies to nurses as leaders in problem solving: much problem resolution is senior nurse led. Some commissioners tend to see clinicians as rather too wedded to

traditional routines and also, if asked to redesign a service, 'they are rather too inclined to opt for a Rolls Royce, cost-regardless, solution'.

Another view, and one found in the literature, is that the optimal approach is for clinicians and managers to work as joint leaders: 'I'm a firm believer in clinical leadership and the double helix concept, clinicians and managers should operate together in tandem'. In terms of communication, 'often it is perceived that they speak a different language. Clinicians like to hear messages from clinicians and vice versa. A double act for presentations works best' (Network Director).

The Sexual Health Network was established at an opportune time because services were in a very poor position. The Strategic Health Authority perceived a real challenge with some of the clinicians across the system. 'Some were purporting to represent Greater Manchester, or the North West, at national meetings and were not mandated to do so nor were their views considered to be in line with national thinking'.

The Network Director observed:

I think the GUM physicians at that time (2003-4) were perceived as a complex group. The SHA gave me three months to establish support for the network. They implied that they would go to totally nurse-led services if the Consultants couldn't or wouldn't move forward. In some ways that gave me a quite a clear message to go with to the BASHH Consultants Forum. I encouraged them to think about the advantages of closer links, the potential in their having collective strength and coherent arguments and views. I suggested we should make this happen and ensure we are in line with system thinking. In retrospect, it was good. I could be honest with them and encourage them to control their own destiny.

The delivery of successful change in Manchester also depended on considerable leadership from below. It was a healthcare assistant who suggested the triage arrangement in one of the clinics. This led to a procedure where patients are asked to complete a form with tick boxes allowing entry onto a computer so that doctors and nurses can see the request for, say, a coil fit and thus staff pick up the task according to their competences and training

In summary, the services before the set of changes started around 2004 were poor in that access was difficult, waiting times were long and there was evidence that much need remained unmet.

The essential drive for change came from the centre in the shape of the national strategy and the subsequent extra funding.

The Greater Manchester Network used the collective influence of 10 PCTs to push for change. Some of the powerful clinical figures who held national positions on bodies such as the predecessor to BASHH were co-opted into



the change process. The network was closely tied to national level thinking and policy. It was chaired by the chief executive of Manchester PCT and drew-in representatives from a very wide range of interested parties.

The categorisation of people as clinicians or managers is problematical as a number of people straddle both and have a dual identity.

It might be argued that Manchester has been able to make pioneering change because of two factors – the relatively small size of its services in GU and contraceptive services and its low baseline of performance. It comprised two relatively weak part-time services. It was less difficult to put together and integrate them than it has proved to be in other territories where there are larger services which resist being pushed together. In other areas, reputations and status issues get in the way to a far greater extent. Institutional issues relating to the power of separate trusts are also a factor.

#### **6.1.4 Lessons about Clinical Leadership from the Manchester Sexual Health Case: Possibilities and Pitfalls**

Table 2 below summarises our interpretation of how local processes of clinical and non-clinical leadership have functioned to produce various kinds of outcomes in terms of new patterns of service provision, including a reworking of organisational and professional boundaries. The top row of the table indicates the extent to which clinicians were in fact involved in activities corresponding to Box D of Figure 2, clarifying public health challenges, whilst also indicating the role of non-clinicians. The second row summarises how far clinicians and non-clinicians participated in activities corresponding to the different aspects of local leadership relevant to service redesign, referred to by Boxes E, F and G of Figure 2. The lower rows of the table indicate how far which kinds of boundaries were reworked as a result and correspond to Boxes H, I, J and K of Figure 2.

In order not to complicate the presentation further, the table does not summarise the national context for all this, as conceptualised in Boxes A, B and C of Figure 2. This national context was however provided by the National Sexual Health Strategy, itself a response to NHS priorities of investing in services that will improve public health through improving access to diagnostic and preventative services. Professional input at national level took the form of endorsement of the national strategy by the British Association for Sexual Health and HIV (BASHH).

We turn now to the first row of the table, concerned with who provided leadership in **clarifying local public health issues**. This took place through the Strategic Health Authority embracing implementation of the national strategy, allocating increased funding to tackle local public health challenges in terms of high rates of occurrence of STIs and high rates of teenage pregnancy. Leadership in focusing the issues to be tackled lay with public health professionals and commissioners, rather than with clinicians

working in provider services. The services before the set of changes started around 2004 were poor in that access was difficult, waiting times were long and there was evidence that much need remained unmet.

The process of transforming provision towards integrated provision of GUM and contraception was instigated, resourced and sustained simultaneously at two levels – that of the Greater Manchester Sexual Health Network and at the level of a number of PCTs, including Manchester. At both levels, health planners, senior managers and public health professionals provided initial leadership, rather than clinicians.

**Table 2. Summary of Greater Manchester Sexual Health Services**

		<b>Developments</b>
<b>LOCAL LEADERSHIP ARENAS</b>	Clarifying public health challenges	<ul style="list-style-type: none"> <li>• SHA and PCT service development managers clarified need to increase access to contraception and STI screening and treatment in face of large-scale unmet demand for both services</li> </ul>
	Patterns of leadership by clinicians and non-clinicians	<ul style="list-style-type: none"> <li>• National Sexual Health strategy provided SHA with opportunity for extensive redesign of GUM and contraception services: commissioners took advantage of additional funding available for expanding services</li> <li>• GM Sexual Health Network and Programme Board provided clinicians with leadership and peer pressure</li> <li>• Key implementation role for service manager with a SH nursing background, supported by public health service development lead</li> <li>• Senior nurses designed protocols for community clinics, and experienced freedom to innovate in introducing new features</li> </ul>
<b>REWORKED BOUNDARIES</b>	Clinical and organisational practices that rework boundaries	<ul style="list-style-type: none"> <li>• Walk-in spoke clinics are 50% nurse-led, &amp; offer contraception, asymptomatic STI screening and chlamydia treatment: symptomatic STI patients and complex contraception referred to hub appointment within 48 hours.</li> <li>• Paperless electronic patient records across hub and spokes</li> <li>• Patients undertake a paper-based triage in spoke clinics to direct them to the appropriate clinician; suggested by a health care assistant.</li> <li>• Links with termination of pregnancy service, providing contraception and counselling</li> </ul>
	Inter-professional relationships	<ul style="list-style-type: none"> <li>• All nurses dual trained, and many also skilled up for LARC. Use of Health Care Assistants for STI screening.</li> <li>• Hub has nurse and medic led clinics, senior nurses fit IUDs and prescribe, also develop protocols</li> <li>• Consultant seen as having to revert to clinical role rather than “being boss of the clinic”, no longer hires staff, etc.</li> <li>• Nurses conscious of retreating from administrative aspects of clinic management, encouraging admin staff to take fuller responsibility</li> </ul>
	Patterns of sentience	<ul style="list-style-type: none"> <li>• Move to full time employment for all nurses, with rotas covering multiple locations.</li> <li>• Nurses and receptionists now identify strongly with integrated service</li> </ul>
	Performance achievements	<ul style="list-style-type: none"> <li>• Volume of patients seen has increased over fourfold</li> </ul>

**Table 2 (contd.)**

<b>Issues</b>
<ul style="list-style-type: none"> <li>• Continuing and growing demand for services as awareness rises and neighbouring areas have not made the same progress in improving accessibility</li> </ul>
<ul style="list-style-type: none"> <li>• Little previous history of clinician-led attempts to achieve better integration between conception and GUM services</li> <li>• Focus provided by Sexual Health Network contrasted with low levels of visibility and funding of most GUM services within acute trusts.</li> <li>• Managers, commissioners lead the GM network; nurses provide much operational leadership. Both see senior doctors as cautious about integrated services, rather than as leading change.</li> <li>• Senior GU doctor however took up “implementation leadership”</li> <li>• Some concern that returning of SH services to the control of acute trusts may lead to disinvestment</li> </ul>
<ul style="list-style-type: none"> <li>• Use of clinical governance meetings to review and improve all aspects of clinic</li> <li>• Young people’s service outsourced through a commissioning initiative, but volume of young people using the main SH service has not fallen</li> <li>• Possibility of [THIS AREA] becoming subsumed within a Greater Manchester network of integrated clinics; the balance of hubs to spokes is being debated.</li> <li>• GPs however remain relatively uninvolved in sexual health services</li> <li>• Tariff for integrated clinics requires further work</li> <li>• How should related services for erectile dysfunction and psychosexual counselling be integrated?</li> </ul>
<ul style="list-style-type: none"> <li>• Nurses have become more experienced and broadly skilled with STIs than GPSIs; which produces resentment since GPs are paid more for the same clinic</li> <li>• For cases outside the PGD, nurses however do need to call on medical expertise related to contraception, which is not always readily available. However having more highly skilled nurses makes the base for more medical posts more difficult to make.</li> <li>• Difficulty of recruiting senior doctors who are dual trained; doctors in neighbouring areas perceived as wanting to protect specialisms.</li> </ul>
<ul style="list-style-type: none"> <li>• Greater Manchester Sexual Health Network has provided an important source of identity for managers, doctors and nurses interested in developing innovative services. GM Sexual Health Network may evolve into a Manchester wide Social Enterprise providing integrated sexual health services</li> <li>• Pressures on funding leading to possibility of rationalisation of services across Greater Manchester, with fewer larger clinics open for longer hours.</li> </ul>
<ul style="list-style-type: none"> <li>• More complex consultations in spoke clinics are proving time-consuming</li> </ul>

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Moving down the table, in terms of the **patterns of leadership by clinicians and non-clinicians**, at the level of Greater Manchester PCT, public health professionals and commissioners – rather than clinicians - were the instigators. The small scale pre-existing contraception and GUM services had not provided scope for clinicians in either kind of service to have undertaken informal attempts to broker greater integration informally. However, the commissioners were able to recruit to the integrated services project two senior nurses experienced in conception services, one as senior nurse and the other as service manager.

Both drew on their experience of the problems of working within previously separate services and a resulting commitment to the benefits of integrated services. In addition, the commissioners found the single GUM consultant amenable to developing and working within an integrated model, albeit on the basis that future funding depended on this level of reconfiguration. Clinicians thus took their place at leading operational implementation within a formally authorised and resources service redesign project to establish the hub and spoke model of integrated services, supported by service manager with a nursing background. They have developed clinical protocols, training programmes for nurses, and models of clinic operation. The conceptualisation of the model and establishing the case for its resourcing were not led by clinicians. They have nonetheless proved themselves to be willing partners in a change initiative of considerable ambition.

The key **clinical and organisational practices that reworked boundaries** within the new service model are those associated with Hub and Spoke system of clinics. The walk-in Spoke clinics are open during extended hours from Monday to Friday and offer contraception and STI screening usually from a single consultation. 50% of these consultations are carried out by nurses working autonomously. Previous boundaries between two service areas have been dissolved, whilst dual training of a cohort of nurses has allowed the boundary of what most nurses do to be considerably expanded, both in terms of specialism and previous divisions of labour between nurses and doctors. Triage forms completed by patients also allow Health Care Assistants to undertake some simple screening consultations. Patients with STI symptoms or more complex contraception issues are referred on to Hub appointment, using paperless electronic booking and patient record systems. A range of practices relevant to service integration have been thought through and fashioned.

A number of areas of clinical and organisational practice relevant to sustaining effective integrated sexual health services appear unresolved and requiring further work. These include the finding an appropriate role for GPs in providing these services, and the development of a payment by results tariff different from the existing undifferentiated acute tariff for STI diagnosis and treatment. Clinicians, managers and commissioners want to move towards a more differentiated tariff system that will allow the range of different services in community settings to be viably financed, so that

funding more closely follows clinical funding. There are also issues to be resolved in how far related sexual dysfunction services are provided within the integrated sexual health service system or by specialist clinics elsewhere.

The outsourcing of sexual health services by commissioners is seen as a retrograde step both by several managers and clinicians within the main service and by some commissioners. This creation of an additional boundary is seen by many as unnecessary and as damaging to the development of resources and capabilities needed for the further development of the system of integrated Hub and Spoke clinics.

In terms of the evolution of **inter-professional relationships**, in addition to developments in the division of clinical labour between doctors and nurses, there are also developments in the relationship between clinicians and service management. It appears that the two medical consultants who are clinically responsible for the service are further removed from the managerial responsibility for the financing and staffing of the service than the GUM consultant was when he was running a smaller and less complex single discipline operation. And at the operating level, senior nurses reported having learned to let reception and administrative staff take up their roles more fully in ensuring the smooth running of a clinic shift. So at both levels, implementation leadership for a new model of working has involved collaboration with and recognition of the appropriate spheres of leadership of non-clinicians.

There are also unresolved issues concerning relations between different professional roles. Having achieved full competence in the main aspects of sexual health services required in Spoke clinics, nurses reported feeling resentful of GPs with Special Interests who were paid higher sessional rates for similar work, and who typically had less experience and knowledge of procedures and current contraception prescribing than they did. At the other end of the scale, senior nurses were well aware of when they needed to call on more complex medical expertise for patients whose conditions lay outside of a Patient Group Directive for which they could prescribe. The issue was that this kind of specialist medical was not always available, even by phone, during clinic hours. There were some perceptions that commissioner faith in nurse led clinics had been taken too far.

A related issue was the perceived difficulty of recruiting to a second consultant post for the service, where a doctor with dual qualification and experience was being sought. Although recruitment was successfully completed, those involved were aware that the development of dual expertise for a senior doctor is very much a matter of individual initiative. Neither of the respective Royal College Faculties responsible for training and certification for Genito-Urinary Medicine or for Reproductive and Sexual Health requires significant cross-skilling in the other discipline.

Reworking of service and professional boundaries appears to have led to **new patterns sentience**. Nurses reported that both their clinical

colleagues and reception staff identified strongly with the new service and its integrated offering, and were willing to work shifts across the set of Spoke clinics as well as at the Hub. The new employment pattern, based on full time appointments rather than the sessional work characteristic of older family planning clinics, appears to have played a key role in establishing such strong sentience.

The Network provides a forum where the achievements of the Manchester service can be recognised and where further challenges and inspiration can be encountered. The sentient strength of this network provides one basis for the possibility of further reconfiguration of formal organisational boundaries and the launching of a Manchester wide network of clinics, possibility constituted as a social enterprise. How the emerging strong identification of clinicians with the service within Manchester could be preserved or incorporated within such a new conurbation-wide identity is a further challenge.

The change process to date appears to have been successful in operational terms. **Service performance** has improved according to measurable indicators relevant to the public health challenge identified. Considerably more people are able to access the service and population rates of STIs and teenage pregnancy are falling significantly from previously outlying levels. One apparently contradictory development reported is that of the increasing length of consultations with many service users in Spoke clinics, as more comprehensive sexual health needs are attended to. The implications will need to be fed into models for staffing and operating future clinics.

Some particular insights concerning **enablers and barriers** to the development of integrated services emerge from this case, which may be of wider relevance. It might be argued that Manchester has been able to make pioneering change because of two factors – the relatively small size of its previous services in GUM and contraceptive services and its low baseline of performance. It comprised two relatively weak part-time services. It was less difficult to put together and integrate them than it has proved to be in other territories where there are larger services which resist being pushed together. In other areas – even within the Greater Manchester area – the existence of larger groupings of specialists, reputations and status issues have been seen as getting in the way to a far greater extent. Issues relating to the power and income streams of separate acute trusts have also been minimal in Manchester. There is one acute trust now responsible for all the medical specialisms and services involved.

A further way of understanding the dynamics of change in this case concerns the small numbers of individuals involved and the relative weight carried by the development of working roles, relationships and personal allegiances, compared to professional identities. So the service manager carried into her role experience as a contraception services nurse, and a good working relationship with the single GUM consultant. The nature of the integrated service was in reality forged between these two and a lead public

health professional from the PCT who also acted as commissioner for a key period. There was considerable fluidity of professional roles, with personal working relationships providing containment.

Although integrated training, ways of working and identification with an integrated service have been successfully fostered by a small group of senior clinicians and managers within this area of Greater Manchester, the next stage of development seems likely to involve the establishment of an integrated network of clinics, with some rationalisation, across Greater Manchester as a whole. This will require a more formal reworking of professional boundaries between genitourinary and reproductive health specialists. While the very small number of individuals concerned within the locality studied in this case have reached an accommodation, a different level of resolution appears to be necessary for the model to travel more widely.



## **6.2 The London Sexual Health Services Case**

As with the previous case we organise the description of the findings here under four headings: the background conditions and prompts for change; the nature and extent of the changes and the achievements; change processes, pitfalls and barriers; the lessons to be drawn about clinical leadership. The case concerns provision of contraception and genitourinary medicine services across two acute trusts (L1, L2) operating in two adjacent London Boroughs, each at the time of the research with its own community provider of contraception services (L3, L4) and Primary Care Trust (L5, L6), with responsibility for commissioning both kinds of service.

### **6.2.1 Background conditions and the prompts for change**

This case is significant because, under difficulties circumstances that will be explained below, the genitourinary and reproductive health services were integrated and transformed to a degree that the commissioners now claim them as among the most advanced integrated sexual health services in the country. This results in lower cost, a more efficient procedure and a better, more complete user experience.

Serious attempts at cross boundary service redesign began in 2004. This was prompted by a major injection of funds by a leading health charity. The extra funding at around £5m was significant enough to mobilise effort at senior trust level. The redesign of sexual health services was one of three service areas funded as part of this modernisation initiative which lasted for 4 years. The idea was to:

'Move beyond small changes, a bit here a bit there, and instead to transform the whole system the whole pathway of care. There was a need for this because if you look at the basic situation there were GPs some of whom did nothing with regard to sexual health and some who took an interest; there was a community sexual health service that offered very basic services through to some quite advanced ones; and there was the hospital genitourinary service which offered basic to advanced interventions. From a user perspective it was madness, absolute craziness' (Service Manager)

Before the formal initiative, some clinicians – especially those working in contraception services - were already aware of the need for changes and they considered the idea of integrating aspects of GUM into their services. They took some exploratory steps by working with a particular commissioner. But this early attempt to exercise clinical leadership failed to make progress.

The funded Modernisation Initiative (MI) was seen by a small set of clinicians and managers working within existing provider organisations as a rare opportunity to bring about a system-wide change to sexual health services in two London boroughs. It involved clinicians and service

managers making a reasoned case for significant change in sexual health services across two acute trusts and across community clinics in the two boroughs. Clinicians put themselves forward as Clinical Champions to be part-funded to bring this about. In addition, there was engagement from a GP Clinical champion, from primary care, and from community pharmacy. The clinical leaders had to learn how to work with this wide range of actors in forging new service arrangements.

At the heart of the proposal was the idea of developing contraception and GUM services to meet the needs of service-users who were not attracted to the existing services: most especially younger people and men who have sex with men. The rationale was to address pressing local public health issues through developing more integrated and user-centred services.

### **6.2.2 The nature and extent of the changes and the achievements**

GUM clinicians and clinicians from reproductive health learned to collaborate and together they redesigned the service offerings, working closely with service managers and above all user representatives.

The services offered to clients were transformed. Clinics which were previously located in inaccessible and somewhat forbidding environments were brought onto the High Street and the environment was designed – with the help of service user representatives – so that it became more akin to the reception area of a High Street bank with soft furnishings and bright colours.

There were a number of significant achievements which derived from these leadership change processes and they can be summarised as follows:

- Users receive integrated contraception and/or STI screening and management, depending on their needs, regardless of which clinic they go to. They only need to go to one clinic rather than two.
- Access has vastly improved. There is a walk-in service and so there is no need to phone for an appointment.
- Services have been redesigned on the basis of rigorous study of user experiences and preferences. The vast majority of users see only one clinician per visit and they experience shorter waiting and total transit times than pre 2007. Issues of dignity and confidentiality have been taken account of, with a calmer, better-regulated atmosphere, and the option of replacing talking to receptionist at an open desk with touch-screen booking in.
- Significantly larger numbers of users have attended since 2007, with men and younger people more strongly represented. This has led to progress with key indicators relevant to public health, e.g.

increasing STI testing rates, reducing teenage pregnancy rates and pregnancy terminations, increasing LARC treatments.

- Staff at all levels have developed broader skills needed for an integrated service, including sharing of learning about different client groups between medical and nursing workforces previously working in GUM or RSH. Nurses are working with greater autonomy and senior nurses have taken on a broader range of examinations, and some prescribing. Client support workers have taken on increasingly significant roles with users and in areas such as sample management. Increasingly effective screen-based triage supports appropriate direction of users to various clinical roles.
- Clinical information systems give effective support for registration of users, coding of tests and other clinical activities, and monitoring of transit times. There is continuing use of performance data, including incidents and errors, to improve the service
- There is perceived to be a culture of collaboration between SH providers across the two boroughs. This includes significant contributions from primary care to the provision of SH services. GPs provide oral contraception and LARC services on a significant scale, as well as chlamydia screening and HIV testing and there are established care pathways for referral for complex contraception or STI cases to specialists in the integrated sexual health service. One of the acute trusts has merged its reproductive health and GUM provision into a single Sexual Health Department.
- There have also been initiatives to provide chlamydia screening and oral contraception provision through retail pharmacies.

Clinical Leadership attributes that the clinicians themselves saw as important to this case and which enabled integration of RSH and GUM were:

- Mutual respect for each other's speciality fully appreciating the public health needs of prevention of unplanned pregnancies and STIs,
- An intention amongst the clinical leads to work together towards a shared vision by overcoming any barriers and prejudices which in turn helped to bring staff from the two specialties to work together.

The London Sexual Health Services case reveals a series of complex interpersonal and inter-professional tensions. The picture that emerges is that initiative is required on multiple fronts, and that a wide range of clinicians need to be involved. Crucially, clinical leadership was found not to

be only the responsibility of a few senior doctors occupying formal Clinical Lead roles.

There was also a legacy of ongoing learning and service improvement. Following an initial success in piloting an integrated service, the integrated model has been transferred and developed across a network of clinics within the two boroughs. The clinic where the pilot took place has also continued to develop its mode of operating.

The operational essence of this clinic is widely seen as the screen-based triage directing users to one of three distinct queues on the basis that the correct queue should be able to provide them with a “one stop shop”. The queues were, and in essence still are:

- (1) Symptomatic clients and those who need long acting reversible contraception (LARC) such as implants and intrauterine devices. Such patients will be directed to see a doctor or a specialist nurse;
- (2) Clients requiring contraceptive advice and less complex hormonal contraception and/or asymptomatic sexual health screening would see a nurse;
- (3) Clients that are asymptomatic would see a client support worker for sexual health screening tests.

Above all, the new way of working meant that all clinicians had their own queues and service-users to deal with. This meant that client hand-over from one health care professional to another was minimised. No one was in a ‘hand-maiden’ relationship to anyone else.

A key challenge posed was the requirement for the majority of nurses to be trained in both contraception and STI testing and management. An agreement that there would be some use of GUM staffing “as needed” proved problematic at the outset, given the need for medical staffing in the existing GUM walk-in clinic which was still in operation. This led to a shared perception by clinical leads in both reproductive sexual health (RSH) and GUM that their two departments needed to merge, and that all walk-in activity should be transferred to the new clinic, which would be jointly staffed. This was an emergent realisation.

The idea of a full merger came from one of the consultants:

‘I first talked to the commissioners and then raised the issue in one of the [L4] Sexual Health Programme board meetings. I said if we are to sustain the benefits of the Modernisation Initiative we really must merge and so overcome the issues raised by trying to operate with two separate departments with different ways of working. I made the case that it would be better if the two departments merged together and put all their budgets together, and staffing resources together, and work together to meet the demand’. (SH Consultant L2).

Without merger there would be problems to face:

I think that unless the budgets come together, there's always going to be this source of conflict between departments, because the earning streams are different. Ours was a block contract, whereas the GUM department was payment by results, and staff, staffing, that staff budgets were different, so we had to really merge to get that (SH Consultant L2).

Formal merger between the two departments in L2 (but not in L1) involved a meeting of all stakeholders which was convened by commissioners. Senior Trust management were also included. Formal integration required merging funding, merging previously separate administrative and reception staff groups, and the development of an integrated IT system for coding clinical activity to meet the needs of different reporting systems for RSH and GUM. Planning the merger took twelve months, leading to full merger in January 2009. This followed the formal end of the Modernisation Initiative in 2008 along with its funded infrastructure of working parties and Board. This merger of departments represents a considerable advance on the levels of integration achieved in the vast majority of UK sexual health services.

The merged department has adopted a participative management structure based on a structure introduced into the old GUM department prior to the MI when a consultancy firm was engaged to help address what was perceived to be a lack of dialogue between senior figures and "the shop floor".

Further development of the integrated walk-in service has been significantly shaped by a multi-professional "patient flow group", which examines how users pass through the service and why delays might be occurring. This has led to a number of refinements in the triage questions put to people through the screens on arrival to make sure that users are directed to the most appropriate clinician.

Other developments include the installation of a small lab, for preparing samples and microscopy for bacterial tests. Nurses undertake the microscopy with client support workers taking a significant role in organising samples for collection and processing by the main pathology service.

The L1 trust working in collaboration with community services launched their own community-based clinic post the MI and did so in collaboration with commissioners:

It's the money that talks, if the commissioners want to do something and there is money then it can happen' (L1 Consultant)

### **6.2.3 Change processes, pitfalls and barriers**

Top level sponsorship was certainly part of the picture. The initiative was formally led by a Board which was chaired by the chief executive of one of the two hospital trusts. The sexual health part was led by a steering group comprised mainly of clinicians from the different services plus

commissioners and staff from voluntary sector organisations such as the Terrence Higgins Trust:

The idea was that you sit there not as a representative of a service but as someone there to consider redesign for the greater good as a whole, but that wasn't easy. In fact the GUM clinicians got very, very, defensive. In fact it required the firm intervention of the chief executive of one of the acute trusts who was himself a clinician by background to say them "We have two roads: we either close this programme down now and we get no money or you work towards a new world order. You show some leadership. You show some difference". And I am not saying it was plain sailing even after that ultimatum but that was a turning point (Service Manager).

From the commissioners' point of view, change was essential. They did not want to continue paying a high tariff cost to the GUM department for simple and quick chlamydia tests which could be done in a high street clinic by a nurse or even on a self-help basis. Some of the GUM clinicians in the acute trusts didn't seem to want to recognise this. Moving parts of the service out of the hospital was very difficult. One senior clinician with a leadership role in the service redesign initiative was described as 'far-sighted' and 'brilliant but five years too early'. This clinical leader went too far ahead of their colleagues and so was 'usurped' by them. As one informant observed:

'The men in grey suits (senior clinical colleagues) stepped in and told [X] that it was time for a sabbatical leave and as a result [X] was removed from all the management structures' (Consultant)

This is an example of an attempt at radical leadership which failed. It led to 'a horrible, hard, dreadful few weeks'. One of the managers commented on the initial fierce resistance from some clinicians. This culminated in a letter of no confidence in the lead clinician sent by colleagues in one of the acute trusts to the Charity and the chief executive of the trust. The same group also initially 'belittled' the concept of user self-management. But, in due course, this opposition was overcome and some members of this oppositional group retired or left for posts elsewhere. In other words the service redesign was a hard-fought process. It required skill and courage.

These events led to the appointment of a clinician from a different acute trust to one of the leadership roles in the change programme. This new clinical lead proved adept at handling the complex array of relationships. Peer pressure was also a related factor: 'some of the clinicians would say to each other "Look what they are doing in the other Trust"'.

Four clinical champions – from reproductive sexual health, GUM & HIV, public health and general practice – were funded to work part time on the initiative. There was, in addition, a full time sector manager was funded by the MI. The MI also funded additional commissioning resource and public health expertise to support it, in particular the development of a data warehouse bringing together information across L5 and L6 (PCTs).

Together, these resources ensured some considerable traction and support for the changes.

The clinical champions and the steering group started work by carrying out detailed research into the experience of users. This was to provide a basis for exploring and developing options for delivering services differently across the two boroughs. In the case of sexual health it was more difficult than other services to find patient representatives and so the paid 'mystery shopper' device was used to test out the service experience. These were recruited from people in the waiting rooms. In addition, some other service users did get involved. The 'combination of great clinical leadership and active patients who came along with lots of ideas was catalytic. It led to the better brighter environment in the pilot high street clinic and the self-service features' (Project Manager). The service users helped set the standards against which the service was to be measured in addition to the way they helped in that measurement and assessment. 'They helped name the new sexual health centre as precisely that rather than some discreet and unhelpful label. This is now what the board says over the door on the high street. Its highly visible; its about overcoming stigma and enabling access' (Service Manager). Service users also drove the idea of self service (for example vending machine access to pregnancy tests). Some clinicians were very uneasy about this idea but once again the service user voice helped counter these reservations.

The preparation of the pilot in 2006 involved trials of different ways of managing queues within the existing clinic. Two key innovations emerged. The first was the use of touch-screen kiosks, initially conceived of as a way for users to book themselves in without having to speak to a receptionist. The touch screens were then developed further as a means of triaging patients as they arrived. They were also combined with a vending-machine style dispensing condoms, self-managed kits for STI tests and pregnancy tests. The STI test kits were for those patients revealed to be symptom-free through answering questions during the screen-based triage. The second innovation was the use of healthcare assistant grade "client support workers" to advise on the use the machines and the test kits as well as to take blood samples for HIV testing for asymptomatic patients.

While clinical leadership was vital to the process, so too was the support of a formal project manager:

The contribution of a full time project manager who was there throughout the three years was really helpful. We also had the funds to make the changes possible (Clinician).

The process itself took a great deal of time as many staff were fearful of the proposed changes:

The initial stages took us two years. We spent a disproportionately long period of time trying to find out the deficiencies in the system. We spent the first two years trying to find out what's wrong with the

system, when to me, even as a junior consultant it was very obvious. I already knew the problems (Consultant).

The same state of affairs is repeating itself in other parts of London as they try to catch up with this pioneering example:

This is general, across London, I think the contraceptive services have been quite poorly funded, they haven't been well supported and with very few consultants running the service, many of them have high ambitions of incorporating STI testing, and other things, but there are some places where there is resistance, there is a feeling that they could be taken over by a very strong department and the STI management could completely take over contraception, and they would have completely no say in how the service is being run. They feel threatened (SH Consultant).

From 2008 onwards, the fundamental features of the integrated pilot were transferred, with some adaptation, to five other clinics in community settings. In one case, this was instigated by one of the SHMI Clinical Champions who was based at a particular clinic and applied for funding from commissioners to take the model forward. In at least two other cases, the drive was no longer directly from the MI but from the commissioners who had been convinced by the MI pilot clinic. They played an instigating role by offering funding to the clinical and managerial leads, at the same time making it clear that the future of the service lay with an integrated service offering a one-stop shop. In each of these cases, existing clinical leads were from a reproductive sexual health background, mostly employing sessional doctors and nurses with qualifications or certification in contraception. Arrangements were made to engage additional GUM sessional staff, by negotiating arrangements with neighbouring hospital-based GUM departments.

Each of these subsequent clinics have adapted the mode of working of the original pilot to meet particular constraints or opportunities offered by its accommodation, or to take advantage of emerging developments in touch screen triage systems.

This successful diffusion of an integrated service model has occurred whilst rivalry and suspicion between GUM and other parts of reproductive health have not entirely disappeared. One RSH consultant talked about how their attempt to establish a full sexual health service in the community equipped with an on-site microscope for analysing swab results was temporarily undermined by some GUM specialists who questioned the capability of the staff in this clinic to operate this service without a recognised GUM specialist on its staff.

The emergent power of the commissioners was also witnessed by one of the consultants who reported how the PCT offered 'half a million to set up a community STI service'. He said to his manager that this was not enough but 'they said you have two options: one take the money and see what you



can do with it or two, they will probably put your service out to tender and someone else will take it over' (Consultant).

So, I went to my staff and said well what do you think? At first they said oh no this will mean seeing lots of men and but in the end they said OK lets try the idea and they took the half million and look ... we now have a wonderful terrific place with IT back-up and a multi-skilled dual-trained workforce (Consultant).

Finally, leaders of this service redesign had to work against the grain in terms of developing their workforce. The training and validation of staff skills nationally was not in line with the desire to move to dual skilling. The national payments system was unhelpful – there was payment by results for GUM and a block payment for reproductive health. And national professional bodies were perceived locally as unhelpful and protective of vested interests.

Two related developments have opened up the possibility of a much wider integration of services. The first is the near fruition of a lengthy project led by a lead GUM consultant from the Trust not involved directly in the original pilot. It seeks to establish an integrated and community-based clinic away from the limitations of the existing hospital STI clinic premises with a view to increasing user awareness and take-up. This has involved putting together a detailed business case and gaining funding within the Trust. The second development is a formal structure for partnership – L2 Health Partners - working between the two acute trusts, combined with a formal integration of all community services, including sexual health services in both boroughs, into this particular Trust.

There is now a framework for not only a large integrated service run by this Trust, and based on its GUM-HIV department, but also a collaborative network to link all the integrated clinics that have emerged. This network has both informal and formal aspects. It is widely supported by the clinicians involved, and is at the same time recognized and encouraged under the aegis of the formal partnership between the two trusts. There is now a regular quarterly meeting of consultants and managers involved in all of these clinics, with working groups looking at how to develop integrated IT, clinical services, teaching, training, and research.

#### **6.2.4 Lessons about Clinical Leadership from the London Sexual Health Case: Possibilities and Pitfalls**

Table 3 below summarises our analysis of how local processes of clinical and non-clinical leadership have worked in this case to produce various new patterns of service provision and a reworking of organisational and professional boundaries. The top row of the table indicates how clinicians and others engaged with activities corresponding to Box D of Figure 2, clarifying public health challenges. The second row summarises how

clinicians and others participated in different aspects of clinical leadership referred to by Boxes E, F and G. As in the previous case, the lower rows of the table indicate how service boundaries were reworked and correspond to Boxes H, I, J and K of Figure 2.

**Table 3. Summary of Sexual Health Services London Case**

		<b>DEVELOPMENTS</b>
<b>LOCAL LEADERSHIP ARENAS</b>	Clarifying public health challenges	<ul style="list-style-type: none"> <li>• Small group of GUM and RSH clinicians collaborate with PCT managers to make case for improving and increasing access to contraception and STI services in face of large-scale unmet demand.</li> <li>• Clinicians also prioritise improving understanding of user experience as central to service improvement.</li> </ul>
	Patterns of leadership by clinicians and non-clinicians	<ul style="list-style-type: none"> <li>• Activist group of clinicians saw the Sexual Health Modernization Initiative as an opportunity to be authorised and funded both by the PCT and a charitable foundation to challenge existing patterns of service delivery and reconfigure them. National SH Strategy provided further legitimacy.</li> <li>• SHMI drew on established informal relationships and previous attempts between some clinicians to improve interface between GUM and contraception services</li> <li>• Gaining backing from SHMI led to project management support and access to expertise in service analysis and organisational change</li> <li>• Implementation work led by doctors, working collaboratively with nurses, service managers and IT staff.</li> </ul>
<b>BOUNDARIES REWORKED</b>	Clinical and organisational practices that rework boundaries	<ul style="list-style-type: none"> <li>• Development of the multi-queue integrated service model, with minimal hand-offs and protocols to guide users to the “right” clinician</li> <li>• Separate IT systems within each clinic for receiving users and triaging their needs, for managing electronic patient records and coding treatments.</li> <li>• These developments led to RSH/GUM department merger in the acute trust piloting integrated services</li> <li>• These practices have been adapted to local conditions across the network of clinics</li> </ul>
	Inter-professional relationships	<ul style="list-style-type: none"> <li>• Significant investments made in training of doctors and nurses so they can work with both contraception and GUM in a one-stop shop clinic. Particularly for nurses, previous specialist identities are merging</li> <li>• Nurses and health care assistants are both commonly working as autonomous clinicians, dealing directly with patients who have been triaged as appropriate for them to see, rather than taking up a “hand-maiden” role in relation to a doctor.</li> </ul>
	Patterns of sentience	<ul style="list-style-type: none"> <li>• Informal collaboration between GUM and reproductive health specialists led to establishment of SHMI and further development of a collaborative ethos between specialisms, managers and nurses at the integrated pilot, with identification with the public health goals of integrated clinics, rather than their original specialism or occupation.</li> </ul>
	Performance achievements	<ul style="list-style-type: none"> <li>• Significantly larger numbers of users have attended since 2007, with men and younger people more strongly represented.</li> <li>• Progress with key indicators relevant to public health, e.g. increasing STI testing rates, reducing teenage pregnancy rates and pregnancy terminations, increasing LARC treatments.</li> </ul>

**Table 3 (contd.)**

<b>ISSUES</b>
<ul style="list-style-type: none"> <li>• Focus has inevitably meant services have become less attractive to some established client groups e.g. middle-aged women who want contraception.</li> <li>• Debates continue about which other related needs might be met at integrated walk in clinics, e.g. medical gynaecology.</li> </ul>
<ul style="list-style-type: none"> <li>• Lack of unanimity amongst senior medical consultants contributed to one of the two acute trusts not proceeding with a model of integrated services for several years, until after the formal end of the SHMI.</li> <li>• Following the pilot of integrated services, commissioners have influenced other clinics to develop a similar approach</li> <li>• Following conclusion of the SHMI, level of project management support &amp; time available to clinicians to think about service improvement has decreased.</li> <li>• Establishment of a formal [WIDER] London Sexual Health Network has encouraged further consideration of cross boundary changes, now also driven by a formal collaboration programme between two acute trusts.</li> </ul>
<ul style="list-style-type: none"> <li>• Work proceeding on development and implementation of an integrated tariff system covering contraception and GUM procedures</li> <li>• Refinements in the multi-queue model as senior nurses realise how to adapt it in the light of increasing levels of integrated skills of nurses and ability of nurses to work autonomously.</li> <li>• Work proceeding on integrated IT system for the entire network of clinics, including text-based booking of appointments and use of text for test results.</li> <li>• GPs continue to provide a wide range of SH services, including complex contraception.</li> </ul>
<ul style="list-style-type: none"> <li>• Some GUM specialists have opposed the idea of community based clinics providing integrated services.</li> <li>• Integrated medical skills may continue to exist in some tension with the requirements of the separate medical Faculties for GUM and RSH.</li> <li>• As more senior nurses become more integrated in their skills, their ability to work autonomously in most areas of service delivery may pose challenges to maintaining medical roles in their current form.</li> </ul>
<ul style="list-style-type: none"> <li>• As the collaborating network of clinics develops, clinicians at all levels may perceive themselves as belonging to this network rather than “home” trusts.</li> <li>• The issue of whether integrated working requires departmental merger at all sites is however unresolved – each specialism fears being taken over.</li> </ul>
<ul style="list-style-type: none"> <li>• More complex consultations in integrated clinics are proving time-consuming and threatening improvements achieved in reducing waiting and transit times.</li> </ul>

As in the previous case, the table does not summarise how the national context, as conceptualised in Boxes A, B and C of Figure 2 affected the case. The national context for the case was again provided by the National Sexual Health Strategy (Department of Health, 2001). As in Manchester, professional input at national level took the form of endorsement of the national strategy by BASHH. The critical importance of national level policy was also evident in the London sexual health case in that the PCT commissioners were seeking to follow British HIV (BHIV) guidelines in routinising the testing for HIV in primary care – for example, at each new patient registration with a GP practice. This illustrates both the importance of the national level and also the importance of clinical leadership at national level.

We turn now to the first row of the table, concerned with who provided leadership in **clarifying local public health issues**. The local context for service transformation was also similar to that in Manchester, with teenage pregnancy and STI rates in the population amongst the very highest in the UK. This documented need was an important part of the basis of the bid for funding service transformation under the Modernisation Initiative. The bid was instigated by a small group of highly motivated clinicians and PCT managers, although also backed at senior level by the acute trusts concerned. As they developed the proposal for funding and subsequently during the planning of service transformation, the core group of reproductive health and GU clinicians worked closely with PCT public health professionals to show leadership in further clarifying the nature of public health needs. They introduced a strong emphasis on the need to better understand what users and potential users valued or responded positively to in sexual health services. This was to be the key in making services more efficient and easy to access, and so more effective.

The more recent service redesign work in the context of a wider emergent 'health partnership' is equally imbued with this perspective on the local public health context – reducing sexual health need in the population requires making services accessible and easy to use. This clinically-led insight can be seen as providing an innovative drive and point of reference for justifying new ways of providing services, a way of conceptualising social need independently of the priorities of any particular clinical or managerial group. It has provided a rationale for working across established boundaries.

Whilst this perspective has been central to clinical leadership in reconfiguring SH services in London, it has also brought tensions with it. In particular, some clinicians have noted that some established client groups – middle aged women looking for contraception services, for example, are no longer prioritised by the integrated services, which have been designed to attract younger people with more complex sexual health needs. So, focusing on the "user experience" can also mean making choices as to

which users and needs should be prioritised, based on public health analysis. Such judgements may need to be made ever more clearly if NHS resourcing for SH becomes more constrained. There may also be judgements to be made in terms of which range of services – for example medical gynaecology – should be made available, perhaps at larger “Hubs”, within an integrated network of SH clinics currently under discussion here as in Manchester. Such decisions are arguably linked to clarifying which users and public health needs are to be prioritised. Clinical judgements also have to be made concerning how far user preferences, such as only being seen by one clinician, should be pursued if it contradicts the rationale for using the time of more expensive or specialised senior clinicians for more complex tasks, with simpler procedures handled by less costly staff grades.

We come now to the second row of the table, concerned with **patterns of leadership between clinicians and non-clinicians** in the process of transforming provision towards integrated provision of GUM and contraception. This was instigated here in a way rather different to the course of events in Manchester and Greater Manchester. Rather than coming from senior SHA managers, impetus came from acute clinicians and PCT managers, with whom they had developed close understandings. Together, they made a case to an independent charitable foundation keen to provide resources to enable significant service transformation.

During the sexual health Modernisation Initiative, clinicians involved on the project board and then in planning the integrated pilot were authorised to examine how services were currently provided and how this could be done differently. They were encouraged to do so in a multidisciplinary forum outside of the context of service delivery. This authorisation came both from a boundary-spanning governance body – the Sexual Health Modernisation Initiative Board – and also from senior figures from the individual trusts who were members of that board. So, there was no question of clinicians being confined to thinking within the scope of existing services. On the contrary, they were challenged and resourced to re-imagine services.

Clinicians worked with service managers to analyse existing service models, and devise new ones. They also worked closely with commissioners to examine how new models could be financed and sustained. The SHMI provided a project management infrastructure led by a director with close links at very senior level both to the PCT and the acute Trusts. It made available techniques and expertise in areas such as user experience analysis, patient flow analysis, and public health analysis. Above all, it bought out time of clinicians and managers to work together on creating change.

This level of authorisation to redesign services was however not simply presented to a fortunate group of specialist doctors by enlightened health service senior managers. It was to a considerable extent negotiated by these activist clinicians who had already developed working relationships

with one another and sought informally to improve the way that contraception and GUM services worked together.

Senior MI project managers and PCT commissioners appear to have taken the lead in terms of identifying where to pilot the first integrated contraception and GUM service. However, once this had been negotiated, the doctors and senior nurses concerned took leadership of the detailed design and implementation, working collaboratively with service managers and IT staff. Commissioners were also closely involved in order to reveal the benefits and value for money of the integrated model.

Following the development of the pilot integrated service, the role of clinical leadership and its relationship to managerial and commissioning leadership in developing services has shown further complexities. Commissioners have continued to back the integrated service model strongly, resulting in a sustained scope of ambition to achieve integrated services.

Clinical leadership has involved both working to achieve sufficient consensus amongst colleagues and working with service and financial managers to develop a business case for a significant investment.

Meanwhile, the second integrated service, in L4 Borough, was explicitly prompted by the commissioners, keen to realise the benefits of the pilot elsewhere, offering additional funding. Clinical leadership at this juncture included recognising the power of the commissioners, even to the extent that a failure to respond to their offer could lead to a tendering out of the service to a different provider. The next step was translating the idea of an integrated service into something that would appeal to a staff body unfamiliar with it.

Across the network of clinics that have now adopted an integrated service model, clinical leads in both genitourinary medicine and Reproductive and Sexual Health can be seen as working in a spirit of realism with a variety of stakeholders who have power to affect the future of their services. Clinicians in both trusts and in community settings have worked closely with service managers to craft a version of the service that would be credible to trust managers, professional colleagues and commissioners.

The end of the SHMI in 2008 meant that there were no longer additional resources of time or project management for designing integrated services. However, a level of collective leadership for the integrated model has been maintained through the continued existence of the South East London Sexual Health Network and the L4 and L5 Boroughs' Sexual Health Programme Board. A formal programme of collaboration between the two trusts involved, led at Board level, has since 2010 offered a further opportunity to convene more discussions looking at further integrating the system of sexual health services across the area. Senior clinicians and managers across the network of clinics have capitalised on this. A number of project groups have been set up, looking at how the network of clinics can work together as a more coherent system of care. Once more, these

formal project groups bring together clinicians and managers in joint leadership, but can be seen as building on existing informal relationships between clinics that were consciously fostered during the course of the SHMI.

Clinicians and managers have over time worked through a wide range of **clinical and organisational practices** required to deliver integrated sexual health services. These include clinical protocols, particularly those that guide which kind of clinician a user needs to be seen by, the appointment booking systems, patient flow systems for ensuring time spent in walk-in clinics is minimised, IT systems for receiving users in clinics and triaging their needs, electronic patient records and IT systems for coding treatment received, and professional training to spread integrated skills. As work with service integration has proceeded, the need for a consistent approach to payment by results (PBR) for both contraception and GUM services across all locations has emerged.

Part of the work of clinical leadership has therefore required cultivating a growing awareness of the variety of places where action may be needed as the implications of particular innovations emerge. The challenge may require locating co-leaders in particular areas. So, progress with the integrated pilot was held up for some months by gaps in senior nursing staffing which made cross-training of nurses difficult with implications for the full implementation and further development of clinic practice. And progress with the L4 Borough integrated service required finding funding for a new post to lead on GU responsibility in that service where previously there had been none.

Current operational challenges include the refinement of the system of multiple queues within clinics to make the best use of the skills available and to address the perceptions of some users that multiple queues are confusing and “unfair”. There is also work on further development of booking by text and delivering test results by text leading to an integrated system across the area with a view to making best use of total capacity. All this is being managed in the context of persisting or even increasing demand for services combined with restricted resources.

The change programme has both depended on and impacted upon significant characteristics of the **inter-professional relationships**. The formulation of the sexual health modernisation initiative grew from informal collaboration between public health, reproductive health and GU specialists, who found common cause in wanting to redesign services to make them more accessible. Leadership in shaping operational practices is broadly distributed, and the resulting patterns of work involve nurses and health care assistants working with autonomy in dealing with patients, based on dual training of all nurses and sufficient cross-skilling of doctors. This strong collective ethos recognises that differences in priorities and interests between different professional groups are real and need to be taken seriously. This includes acknowledging the way that changes in skills



practised by one group or specialism may have implications for the future role of another.

In terms of challenges associated with this aspect of clinical leadership, it is important to note that this kind of collective ethos is far from the norm within and between professional groups in many NHS services. At a number of points, it appears that some GUM senior clinicians, particularly in historically better resourced settings, have chosen to defend the established boundaries of their specialism and mode of working rather than enter into negotiations as to how roles might be developed within an integrated service model. The collective model of leading service change may be more attractive to those with less to lose.

It is likely that maintaining this collective ethos will require continued attention. Issues currently being addressed include tensions between the requirements of working in an integrated service and the professional training requirements of medical faculties. Specialist trainees or registrars may not prioritise broadening their skills beyond a certain point, if this is not required for their certificate of completion of training, even though future employment opportunities are likely to be integrated settings. There do not appear to be national requirements for nurses to conform to any particular pattern of dual training, which paradoxically makes it easier in some ways to agree integrated standard locally. However, this may also produce tensions between doctors and nurses, as more experienced nurses perceive they are becoming in some respects better adapted to working in an integrated service than trainee medical colleagues staffing the service alongside them.

In terms of **patterns of sentience**, the pilot integrated clinic has arguably now offers a strong sense of belonging for its staff, bound up with decision to merge GUM and RSH departments in 2009 and continued fostering of a collaborative ethos. Senior doctors are aware that they are unusual in the context of their respective specialisms in being employed within an integrated department. Some see themselves as belonging to a new breed of public-health oriented GUM consultants, keen to provide integrated services and with a different conception of their professional accountability from the narrower specialist focus of many in their professional community. The integrated department in itself provides a significant element of sentience.

These issues of professional identity appear as yet unresolved in other integrated clinics. Some GUM and RSH doctors working outside of the acute trust hosting the pilot project were widely reported as being wary of departmental mergers, because they wished to maintain a primary professional allegiance. There was some fear within each specialism that ethos of the other would "take over".

In terms of **performance achievements**, the integrated clinics have over the last four years demonstrated many of the anticipated performance benefits. Significantly larger numbers of people have attended, with men

and younger people making up a larger proportion. STI testing rates have greatly increased, as has the number of women receiving long acting reversible contraception. Teenage pregnancy rates in the population have begun to fall.

One persistent area of struggle in the life of the pilot clinic has been with maintaining low transit times – the amount of time a user actually spends in the clinic. As in Manchester, the success of the clinics in encouraging take-up, combined with the one-stop shop clinic template has led at times to heavy demand, combined with increased consultation times as the single clinician seeing each user deals with multiple needs. This problem has been worked with in terms of improving triage criteria in order to identify more accurately patients with complex needs so that they can be removed from queues for simple consultations that would otherwise flow more freely.

Finally, a number of themes emerge from this case concerning the overall pattern of **enablers and barriers** that have allowed the various forms of clinical leadership identified to function and produce this range of outcomes.

A first theme is the wide range of fronts in which clinicians have been involved in providing some form of leadership. These include clarifying public health need, defining and winning resources for new service models, working on detailed implementation, as well as developing informal collaborations across service boundaries. The key insight here is that each of these activities involves collaboration, but with different others – sometimes other clinicians, sometimes managers, sometimes public health practitioners or commissioners. Clinical leadership in this case featured much collaborative leadership with a wide range of different people. This is perhaps a distinguishing feature of clinical leadership.

A second theme concerns the relationship between large formal service redesign initiatives and informal cross-boundary networks or relationships. At some points, the focus has been on large formal initiatives, such as the SHMI, and at others on more informal discussions about operational details and the development of ideas as to how services could be delivered differently. Informal collaborative relationships between doctors and thinking about how to move outside of the confines of existing boundaries arguably stimulated the winning of funding for the SHMI. The working groups and pilot project resulting from the SHMI then triggered many further developments and ideas as to how run services, including nurses as well as doctors, which have been developed informally first and then found a way into formal implementation. Thus, an overarching lesson is the importance of the counterpoint between formal initiatives intended to redraw the landscape of service provision and the emergent ideas that have been developed between clinicians working within existing services.

Both the SHMI and the current inter-trust collaboration programme can be seen as momentum-giving, large scale, initiatives. They contrasted with the more piece-meal and circular patterns of reorganisation that the clinicians involved said they had experienced in the recent past. The challenge for

clinicians is then to seize the opportunity when it arises for taking a broader and more comprehensive approach to service redesign.

This case illustrates the way that clinicians working within current services can also be important sources of innovative ideas when given the time and resources to develop them. A stronger version of this point is that redesign initiatives that fail to locate emerging innovative clinical communities and tap their potential are unlikely to succeed.

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## 7 Clinical Leadership in Dementia Services

In this section the nature and extent of clinical leadership in the redesign of dementia services are described and assessed – first in Greater Manchester, and then in London.

### 7.1 *The Greater Manchester Dementia Services Case*

The findings for this case are arranged into four headings: the background conditions and prompts for change; the nature and extent of the changes and the achievements; change processes, pitfalls and barriers; the lessons to be drawn about clinical leadership.

We begin by outlining the current map of service provision, highlighting all the different agencies and boundaries between them. It became evident that, despite the policy level rhetoric about the importance of clinical leadership, its practice in the everyday reality of this service area of the NHS is that there are very significant challenges to be overcome. For example, respondents described how fragmentation of services and decision-making has often limited the opportunities for clinical input into service design. Despite these challenges a number of positive examples of how clinicians have taken leadership in shaping services are described. These include examples of creative and positive responses to apparent fragmentation with a number of clinicians finding ways of being influential across boundaries and giving effective voice to their perspectives. The case also reveals what people told us about the challenges currently facing the system of dementia care; it is evident that some form of clinical leadership has a further potential role to play. The final sub-section presents an analysis of how various forms of clinical leadership have functioned in this case.

#### 7.1.1 **Background conditions and the prompts for change**

The first point to note about this case is that it operated within a general context of what many interviewees reported as ‘well above average’ partnership working between the local authority and the NHS. It had an array of Section 75 Agreements under the National Health Service Act of 2006 between the Primary Care Trust and the Local Authority in various aspects of health and social care. These allow pooling of resources and the delegation of health service and/or local authority functions to enable partnership working. The area has benefited from some additional central government funding and several interviewees noted that there have been instances of key passionate individuals offering leadership of a partnership kind between the PCT and the local authority in relation to old people.

Clinicians were, for example, able to report that respite care for dementia sufferers experiencing a crisis was readily available through the local authority. Additionally, this area of Manchester was reported to have practised many of the features of the Dementia Strategy well in advance of its publication. And the voluntary sector presence was said to be above average, most notably because of the work of a local charity whose contribution included a £2 million spend on a Resource Centre. In these various ways, the locality might be seen as ahead of the game.

The range of services provided can be seen to meet already most of the recommendations of the National Dementia Strategy. Mental Health clinicians working in a variety of roles were able to paint a consistent picture of a single point of referral to be used by GPs who suspect that a patient has dementia. Up to the end of 2011, patients were first referred to an old age community mental health team, who reviewed the referral and passed it to a Memory Assessment and Treatment Service if they considered a dementia diagnosis was likely. Patients with mild dementia might then be passed back to the care of their GP, perhaps under medication if diagnosed with Alzheimer's disease. Manchester has a shared protocol whereby medication for Alzheimer's is initiated by Psychiatrists in specialist services, but is prescribed by GPs. Monitoring takes place almost exclusively in secondary care, it is said that most GPs do not feel able to undertake this responsibility.

More severe cases with problematic behaviours would be treated by the CMHT, where psychiatrists and nurses also provided support to private sector residential care homes, commissioned by the local authority for the elderly no longer able to live at home, including more severe later stage dementia sufferers. Should a person develop problematic behaviours that are no longer manageable within a care home, they would be admitted to an inpatient ward in the Mental Health Trust, initially for assessment. A care plan resulting for this might involve medication and discharge back to the care home. There are no long-stay psychiatric inpatient beds per se. Although there are patients identified as having intensive continuing care needs, currently there are no dedicated facilities for providing this and there is an expectation that patients will be discharged from the assessment wards. Sometimes their care has been provided in EMI nursing homes and in certain cases this has been supplemented by continuing care money to facilitate increased observation.

This care pathway is filled out by a range of services for sufferers who have been diagnosed but are still able to live at home. Following the closure of the mental health trust's day hospital, a "Dementia In-reach" team was created. This was funded out of money that had been saved by closing the Day Hospital after the contribution to that years cost improvement programme was made. This team is comprised mainly of occupational therapists, a psychiatric nurse and one psychologist. They also support six assessment beds in two private care homes as well as providing support, education and advice to patients and their carers attending a Day Centre.

The In-Reach team – recently merged into a new CMHT structure – also provided advice and support to dementia sufferers and carers living at home. Age Concern also contracts to the Local Authority to support In-Reach for families and persons with dementia.

In addition to dementia patients who enter the system via referral from GPs or via a day centre, the acute hospital recognizes that a significant proportion of its elderly – and other – in-patients prove to have some level of cognitive impairment or confusion. Following an initiative from the Royal College of Psychiatrists, from 2010 the PCT has funded a small psychiatric liaison team of MH Trust staff to work full-time in the acute hospital, providing assessment and guidance in the management of in-patients, as well as training to nursing staff in particular on elderly medicine wards. The team's remit covers mental health in general, but most of its work concerns dementia. It is led by a consultant psychiatrist, who is both an old age specialist and a general adult specialist. The liaison team works closely with medical and nursing staff within the acute trust, as well as referring patients post discharge to a CMHT for further diagnosis and a memory assessment.

The acute hospital further contains a specialist neurological unit consisting of three consultant neurologists, two neuropsychologists, and two research associates. In addition to running a programme of research on various forms of dementia, this unit provides specialist assessments needed to diagnose less common or more complex forms of dementia, some of which typically occur in people under 65.

This complex array of services can at one level be understood as an appropriate response to the diversity of kinds of dementia, the different stages of deterioration that people may present with, the variety of levels of support they may receive from carers at home, and the variety of physical health problems they as elderly people may also suffer from. Dementia patients are scattered across domestic premises, independent sector care homes, GP care, acute hospital wards (for co-morbidities such as falls) and the mental health services which in their turn were split between Community Mental Health Teams, inpatient facilities, a day centre run in partnership with a charity, and an In-Reach Team.

Our interviewees were aware of a major redesign initiative within the mental health trust involving a regrouping of services on a non-age basis. So, old age community mental health services will be dispersed into teams dealing with functional mental illnesses on the one hand, and a central Organic Team, dealing with dementia patients of all ages. At the time of our inquiries it was not at all clear whether patients with functional illnesses and some dementia will be allocated to functional teams or not. It was suggested that this is likely to be decided on a case by case basis. It was further suggested that this presents a risk of patients being passed between teams with no one wanting to take full ownership and responsibility for them.

The underlying rationale was also in dispute. Some people suggested that the main intent was to save money; others thought that the purpose was to achieve improved integration of services.

In this context of a system of care that spans many organisational and professional boundaries, the focus of our interviews was to discover what clinical leadership means and what has helped and hindered its emergence. In what follows, we examine views on the different ways that commissioners, service managers and clinicians have led in shaping these services and how far the resulting system of care is effectively integrated across boundaries, as opposed to unnecessarily fragmented. As general context, it is worth noting that a clinician involved in commissioning for dementia reported that carers were full of praise for the services, which were considered by commissioners to be at the forefront of national practice in terms of quality and comprehensiveness.

One question is the extent to which commissioners saw themselves as being responsible for the overall pattern of services for dementia (the grand design). The governance arrangements for dementia in Manchester sit under a joint body known as the 'Older People's Partnership Board'. In turn, under this sits an 'Older People's Mental Health Programme Board'. This latter body develops and drives a Dementia Action Plan. Thus, to this extent, the overall architecture for dementia services is shared across commissioners and a range of providers.

The Integrated Commissioner for Older People is the officer (and vice chair) to the Older People's Mental Health Programme Board. In a sense the members of that programme board could be seen to set the agenda. Some of that agenda involves the development of oversight of commissioned services – though this is not to be regarded as contract monitoring per se. This oversight includes services offered by the voluntary sector and the [M2] mental health service – most notably the memory assessment and treatment service.

Other issues discussed by the Partnership Board include points about the development of services delivered through the city council and through the residential care sector. There is also attention paid to the provision of services by the [M1] NHS Foundation Trust and from Primary Care.

The Integrated Commissioner (that is, the joint local authority and NHS primary care trust appointee) has overall responsibility for driving the work of the programme board. Given that, in theory at least, the programme board is the main vehicle for managing dementia services in Manchester, then this commissioner could be seen as having prime responsibility for the pattern and design of services overall.

Representatives of the diverse providers of services are invited onto the Programme Board to give their views about matters on the board's agenda. So, in that sense, clinical expertise is available to the board. There are a range of service and topic specific meetings that take place across the

dementia agenda and these meetings take place often as sub-groups to the Board. Many of these are led by clinicians and they result in service re-design. This could be considered as clinical leadership in action but delivered through a partnership approach.

The processes of leadership and governance of dementia services are thus rather subtle in practice. A great deal is said to depend on 'good-will' and 'good relationships'.

A senior member of the Older Person's Mental Health Partnership Board commented:

"I think it is fair to say that most people are not in a position to know what that detail looks like, nor what resource is needed to maintain it. I think most of the members of the partnership express their understanding of the infrastructure in terms of good-will and the willingness to work together. These are very strong emotional messages. The infrastructure which allow these interactions to happen exist below the surface and somewhat hidden from view. It is my job to worry about that infrastructure' (Local Authority/PCT Director).

The commissioners are open to suggestions for service redesign from clinical leaders though they generally require these to be cost-neutral and they want to be convinced that such proposals are based on demonstrable clinical best practice with a strong evidence base. Whether any such designs which save money lead to that money being clawed back and spent elsewhere is a moot point. This question is subject to high level scrutiny within the public sector at the moment. This area of the Greater Manchester PCT claims to have a track record of taking what they term 'safe' savings out of the system. These savings have been noted on the balance sheet for the PCT for reinvestment. A claimed good example of this is to be found in Intermediate Care.

### **7.1.2 The nature and extent of the changes and the achievements**

Despite the above account of the official governance structure, a number of interviewees made clear that there were substantial obstacles to the exercise of clinical leadership in the area of dementia services. This subsection explores this perspective.

We heard a substantial body of opinion that clinical influence has often been severely limited when services have been changed in ways that have cross-boundary implications. The services for dementia in this health economy were said, by many, to be shaped in a fragmented way and in a manner that excluded clinical input. This apparently resulted from a series of piecemeal initiatives – sometimes in response to bids for pots of funding, the emergence of new national priorities or targets, plus a series of one-off re-organisations within individual Trusts as they went in search of specific efficiencies. Such piecemeal changes in discrete parts of the value chain



were of course the kind that are criticised by whole-system theorists such as Porter (2006) and Christensen (2009) as discussed earlier in this report. Arguably this approach in turn stems from a view that each part has only been commissioned for a specific, bounded, service. Clinicians aspiring to wider cross-boundary influence would thus be defying the current design logic of the value chain. For this to succeed would require a re-imagining of that commissioner-provider relationship.

Despite exemplary partnerships in other areas of public health and health services in this health economy, many felt there was a relative lack of coordination or consultation in the area of dementia. It was noted that no one actually 'owns' dementia as a total service area as responsibility is scattered across multiple types of provider.

Perhaps in part as a result of this complexity and fragmentation a number of the clinicians and managers interviewed reported that they had limited understanding of the various parts of the system or of how they worked together. For example, when new posts were created within the acute hospital trust in order to meet the requirements of the National Dementia Audit, one of the consultants observed: 'Unfortunately we were not consulted'. Indeed, amplifying this point about circumscribed authority this medic also reported that 'We have been actively prevented from engaging with the community by the PCT'. Such observations illustrate the inconsistent institutional expectations or incentives for clinicians and their organisations to rise to the challenge of cross-boundary working.

A similar perception emerged from the clinicians employed by the mental health trust. One said: 'We are powerless. Change takes place without the approval of clinicians'. Other clinicians in the mental health trust argued that the executives on the board of the trust had both a poor understanding of dementia services and that they tended to give these services a low priority. Another interviewee reported that they had not been consulted when a review of dementia services was conducted by the PCT and when the mental health trust introduced an 'in-reach team' to work with dementia patients in the community 'I was not told this was happening'. These reports of perceived marginalisation were a common theme among many clinicians across different providers in this case.

Some GPs reported that the infrastructure of provision was unclear to them. For example, one observed: 'My personal view is that there is a lot of confusion about who is in charge of what. And the referral pathways have become confused and muddled'.

There is also a suggestion that some re-organisations have represented a moving around of the furniture rather than a fundamental attempt to tackle core issues. For example, dementia services 'previously came under the Old Age Partnership Board, it now comes under the Mental Health Partnership Board' (Local Authority Commissioner). This kind of moving around of responsibility occurred on both a large and small scale but it seemed to reflect a constant series of administrative adjustments rather than a serious

confronting of the identified problems. Another example was the way in which Community Mental Health Teams were allocated responsibility for different geographical areas and how a separate 'In Reach' team, staffed in similar ways, and which undertook similar work was created. This was eventually merged back into the CMHTs.

Another example of piecemeal responses was the way in which the PCT funded a psychiatric liaison service at the acute trust in response to the national initiative launched by the Royal College of Psychiatrists. The liaison staff perceived that they were viewed initially with some suspicion by the existing psychological services as they were thought to be providing a competing service. Additionally, they found that at first there was no lead clinician for dementia within the acute trust, leaving a gap in terms of their ability to raise the profile of dementia care with trust board. When the National Dementia Audit found the acute trust wanting in its provision of a strategic overview of care for patients with dementia, a senior nurse was appointed to fill this gap. Ironically, as one of the consultants responsible for older people in the trust pointed out, neither he nor his colleagues were consulted about this.

Crucially, many clinicians felt that they had not been involved or consulted about these various changes and that even when they tried to intervene they were excluded. The changes were seen as designed by trust level managers (both commissioning bodies and provider trusts) mainly in response to national level targets and directives and/or prompted by cost-cutting opportunities. The commitment of senior management to the needs of old age services and dementia in particular was widely questioned by clinicians, given that until recently these have not been national priorities. Some saw the closure of the Day Hospital in 2010 as one clear example of a cost saving initiative by the mental health trust. Budgets could also be cut during the year, without consultation. There was widespread concern that expertise in old age mental health would not receive sufficient support and profile in the reorganization of services along functional illness versus organic illness lines.

### **7.1.3 Change processes, pitfalls and barriers**

Whilst recognizing the constraints and limitations often placed on clinical influence, our interviewees also revealed a number of ways that they were able to show leadership in shaping how services were delivered. Indeed, given the nature and size of the barriers noted in the previous sub-section, the examples of the exercise of clinical leadership which follow are all the more remarkable.

First, clinicians working in various secondary dementia services showed understanding of how and why patients are referred to their part of the service and where they might best be referred to next. So, there is at least some evidence of clinical leadership in the sense of demonstrating

willingness and expertise in making the current, somewhat complex, arrangements work well. Examples of this included:

- CMHT clinicians understanding when primary care counselling might be best used, or when someone might need to refer to the local authority integrated health and social care team for social work or community nursing support.
- Highly developed interdisciplinary working between health and social care professionals in the old age CHMTs.
- Close informal working relationships between the MATS team and old age CMHTs, and between CMHTs, local authority health and social care teams, and voluntary sector activities for sufferers and carers.
- Geriatricians and nurses dealing with elderly patients in acute hospitals being able to explain clearly what they had learned from their psychiatric liaison colleagues and the referral options available to them when dealing with suspected dementia sufferers as in-patients. This has been facilitated by shared access to the acute trust's electronic patient record system, which makes it easy to call psychiatric liaison in and for clinicians to work together.
- Acute sector mental health clinicians believed that GPs are very clear about the referral pathway for dementia, and indeed are referring increasing numbers for memory assessments.

A second form of clinical leadership reported concerned involvement in recognized forums responsible for shaping how the service is resourced and delivered. Clinicians widely report on being involved in discussions with service managers on developments in their particular services. MATS clinicians feel they have together shaped the working model for Manchester MATS with complementary roles for psychiatrists, psychologists, CPNs and allied professionals. This includes finding a way to deliver the diagnosis sensitively and developing an effective care plan. Indeed the establishment of the MATS service and the development of the case for initial funding some years ago had strong elements of clinical participation and leadership.

There was much less evidence of clinician involvement in shaping the system of care outside of their particular service or clinical microsystem. However, an example of this was the GP clinical lead from the PCT working with MATS clinicians to establish a shared prescribing protocol for Alzheimer's medication. GP leads in the PCT have also worked to establish a GP practice that focuses on the needs of patients in residential care homes and nursing homes. This practice is however perceived by some as not very joined up with dementia services within the Mental Health Trust. Some attempts to try to work more closely with this Practice have not been encouraged by Commissioners. The Practice has its own Community Psychiatric Nurse but it was argued this nurse does not work in partnership with Community Psychiatric Nurses in the Dementia Service.

A different example of cross-boundary leadership is that of an old age CMHT team leader who made the case for locating their team in a voluntary sector community facility, thereby raising the team's profile in the community and improving collaboration with related services. During 2011, a senior old age mental health clinician was also playing a prominent role in working parties designing the new service structure, including the establishment of the specialist Organics Team.

Beyond these examples of taking part in formal cross-boundary initiatives to redesign how services are delivered, our interviewees gave several well-reasoned examples of how they thought that services could be improved by re-organising some aspects of work across boundaries. For instance, some MATS clinicians had ideas as to how the system of care could be developed to make better use of their specific expertise, by encouraging GPs to order the tests and scans needed prior to memory assessment.

A number of clinicians were also able to explain how they had gone about achieving a kind of informal integration across service boundaries, apparently in the face of disjointed decision-making at higher levels, and without being involved in any formal cross-boundary working group. For example, the head of the psychiatric liaison service welcomed the appointment of the lead dementia nurse within the acute hospital as offering a clearer route to influence the acute trust senior management, whilst the lead geriatrician also saw it as priority to work in collaboration with the person in this new role. This illustrates how clinical leadership involves taking advantage of developments as they arise, fashioning coherence from apparent fragmentation.

Similarly, although the lead geriatrician had experienced a past lack of support by the PCT for his input into community rehabilitation services, he saw the recent integration of community nursing services into the acute trust as a way for rebuilding this clinical collaboration. In a neighbouring acute hospital, a similar psychiatric liaison team has worked through the Director of Nursing to make the case for dementia training for nurses across the hospital, illustrating the clinical leadership function of finding ways of influencing managers to provide resources.

A further example of this kind of emergent and responsive form of clinical leadership takes the form of the experience of the recently disbanded "Dementia In-Reach" team, a group of professionals who have been the subject of a sequence of cost-driven reorganisations. This team initially supported patients attending the now-closed day hospital. It was reconfigured for a period of about 18 months, providing patient assessment, education and support for day centres and for sufferers living at home and in residential care homes, and finally merged into a new Organics Team. These clinicians see themselves as having a key role in bringing understanding of the range of health and social care services that are relevant to the needs of particular dementia sufferers, and are seeking to

bring this perspective into their roles as they experience yet another re-organisation.

Interviewees indicated that the following issues need to be addressed in taking forward this system of care for dementia.

There is widespread recognition of the need to maintain the quality of services in the face of funding reductions, and the need to continue to raise GP awareness of dementia, as well as the awareness within social care and health services in general. For example, whilst nurses in acute elderly medical wards have developed a good understanding of how to keep confused patients safe and how to manage difficult behaviours, these skills have not been developed in other wards where dementia is becoming increasingly common, such as orthopaedics. Thus, expertise in dementia care cannot be located only within a centralised Organics Team within the MH trust.

Late referrals for memory assessments are not simply a matter of GPs failing to pick up on dementia cases. Mild to moderate sufferers tend to be managed independently by carers, and then present at GP surgeries only when a crisis arises. Hence, there is also a need for continued raising of awareness of dementia in the community.

The level of referrals to MATS has increased significantly over the last year or so. So there is now a considerable waiting time and a need for more support for those diagnosed with mild to moderate Alzheimer's – the "gap in the middle" of the pathway, including activities and carer support. The capacity of MATS to handle the increased volume and the implications for GPs in managing the amount of prescription review implied are further significant uncertainties. There are some unresolved debates about how far memory services should be nurse led and home based, as opposed to psychiatrist or psychologist led and clinic based, on the basis that this is more efficient. Nurses feel that their involvement leads to a broader diagnosis of the care arrangements and provide the basis for a more sensitively delivered diagnosis. Currently, diagnosis is predominantly undertaken by medical staff. It was argued by the medical staff that other CMHT staff are less equipped to make the diagnosis with confidence.

Nurses within the Dementia Assessment Service are seeing patients predominantly in clinics rather than at home. Psychologists and Psychiatrists are no less likely to see patients at home than nurses. Historically, all patients within Old Age Psychiatry Services were seen at home but the volume of demand for dementia assessment and diagnosis within current resource constraints now precludes this.

GPs need to be given a clear and definitive briefing about the new non age-based system for acute MH care and how they should refer into it. They also need easier access to web-based service maps and educational resources and follow-up support for patients and carers.

Finding a single integrated way of working within the new non-age based Organics Team will be demanding, given the disparate nature of dementia sufferers and the variety of their needs. However, one priority widely reported is the need to identify earlier the emergence or potential emergence of challenging behaviours, particularly in residential homes, so their management can be improved. The new Organics Team may provide an opportunity to develop more consistent support for patients with vascular dementia, who may currently be discharged back to the care of GPs without further specialist input until a crisis arises. There is also a possibility of further increasing integrated working between health and social care professionals on the new Organics Team, in ways that are more specifically relevant to dementia

Acute MH clinicians with old-age expertise are aware that they will need to “fight their corner” in the context of the non-aged based reorganisation and funding pressures. There is a danger that expertise that has developed in straddling of primary and acute care in the old age CMHTs will be lost in the current re-organisation. Several clinicians appear to understand that promoting one’s expertise and its relevance to public health goals is an important and at times political component of clinical leadership. For example, psychiatric liaison clinicians have recognized that their input can be represented as reducing length of stay of elderly people in hospital.

#### **7.1.4 Lessons about Clinical Leadership from the Greater Manchester Dementia Services Case: Possibilities and Pitfalls**

Table 4 summarises our analysis of how local processes of clinical and non-clinical leadership have worked in this case to produce various new patterns of service provision and a reworking of organisational and professional boundaries. As in the previous cases, the top row of the table indicates how clinicians and others engaged with activities corresponding to Box D of Figure 2, clarifying public health challenges. The second row summarises how clinicians and others participated in different aspects of clinical leadership referred to by Boxes E, F and G. The lower rows of the table indicate how service boundaries were reworked and correspond to Boxes H, I, J and K of Figure 2.

The national context for the processes described for this case can be seen as stemming from the National Dementia Strategy (Department of Health, 2009). This provided the initial emphasis on early diagnosis through specialist memory services, individual care plans and support for carers.

An important part of the local context for the development of services described to us consisted of an array of services put in place over a number of years with funding from both health and social care, in fact anticipating many of the features specified in the National Strategy, including a specialist memory service. In many ways the system of care was already designed and from 2010 onwards the question was becoming how to maintain it in the face of increasing numbers of referrals for memory

assessment on the one hand a decreasing levels of resourcing in real terms, leading in particular to a need for a reorganisation of community mental health teams.

With reference to the first row of the table, most clinicians appeared to be well aware of the public health challenge of increasing rates of diagnosis to reflect the likely prevalence of dementias amongst the over 65s in population. Whilst there did not appear to be involvement of clinicians in further clarifying public health needs in a formal sense, there was widespread awareness of more detailed need in the sense of users and carers wanting greater continuity of care post diagnosis. Many clinicians were also aware of the way that dementia care often needs to be customised to particular medical and social circumstances and the way these may change for an individual over time – disease pathways and thus care pathways are to a considerable extent unpredictable. A related common theme was the need to identify “difficult to manage” behaviours earlier for those sufferers in day care or residential care, so that carers or staff could learn to manage conditions that might otherwise lead to inpatient psychiatric admissions.

Moving on down through the rows of the table, in terms of the **patterns of clinical and non-clinical leadership** in processes of change within this system of care, using the categories of the framework in Figure 2, the evidence for leadership in *implementing* and in *collaborating on improving service interface arrangements* is much stronger than that for *defining and negotiating new service models*. Many clinicians felt fully able and authorised to work with their service managers to improve the particular service they worked within – be it psychiatric liaison, MATS, a CMHT, and so on. But there was considerable clarity that budgets, service remits and staffing levels were set by higher authority and needed to be taken as given. The psychiatrist leading the relatively new liaison team working with the acute hospital was one such “leader-implementer”. In addition many clinicians – doctors, nurses and other therapists – provided examples of how they had taken informal initiatives to improve coordination with related services. Examples include members of the old age CMHTs discussing cases with their MATS colleagues and with clinicians and social workers on the local authority integrated health and social care teams.

One significant example of where a clinician – a senior psychologist – had taken a lead role in defining and negotiating funding for a new, boundary redefining service was in the establishment of the MATS team. This had been possible because of the willingness of the SHA to make funding available on the basis of national service frameworks for older people that were in place some years before publication of the National Dementia Strategy. More recent examples of clinicians taking up this innovator role were more limited in scope, for example that of a GP lead for mental health working with the PCT to establish a shared prescribing protocol between primary care and the mental health trust psychiatrists for medication for Alzheimer’s sufferers.

In principle, the Older People's Mental Health Partnership Board provides a forum for review of the total system of care and where clinicians can work with health and social care managers to propose improvements, as long as they are cost neutral. We however found little evidence of substantial proposals for change being developed by clinicians in connection with this forum. A likely explanation is the difficulty of proposing substantial changes without implying some form of additional expenditure. As we have already reported, many clinicians experienced themselves as somewhat bewildered by the complexity of dementia services and uneasy about how decisions were being made, rather than feeling themselves to be partners in a process of coherent and transparent decision-making.

Some clinicians saw the establishment of the new Organics team, integrating memory assessment, community mental health treatment and day care support for dementia sufferers of all ages, as an opportunity for genuine rethinking of how these different services work together. However, they were also clear that their remit was to work with service managers as implementers, working out operational detail on a bundle of services and resources that senior management had decided upon. There were also some pronounced concerns that senior management within the mental health trust did not see maintaining budgets for older people's services as their highest priority, at a time when "difficult decisions" were likely to have to be made.

The initiatives described have over a number of years resulted in the development of several **clinical and organisational practices** that have reworked previously established boundaries between different services. So the MATS team brought together psychologists, psychiatrists and psychiatric nurses to develop complementary roles in diagnosis, including finding an effective balance between carrying out assessments in homes and in a clinic. Community Mental Health Teams have established processes for transferring patients to the MATS team and back again. More recently, the psychiatric liaison team at the acute hospital has established a way of working with elderly medicine wards so that it can respond rapidly to patient management issues and also train acute nurses in how to care for patients who are confused or have cognitive problems.

A number of areas of clinical practice with implications for boundaries between services remain unresolved. These include concerns with the mental health teams that GPs continue to refer patients too late in the progression of their dementia, and that GPs are failing to take up an effective role in the monitoring and management of mild to moderate sufferers who are still able to live at home. Psychiatric liaison clinicians are keen to extend the kind of collaboration they have developed with elderly medicine wards to other departments, such as orthopaedics, where the proportion of patients with dementia is also likely to be significant.

Above all, many clinicians working in MATS, psychiatric liaison and community mental team roles see the need to develop clearer protocols and



practices by which more mild and moderate sufferers can be managed by their GPs, with sufferers and their carers receiving peer support in the community, brokered and co-ordinated by third sector support workers. The acute mental health services could then be reconceptualised as dealing primarily with relative short-live crises and difficult episodes, following a rapid referral “back in”. This is seen as a way of maintaining the overall quality of support without overburdening the acute sector at a time when resources are being cut and demand is rising. The desire for this kind of model of collaborative working between acute mental health and third sector organisations is arguably a major part of what is behind the various perceptions we have noted that the system as a whole lacks co-ordination.

The extent to which **inter-professional relationships** have been reworked reflects the extent to which progress has been made in redefining clinical practices. We have already noted the way that medical and non-medical roles have mutually adapted to one another within the MATS team. Within the CMHTs, various clinicians perceive that the various professional roles have developed in relation to one another, but more in terms of sharing and overlapping roles and tasks between occupational therapists, psychiatric nurses, and psychologists.

A more difficult dynamic arguably stems from the wide range of professions and models of working involved in dementia care. The list includes, but is no means limited to: old age psychiatrists, geriatricians, neurologists, community and acute psychiatric nurses, general nurses in community services, acute hospitals and care homes, GPs, social workers, occupational therapists, physiotherapists, counsellors, care assistants working in wide range of settings, dementia advisors, and therapists offering activities such as reminiscence group work, story-telling and singing. The diversity of ways of working across this spectrum makes dialogue across the boundaries of clinical or caring professions difficult and even fraught. In times of financial cut-backs, being open to influence from a different kind of professional may be seen as an attractive innovation, but it may just as easily be seen as threatening. So, some of our non-medical interviewees referred to some doctors as reasserting the primacy of “the medical model”, suggesting that other non-medical modes of care were of low priority. This was seen as a barrier to developing the kind of collaboration many desired between acute mental health services and therapists and support workers employed by third sector organisations.

Consideration of what has happened within this case in terms of **patterns of sentience** reveals a similar set of achievements and challenges to be faced. Clinicians working in MATS, CMHTs, and psychiatric liaison have developed strong identifications with their teams and the quality of the work they do. However, the initiative to set up the Organics Team and the general awareness of dwindling resources mean that there is recent widespread concern to think more widely about the system of care, along the lines just described. Many mental health clinicians appear to feel that more GPs should join them in identifying with a more complete system of

dementia care, where more patients are managed in the community. There is also widespread recognition of the importance of training programmes in dementia awareness being delivered within many health and social provider organisations by third sector organisations, commissioned by the PCT. The challenge is to strengthen the sentience of all these organisations as a system of dementia care.

The resulting **performance achievements** for the existing system of dementia care can be summarised thus. The services have achieved considerable success in terms of increasing rates of referrals for diagnosis, and indeed also in maintaining a level of continuing care for sufferers. Diagnosis and treatment for likely dementia sufferers admitted to acute hospitals for physical health issues have also improved. The challenges are now to maintain the quality of diagnosis and care that has been achieved, to improve the continuity of care available post diagnosis, and to find ways of redefining the role of acute mental health care so that much continuing support of dementia sufferers and their carers is provided by lower cost third sector organisations which are able to mobilise and sustain peer support networks and activities. One further desired benefit of raising community awareness of and support for dementia sufferers would be to reduce the proportion of those being referred for diagnosis who already have advanced symptoms.

This case brings into focus some particular **enablers and barriers** concerning the role of clinical leadership in bringing about cross-boundary service innovation. There is a strong case, illustrated by examples from the data we have gathered, that clinicians are uniquely placed to understand and negotiate the interfaces between different services. The complexity of the existing system is driven partly by the wide range of services and kinds of professional expertise that may be relevant to different kinds of dementia and stages of its development. Dementia care is by its nature cross-boundary. Clinicians are often painfully aware of gaps in co-ordination as well as of how they might be addressed. So, clinical leadership that spans professional and organisational boundaries is crucial to developing dementia services.

The case reveals that such clinical leadership is however by no means easy. Depending on the situation, it can require what is evidently rather exceptional understanding of complex care pathways, diverse institutions and a willingness to challenge each of them to contemplate a change in their familiar routines. A further element is a capability to influence other professionals (and managers) outside the customary circumference of control. Under present conditions it is not clear what incentives impel clinicians to take on such considerable challenges, other than an intrinsic motivation to understand the broader patient journey and to improve it.

One significant aspect of the problems facing effective service development for dementia is arguably structural. The existing system can also be seen as a result of mere historical accretion of diverse opportunistic, piecemeal and

partial solutions to particular issues. Disparate decision-making, shaped by top-down targets addressing particular parts of primary and secondary care, has led to a complex and fragmented array of services which are difficult for many clinicians to understand, let alone patients and carers. It is worth considering whether a result of the top-down command and control regime in the NHS combined with tick box approaches to regulation have contributed to some of these problems. For example, a regulator may ask the question "Is there a named lead for service X?" rather than "Does the named lead have the power, resources and authority to do the job?"

An apparent paradox in this context is presented by the work of the Older People's Mental Health Partnership Board. This offers a well-intentioned and indeed respected forum for multi-disciplinary consideration of the whole system of health and social care for dementia and is also led by the joint health and social care commissioner with responsibility for dispersing much of the funding. The question is then why this has not as provided a basis for improving the integration of the system of care, tackling the range of issues described here. A likely answer is that the management of individual services within the system have felt the need to focus on creating subsystem efficiencies as resources have become tighter. So it is difficult to muster much energy for larger scale initiatives, in spite of distributed awareness that they are needed. The design of the Organics Team within the mental health trust is perhaps a counter example, but even there the financial context means that many clinicians involved appear at least as strongly aware of the losses involved in this reconfiguration of dementia services on a non-age basis as of the potential gains. Specifically, they are concerned that old-age psychiatric expertise is being devalued and will not continue to be properly supervised and developed.

We may tentatively argue that there are underlying reasons why the legacy attempts at reorganisation have been fragmented and partial, and why it now appears difficult to break out of this pattern in spite of widespread awareness that the level and nature of collaboration between acute mental health, primary care and the third sector needs to change. These reasons may be traceable to the kinds of perceptions and understandings of the nature of dementia many of our respondents reported as being influential. These perceptions included, most notably, that dementia is primarily an affliction of the elderly and that in turn the elderly were low on the list of priorities of funders and trust senior management, and so there was little point in seeking radical change which might depend upon additional resources, particularly in a time of austerity and cut-backs. Further, several respondents felt that other clinicians and managers held a view that dementia was to a large extent 'untreatable', and so was not an area to invest professional effort in, because, in a performance driven culture, there would be little to show for doing so. Even clinicians who had invested years of their careers in providing and developing dementia services appeared to be demotivated from engaging further because of expectations that key managers, commissioners and other clinicians would not match their own

commitment. The likely result of this sort of despondency is acquiescence to the continued operation of limited, target driven initiatives.

The implication is that effective development of the work of the Older People's Mental Health Partnership Board will require development of a more central role for a different culture of thought on dementia, bringing out the positive role of community acceptance and support for those suffering with the condition. There is arguably a central role for clinicians in forging and establishing this way of thinking, since it involves working further on the conceptions described earlier of different professional roles and how they relate to one another. A further challenge concerns relating an emerging new model of collaboration between acute mental health, primary care and the third sector to the levels of funding still available. This is likely to involve the tackling the thorny issue of re-examining the distribution of funding across the three sectors.

In summary, the Manchester dementia case revealed a very challenging context for the exercise of clinical leadership. There was complexity, fragmentation, and even alleged discouragement of clinical engagement. In such a context, it required considerable energy, skill and commitment to seek to exert the much-lauded clinical leadership. Perhaps not surprisingly, the instances found were relatively modest. Yet the case for clinical and managerial leadership working collaboratively on system-wide issues appears strong and realisation of something along these lines appears still plausible.

**Table 4. Summary of Dementia Services Greater Manchester Case**

		<b>DEVELOPMENTS</b>
<b>LOCAL LEADERSHIP ARENAS</b>	Clarifying public health challenges	Clinicians aware of focus on improving rates of diagnosis against projected rates of occurrence in the population over 65 Focus in terms of measurable public health indicators for other parts of dementia care system is less precise, e.g. Identifying potentially unmanageable behaviours earlier
	Patterns of clinical and non-clinical leadership	Most clinicians feel authorised only to improve existing clinical settings (microsystems) that they work within. Within existing services, clinicians & managers have continued to work together to shape services in the context of budgets decided by commissioners & senior management Some clinicians have taken authority to develop constructive relations informally with related services e.g. CMHTs and social care. At least one instance of a clinician leading a proposal for funding a particular service – the Memory Assessment and Treatment Service. Clinicians in principle have input to wider proposals for service improvements under the Older People’s Mental Health Partnership Board. Yet there are few examples of clinicians explicitly authorised to co-ordinate and optimise service provision across boundaries
<b>REWORKED BOUNDARIES</b>	Clinical and organisational practices that rework boundaries	Memory Assessment and Treatment Service (MATS) has decided how to balance home-based versus clinic-based assessment. CMHT clinicians effectively manage issues in transferring patients to and from MATS and local authority social care teams on basis of established informal relationships Interface between psychiatric liaison team and geriatric care in acute hospital is well established, leading to better management of patients and reduced length of stay.
	Inter-professional relationships	MATS has developed shared understanding of the complementary roles of psychiatrists, psychologists and psychiatric nurses in diagnosis Sharing and overlapping of roles between CPNs, OTs, psychologists within CMHTs, with each team developing local preferences Mutual learning between psychiatric liaison team and geriatric medicine, for both doctors and nurses.
	Patterns of sentience	Strong identities have been shaped primarily around particular parts of the system of care, e.g. MATS, CMHTs These subsystems are however now experienced as inadequate on their own to deliver effective care within currently constrained resources.
	Performance achievements	Numbers of referrals for memory assessment have recently increased significantly, both from the community and from the liaison service at the acute hospital.

**Table 4 (contd.)**

<b>ISSUES</b>
<p>Clinicians perceive need to provide greater continuity of care throughout the progress of dementia, but in particular for mild and moderate sufferers who may currently be referred back to GP after diagnosis</p> <p>Concerns about addressing volume of need for diagnosis now being revealed</p> <p>How to configure services to meet range of individual conditions &amp; contexts?</p>
<p>Some clinicians have experienced developments in related services happening without their consultation or even knowledge</p> <p>Organics team seen by some as offering an opportunity to achieve greater coherence, and provides some formal structure and project management for reworking how different strands of care are integrated within the mental health trust.</p> <p>Clinicians involved in designing the work of the Organics Team experience themselves as having considerable scope of decision-making, however within reduced resources made available by the mental health trust.</p> <p>Perceptions that senior management are not committed to old age services at a time of cutbacks; some resulting despondency amongst clinicians</p>
<p>Volume of GP referrals to MATS is putting pressure on its capacity</p> <p>At the same time concerns amongst MH trust clinicians that GPs refer patients too late – awareness of mild dementia needs to be raised</p> <p>MH clinicians would like GPs to take a greater role in managing care post diagnosis, referring patients back to the acute sector for episodes of treatment, and making use of community support from the third sector.</p> <p>Psychiatric liaison in acute trust would like to develop closer working relationship with wards other than elderly medicine.</p>
<p>Overlapping of roles and adaptive ways of working established in CMHTs seem likely to continue within the newly formed Organics Team</p> <p>Aspirations that acute mental health clinicians develop a clearer sense of the boundary between their work of “treatment” and the “support” work of third sector organisations, in order to limit demands made on them.</p> <p>Perceptions that some psychiatrists are reasserting the primacy of the “medical model” as the most valid way to invest dwindling resources.</p>
<p>Concerns to bring GPs, and hospital clinicians other than geriatricians into discussions about the management of dementia.</p> <p>Gathering emphasis on the third sector in providing education and focus for establishing this broader community of practice in dementia care.</p>
<p>Maintaining the quality of care throughout the care pathway given the increased level of take-up and reductions in funding in coming years</p> <p>Reducing the proportion of people referred with later stage dementia.</p>

## **7.2 The London Dementia Services Case**

This case illustrates how a measure of cross boundary service redesign was achieved through the establishment of an 'integrated memory service'. Two London Boroughs and their PCTs were involved along with a number of acute and mental health trusts, GP services, and voluntary sector agencies.

### **7.2.1 Background conditions and the prompts for change**

Memory services for diagnosing different forms of dementia had previously been available in a number of different locations and were inconsistent in their approach. Geriatricians in acute hospital trusts offered outpatient memory clinics, where patients would also be assessed for a range of physical problems. Alternatively, patients might find themselves referred by their GPs for assessment by psychologists working within psychiatrist-led old age community mental health teams (CMHTs) run by the mental health trust. GPs were unclear as to where to refer patients for diagnosis and treatment and so there was a degree of happenchance about where a patient might end up and indeed in the kind of diagnosis and treatment they might then receive. Once dementia was diagnosed, patients would be referred on to a network of supporting services in essence similar in its complex and uncoordinated nature to that found in the Greater Manchester case. However, many of these services, particularly those offered by social services were less well funded and developed in this London case.

Over a number of years while many geriatricians and psychiatrists worked apart from each other in institutional silos, a few had established informal contacts with one another. These latter expressed their mutual dissatisfaction with the uncoordinated nature of their services in separate clinics. They were also aware that the capacity of their separate services was inadequate to accommodate the number of people in the local population likely to need a dementia assessment. However, initial attempts by managers and clinicians in the mental health trust to establish a new specialised memory service in one borough foundered due to lack of funding available from the PCT. Then, in 2009, the commissioners across a number of PCTs responded to the National Dementia Strategy by seeking to establish, with additional funding, exactly such a new memory service to serve two boroughs thus providing GPs with a single point of referral and a consistent approach to diagnosis.

This was prompted by the simplicity of such a process and also by the cost-efficiency of removing dementia assessments from the expensive and specialised tertiary and secondary clinics. The new service was classified as a community clinic and thus attracted a lower tariff. Apart from a senior psychiatric consultant most of the assessments were administered by specialised nurses. The main trigger and rationale was to enable 'early diagnoses' and to make inroads into the backlog of undiagnosed cases. A number of senior clinicians from the multiple teaching hospitals were ambivalent about the initiative as they feared for their own clinics, whilst

supporting the overarching goal of developing and extending the availability of memory assessment.

### **7.2.2 The nature and extent of the challenges and the achievements**

As indicated above, a significant challenge was the extant range of clinics which were offering and running memory assessment services which overlapped and even competed. These existed in the teaching hospitals and they were headed and operated by clinicians from different disciplines including geriatricians and psychiatrists.

The challenge was to bring a very diverse and powerful set of figures together to design and operate a new memory service based on the principles outlined in the National Dementia Strategy and further elaborated under the plan from the London Strategic Health Authority. Some of these clinicians had international reputations and they operated clinics dealing with various aspects of memory assessment, some closely related to dementia and some related to other kinds of brain dysfunction, which they fervently wished to protect. One or two were hostile to the national strategy, on the basis that they disagreed that the key issue with dementia was improving services for initial assessment. Such clinicians argued that the key issue was improving services for management of dementia post diagnosis.

Despite the scale of the challenges there were some significant achievements as a result of both clinical and managerial leadership. An integrated "memory service" was successfully launched and GPs in two London Boroughs were encouraged to use it as their single point of referral when they wanted a diagnosis of suspected dementia. The senior consultants from different teaching hospitals and a major mental health trust eventually succeeded in working together as a group to set up a system for managing the triage of these referrals.

Despite the conflictual nature of the design process, the new service settled down relatively unproblematically. In part this was because there turned out to be no significant loss of referrals for any of the existing clinics. There was even an unexpected gain in that 'there has been a gradual coming together of two different cultures – mental illness and the physical health model of people in hospitals'. Thus, despite the unpropitious start to the process with clinicians being essentially reluctantly led rather than in the lead, the clinicians learned to adapt to the newly emergent situation and within it to exercise a degree of cross-boundary joint leadership which they had not tried before.

The number of patients being diagnosed across two Boroughs as a result of the new memory clinic rose substantially. Significantly, this population included many who would formerly not have been referred or seen as they would have not met the previous more stringent secondary care thresholds.



This also meant that the commissioners could demonstrate that they were closer to meeting national targets on levels of referral.

An unanticipated positive outcome was that the new integrated memory clinic was able to act as a kind of triage service. Staff operating the clinic were able to direct patients to the other secondary clinics which most especially aligned with their particular needs, in particular associated physical conditions that needed to be treated.

A further positive outcome was that the erstwhile siloed and isolated medics from different specialisms who had previously experienced themselves somewhat in competition for funding began to work more closely together in developing their understanding of how a system of care could be developed. The continued existence of this professional grouping which started out as a secret even subversive cabal in the face of a perceived common threat matured into a recognised and productive working group where clinicians were able to practice peer and service leadership.

### **7.2.3 Change processes, pitfalls and barriers**

Senior clinicians and managers from a mental health trust played an important role in bringing the national dementia strategy to the attention of commissioners. Once they had done this, the project was driven by the commissioners (from the two PCTs). They established a formal project board which included commissioners, service managers and senior clinicians from the acute and mental health trusts. This represented an opportunity for the clinicians to work on an authorised body responsible for redesigning services across existing boundaries. Two years of painstaking negotiations commenced. The consultants around the table were fearful that this might threaten their existing clinics and they raised a number of objections. According to one leading consultant, the perception was that 'everything had to be moved out of the hospitals ... this caused a huge upset with the clinics'. The commissioners, keen to redesign this service area and fearful of losing the special funding, at one point threatened to put the new service out to tender if cooperation was not forthcoming.

Outside of the Project Board 'We, the consultants from these different clinics, began to meet in secret'. The clinicians initially used their meetings to establish a uniform approach to memory assessment, bringing together knowhow and methods developed by the geriatricians and psychiatrists. Under the leadership of a senior psychiatrist from the mental health trust, the consultants negotiated between themselves and reached a working understanding which resulted in the new memory service being established for initial diagnosis of patients who did not have complex neurological conditions or physical health complications. The new memory service would function also as a triage service, allocating referrals from GPs either to the other existing memory clinics or to its own assessment clinicians, according to which kind of assessment would be most appropriate for each patient. So patients with physical health conditions would be seen in a memory clinic

within a geriatric medicine outpatient service, or those with likely neurological complexities would be seen in a neuropsychiatry clinic. As a leading hospital consultant noted, 'we were slow to progress over the past two years because there were big personalities involved ... throughout there was quite a bit of tension'. The key issue was whether a central referral point, required by the commissioners, could be trusted to represent the best interests of all the existing clinics.

A further feature of the new memory service was the role of its nursing staff in care planning for people once they had been diagnosed, including arranging periodic reviews for those prescribed with medication to arrest the development of Alzheimer's disease. Sufferers were also allocated a Dementia Care Advisor employed by the memory service, as advocated in the National Dementia Strategy. The purpose of this role is to advise people on the various legal processes and social supports, as well as health services that will be available to them as their condition progresses.

The new integrated memory clinic was launched and careful evaluations of numbers being referred and dealt with indicated a successful launch. The initial fears of many clinicians seemed to have been unfounded. However, some senior clinicians remained unconvinced and cautious. They saw an element of 'propaganda in [the commissioners] showing the Department of Health that they have implemented the National Dementia Strategy ... maybe I am paranoid but I see them closing down dementia services outside this memory clinic'.

The work of these senior clinicians in leading service redesign reveals the situation-dependent nature of the leadership of service redesign. In a context where prestigious clinicians, working within powerful institutions with world-renowned reputations faced determined commissioners, skilled leadership was required on the part of both clinicians and commissioners to bring about change which was perceived to threaten professional investments in existing clinics.

In such a context, it could be argued that the resulting new memory clinic was a significant achievement. But, when compared with the wider canvas of services needed to support people with dementia post diagnosis, this example of a cross-boundary service redesign could be regarded as a fairly modest outcome. The redesign of memory services in the London case at one level achieved an outcome already achieved several years previously in the Greater Manchester Case. Clinicians and commissioners alike acknowledged that funding cut backs across the London boroughs meant that support services particularly for people with mild to moderate dementia living with their carers at home were patchy and needed further development. Even more so than in the Greater Manchester case, clinicians in this London case did not apparently have an institutional forum for engaging in a more comprehensive approach to service redesign.

Notably, this did not prevent clinicians from thinking about how services could be better integrated, or showing cross boundary leadership often of

an informal or emergent kind, as in the Greater Manchester case. They found opportunities to improve interfaces between services, often establishing direct contacts with other clinicians even though the formal management systems were fragmented and difficult to work with. So, the consultants involved in the memory service found a way to share a nurse post between the new memory service and one of the existing geriatric clinics, leading to sharing of learning between hospital nurses in geriatric clinics, psychiatric nurses working in the new memory service and general nurses dealing with dementia through the acute hospital. The nurse leading the new memory service worked with her opposite numbers on CMHTs to clarify guidelines for when patients should be referred on from the memory service, and the lead nurse in a geriatric outpatient memory clinic worked with community nurses from various acute trusts and third sector dementia advisors linked to the new memory service to improve their understanding of how geriatric outpatients could continue to support patients. These instances of cross-boundary collaboration reveal the emergent and dynamic nature of clinical leadership.

#### **7.2.4 Lessons about Clinical Leadership from the London Dementia Services Case: Possibilities and Pitfalls**

Table 5 summarises our analysis of how local processes of clinical and non-clinical leadership have functioned in this case to develop a new element of service provision with accompanying reworking of organisational and professional boundaries.

Referring back once more to the framework shown in Figure 2, the national context for these processes has, as in Greater Manchester, been provided by the National Dementia Strategy (Department of Health, 2009) , with its emphasis on early diagnosis through specialist memory services and subsequent care planning. In this particular case, it is worth noting that a key mechanism for bringing the national strategy to the attention of the local system, in particular the PCT commissioners, was provided by a senior clinician in the mental health trust who had been one of the principal authors of the national strategy. The national strategy had drawn to a significant extent on experiences of establishing a specialist memory service in another London borough. So the national clinical leadership role of writing a Department of Health strategy merged with the more local clinical leadership role of proposing the setting up of a specialist memory service in the boroughs involved in this case.

The first row of Table 5 describes how clinicians and others were involved in clarifying public health needs relevant to this case of service development. The national strategy shaped the local context through its direct influence on the London Dementia Strategy (NHS London 2009), produced by the Strategic Health Authority. This was generated by a group composed of commissioners and senior clinicians from across London, and contained more detailed guidance on the commissioning of dementia services as well

as psychiatric liaison services, and guidance for acute hospitals on how to improve detection and management of dementia for in-patients. Most significantly it included a table indicating the proportions of people over 65 in each London Borough registered as having been diagnosed with dementia, compared to the projected number based on the population size and the known prevalence. Across London, this proportion was less than 40%, indicating significant under diagnosis. This table and the strategy it supported can be seen as the joint product of commissioners, public health professionals, and clinicians. It indicates that leadership in defining the public health focus for improving dementia services was jointly held between these three groups. The London table showing under-diagnosis of dementia had a direct bearing on confirming the need for additional memory service capacity in the two boroughs.

Turing to the second row of the table, in terms of the **pattern of leadership** in processes of change, this case at one level appears to offer a prime example of clinicians taking leadership, jointly with managers, for defining a new service – the memory service - and negotiating resources needed to bring it into reality. Senior clinicians from the acute and mental health trust worked with commissioners to identify how a combination of new funds released through the National Dementia Strategy and some re-allocated funds from other old age mental health services could fund the new memory service. This same group of senior doctors then worked with a service manager and with senior nurses recruited to lead the team for the new service to develop operating protocols. The model that emerged was in fact not a single new memory service, but a new memory service team that had its own capacity to diagnose patients with suspected dementia and plans their care, whilst working collaboratively with a small network of existing memory services in various hospitals, which fulfilled similar functions for particular kinds of patients.

This formal, project-managed work of service definition and then implementation drew on the relationships previously established informally between senior geriatricians and psychiatrists – the fact that they knew one another already and had previously experimented with ways of improving interchange between their clinics meant that they were more rapidly able to get down to the work of reviewing the range of possible clinical protocols and making choices. So, as in the London Sexual Health Services case, a formal redesign initiative can be seen as springing from previous informal work at spanning boundaries.

It is worth noting that a particular set of circumstances led to the resourcing of this project to set up a new service, in particular the availability of additional funding from the national dementia strategy. Participants are aware that future commissioners may want evidence that the particular model of memory service developed – a network of memory clinics, but with a single point of referral – is the most effective use of resources.

It is also apparent that the system was designed collaboratively by senior clinicians already in some way involved in memory services. The project board included a representative of the third sector organisation supplying the dementia care advisors who would work within the new memory service. But otherwise, there was little input from clinicians involved in other aspects of dementia care, such as GPs and community mental health team practitioners. Whilst the memory service project board and senior clinicians meetings provided forums for debate and discussion on difficult issues concerning how the network of memory services would function, there was no such recognised forum for involving clinicians or social care professionals involved in other parts of the system. Once the new memory service was operating, leadership in terms of liaising formally and informally with other related services was however taken up by senior nurses working within the various clinics.

Moving on to the third row of the table, the central point of referral leading to triage of cases and onward referral to the most appropriate memory clinic was clearly seen by participants as a central feature of the new **clinical and organisational practices** resulting in this case. We have already described the intense clinical input that went into crafting this arrangement. A further key area of changed practice concerned the set of diagnostic techniques agreed on and used, albeit with some variation, across the network of clinics. The variation most importantly took the form of largely home based visits by community practitioners working for the new memory service, contrasted with initial memory assessments carried out by doctors in geriatric outpatient clinics. Home based visits allowed clinicians to ask carers to fill out assessment instruments which allowed further assessment of the sufferer's mental state and capabilities. Nurses in the new memory service team provided care planning for people once they had been diagnosed. A new element in this was the role of the two Dementia Care Advisors (DCAs), also attached to the memory service team, who provided further advice on accessing services over time. This DCA role can be seen as an attempt to help dementia sufferers negotiate the boundaries between various health, social care and legal services that they may need. We have also already referred to the protocol agreed with Community Mental Health Teams for transferring patients with psychiatric needs once they had been diagnosed within the memory service.

A number of areas of practice remain unresolved, illustrating areas where clinicians will need to continue to work with others to bring about progress. The issue of the relative benefits and costs of home-based assessments versus outpatient clinic assessments was still being debated at the time of fieldwork. The new memory service team worked through visiting patients at home, reflecting the established way of working of old age psychiatry and also shaped by the fact the new team did not have premises suitable for running its own clinic. A move to better equipped premises was under discussion, which would allow offering users the option of coming to clinic for assessment. The geriatric memory clinics were all conducted with

outpatient clinics, with the doctors concerned clear that this was essential for them to be able to see several patients during one session. The counter argument from the new memory service team was the desirability of being able to spend time with the carer as well as the patient being diagnosed, and also to be able to assess the wider family situation and physical home environment.

A further unresolved set of issues concerns how patients are followed up with across the different clinics within the memory service network. The new memory service team retains for periodic review patients who do not need to be referred to community mental health teams, but otherwise does not have the resources to become closely involved in their further care. One of the geriatric service-based memory clinics decided to pass its diagnosed patients on to the new memory service team for care planning and review. Another one had however developed its own capability for care planning and oversight of care on a continuing basis. As a result, at least two different approaches to supporting continuing care and care planning co-existed across the network of memory services. This was seen as unproblematic for the moment, but as more people were diagnosed through the new memory service team, there was also recognition that greater standardisation might be needed in order to make the best use of resources.

Closely connected to debates about the best way of managing continuing care was a widespread concern about difficulties in arranging basic social care for sufferers. The local authorities concerned had both adopted high thresholds for accepting patients as eligible for personal care support, due to reductions in social care budgets. This meant that assessments of need carried out within NHS clinics could not be taken account of – local authority social service departments had to carry out their own assessments, according to stringent criteria. Staff across the network of memory clinics had begun to experience their social care colleagues as increasingly remote.

A third set of issues indicating the need for further development of cross-boundary practices concerned financial and reporting frameworks for memory clinics. The four clinics involved in the network each had different reporting systems and bases for payment from PCTs. Three of the four did not have payment or reporting systems that were specific to memory assessments or dementia care planning – these services had to be coded using more generic service headings in geriatric care or neuropsychiatry. As a result it was not possible to produce accurate figures across the network of clinics as to how many dementia patients were being seen and diagnosed, and how much this was costing.

In terms of developments in **inter-professional relationships**, the work of doctors and nurses across the network of clinics can be seen as following patterns already developed in both geriatric care and old age psychiatry where senior nurses work with high levels of autonomy. In the new memory service team, cognitive assessments were carried out by experienced psychiatric nurses or community practitioners with a related background

such as psychiatric social work or occupational therapy. Diagnoses are however agreed within a regular weekly multidisciplinary team meeting, which is led by a psychiatrist, and also sometimes attended by one of the geriatricians. In the geriatric clinics, initial assessments were carried out by doctors in the context of a physical examination, but care planning and cognitive reviews were undertaken by nurses. The main innovation in this picture was then the introduction of the DCA to undertake longer term care signposting, including working with dementia sufferers and carers on legal and financial issues they may have to face such as making living wills and transferring power of attorney. The interface between this role and that of nurses in the geriatric clinics and in the new memory service team was at an early stage of clarification.

The network of clinics is widely seen as having provided the opportunity for deepening professional learning and exchange between elderly medicine and old age psychiatry clinicians. The weekly multidisciplinary meeting held by the new memory service team provides a particularly strong focus for this, but closer relationships at the level of senior nurses has also been made possible by some sharing of posts of across the clinics. The relationships that have developed further take the form of rapid email consultations, for example when the psychiatry-based memory service team wants a medical opinion as to whether a particular patient is sufficiently clear of physical health issues to be able to benefit from anti-Alzheimer's medication. Overall, the professional roles appear to have become more collaborative, without significant contests emerging over particular areas of jurisdiction. This inter-disciplinary collaboration has been further extended to take in the vital role of specialist neuroradiologists, who are able to interpret MRI brain scans to allow judgements to be made as to whether an individual should be treated as a case of Alzheimer's disease or as predominantly a case of vascular dementia.

The development of the network of memory clinics appears to be accompanied by some interesting dynamics in terms of **patterns of sentience**. Staff within the new memory service team identify with this team, whilst finding their interactions with the other memory clinics valuable. The senior clinicians group that has fought to gain recognition for the triage system across the network of clinics have however developed a degree of collective identification with this enterprise. One member of this group referred jokingly to the group as "rebels", meaning that they had achieved a degree of autonomy from their home trusts in the way they worked. Other members of the group took similar satisfaction in the way of working achieved, but also recognised that it had been made possible by an ambitious programme of collaboration agreed at very senior level between the trusts, which was looking for trail-blazing collaborative projects.

This emerging collective identity across the network of memory clinics contrasted markedly with expressions of frustration by clinicians involved at lack of participation by GPs and also social care agencies in taking dementia care forward. However, the sentient boundary around the wider system of

dementia care was clearly weak. Relationships between the memory clinics, primary care and social care were underdeveloped.

In terms of service **performance achievements** resulting from all of these developments, the new memory service team is now diagnosing significantly larger numbers of people than could previously have been seen within community mental health teams. Moreover many of these are early stage sufferers ie who would not have met the normal criteria for being seen by a secondary mental health service. So the new service is meeting the public health need it was set up to provide for, the need to provide access to early diagnosis for dementia. It may be difficult to balance success in increasing rates of diagnosis with success in providing sustainable continuing care.

We may summarise the **enablers and barriers** to clinical leadership for bringing about cross boundary change in this case as follows. Clinical leadership for extending and harmonising the existing capacity for diagnosing dementia for this has drawn on existing informal relationships between senior clinicians. They experienced themselves forming a kind of "rebel" grouping or cabal, to win resources from the PCT and their respective home trusts, to establish a new memory service team and at the same time consolidate a multi-clinic network of memory services. They made the case that this differentiated network of clinics better met the range of public health needs related to dementia, in particular the fact that dementia is often accompanied by old age medical issues.

Within this new network of clinics, psychiatrists, geriatricians, CPNs and general nurses have worked to establish new diagnostic processes and learned how to develop their roles to work effectively with one another. Key unresolved issues are however: establishing effective working relationships with GPs, who appear reluctant to refer people to the memory service in a timely way and to take up a role in the management of patients; and finding an effective way of working with services for continuing support of mild and moderate sufferers. Working relationships in both directions appear under-developed. And there is a lack of a forum or mechanisms for building identification with this wider system that could provide the basis for leadership and action.



**Table 5. Summary of Dementia Service London Case**

		<b>DEVELOPMENTS</b>
<b>LOCAL LEADERSHIP ARENAS</b>	Clarifying public health challenges	Clinicians, commissioners and managers share a focus on increasing rates of diagnosis: clinical commitment to improving memory services and rates of diagnosis has been taken up by commissioners via the National Dementia Strategy
	Patterns of clinical and non- clinical leadership	Senior clinicians group fought for authority to design and operate system of triage between a network of memory clinics over two boroughs, taking into account existing investments in expertise and building links between psychiatric and geriatric acute diagnosticians. Senior clinicians and managers collaborated with commissioners to re-allocate some existing service budget and take advantage of new funds linked to national dementia strategy, also linking the new networked service to formal programme of collaboration between the acute trusts Project management support made available for memory clinicians in designing the service, supplemented by use of discretionary time in establishing senior clinicians group Redesign initiative built on previous informal collaboration between psychiatrists and geriatricians Senior doctors and nurses both led in implementation of clinic operation
<b>REWORKED BOUNDARIES</b>	Clinical and organisational practices that rework boundaries	Single point of referral for dementia diagnosis, with triage leading to assessment within one of a network of differentiated memory services More consistent diagnostic techniques used across this network, with evidence of learning between clinics Care planning process in place for mild and moderate dementia sufferers, with some links to community support Protocol agreed for referring patients with psychiatric complications on to Community Mental Health Teams.
	Inter-professional relationships	Senior nurses involved in operational development of protocols and work with considerable autonomy Dementia care advisor role introduced within the memory service, providing signposting advice to sufferers over an extended period. Collaboration and learning between geriatricians and old age psychiatrists, drawing in neuroradiology for effective diagnosis
	Patterns of sentience	Senior Clinicians have developed sense of belonging to a “rebel” group running the network of memory services, together managing their relationships with their “home” trusts.
	Performance achievements	New clinic diagnosing significant numbers of people who would not have met previous secondary care thresholds and offering a consistent service

**Table 5. (contd.)**

<b>ISSUES</b>
Some uncertainties about the future priority of old age mental health, although has recently risen up the priority rankings of the PCT.
<p>Alternative commissioner-led model of a single discrete memory service was resisted by clinicians</p> <p>Continued funding of the networked model under future commissioning arrangements may depend on demonstrating its cost effectiveness</p> <p>CMHT continuing psychiatric care clinicians and managers were not involved in planning the memory service, but some involvement after implementation</p> <p>Lack of a forum for discussion between the wider network of clinicians and care professionals and development of more integrated plans for the dementia care pathway</p> <p>Informal leadership in making interfaces between diagnostic and continuing care tends to lie with a few senior nurses</p>
<p>Relative costs of different models of staffing and home vs. clinic location of memory assessments unresolved</p> <p>Different clinics have inconsistent follow-up processes and criteria for discharging patients vs. keeping them registered; uncertainty about the nature of follow up care to be expected under the geriatric service tariff</p> <p>Lack of effective interface with social care: little interaction with community support for mild and moderate sufferers, other than through DCAs.</p> <p>Lack of integrated systems for financing memory assessments or recording levels of activity</p>
<p>Boundary between diagnosis and care planning roles still being negotiated; how much autonomy will DCAs have?</p> <p>Can memory assessment be further routinized and detached from the sphere of senior doctors?</p>
<p>Sense of belonging to a wider set of dementia care services is confined to senior nurses in the memory clinics who have developed informal relationships with counterparts in community services and the third sector</p> <p>Boundaries between memory service clinicians, GPs and social care professionals are underdeveloped</p>
<p>Is the priority improving diagnosis rates or also improving subsequent care planning and coordination?</p> <p>Will increasing rates of diagnosis actually make services more manageable or produce overload?</p>

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## 8 Cross Case Comparisons

The four cases reveal some interesting common and dissimilar features in terms of the kinds of clinical leadership involved, the kinds of cross boundary service redesign or innovation involved, and the factors that have helped and hindered the role of clinical leadership in achieving more effective services. These are summarised in Table 6. The order of topics for the rows of this table correspond to the boxes describing the “local leadership arenas” and “reworked boundaries” constellations in Figure 2.

The first row summarises the cross boundary agenda in each case - the kind of cross boundary arrangements that were being sought or debated and how these aspirations related to better meeting public health needs. This corresponds to the aspirations for cross boundary service redesign at local level resulting from activities in box D of Figure 2, as shaped by national level processes in boxes A, B and C.

The second row indicates how various forms or arenas of clinical leadership described by boxes D, E and F actually manifested themselves in each case. The third and fourth rows correspond to Box H, dealing with the actual changes in clinical practices and other related practices, and those that are still under discussion. The fifth and sixth rows correspond to boxes I and J dealing with changes to professional roles and patterns of belonging (sentience) associated with cross-boundary changes in how services are delivered. Row 7 summarises performance achievements reflecting Box K.

In what follows, we now discuss the implications raised by each row in the table.

**Table 6. Cross Case Comparisons**

	Greater Manchester Sexual Health	London Sexual Health
<b>1. Cross boundary agenda</b>	<b>Horizontal integration with vertical differentiation:</b> providing integrated sexual health services for through a network of differentiated clinics: Spoke clinics, offering basic services, and a Hub, offering more complex services.	<b>Horizontal integration with vertical differentiation:</b> providing integrated sexual health services through a network of one-stop-shop clinics, each offering comprehensive services, but with tiered queues according to complexity within each clinic.
<b>2. Forms of clinical leadership</b>	<b>Implementation leadership</b> Integrated model proposed and resourced by service development managers. Medics and nurses led implementation rather than conceptualisation. <b>Informal collaboration:</b> exchange & learning within a wider network of Sexual Health clinics	<b>Informal collaboration:</b> Informal linkages between doctors in separate services led to... <b>Defining new service configuration:</b> funded transformation programme with significant medical leadership. <b>Implementation leadership:</b> medics and nurses led implementation <b>Informal collaboration</b> between doctors has fed into to further integration across clinics
<b>3. Cross boundary practices developed</b>	<b>Merging clinical practices:</b> GU and contraception nursing <b>Incorporating elements from one area of practice into another:</b> GU medicine into reproductive health medicine and vice versa <b>Reworking administrative systems:</b> IT systems for booking and records	<b>Merging clinical practices:</b> GU and contraception nursing <b>Incorporating elements from one area of practice into another:</b> GU medicine into reproductive health medicine and vice versa <b>Reworking administrative systems</b> IT support and booking systems <b>Reconceptualising the role of users:</b> self-triage using IT kiosks
<b>4. Practices still needing development</b>	Tariff systems for integrated services	Tariff systems for integrated services
<b>5. Professional roles and relationships</b>	<b>Development of nurses</b> with dual skills often <b>working autonomously</b> , challenging the relevance of part time less specialised doctors. More <b>autonomous working by healthcare assistants</b> & receptionists. Difficulties of recruiting <b>dual trained senior doctors</b> .	<b>Nurses</b> have merged specialisms and work with <b>greater autonomy</b> . <b>Health care assistants working with considerable autonomy</b> across a range of clinical and diagnostic functions. <b>Tensions between dual-trained nurses &amp; trainee doctors</b> under separate specialisms
<b>6. Development of patterns of sentience</b>	Emergence of significance of regional network of services and clinics	Emerging identification with network of integrated clinics vs. identification with existing specialisms
<b>7. Performance achievements</b>	Service redesign increased rates of attendance and diagnosis & reduced waiting time	Service redesign increased rates of attendance and diagnosis & reduced waiting time

Table 6 (contd.)

	Greater Manchester Dementia	London Dementia
<b>1. Cross boundary agenda</b>	<b>Improving boundary navigation:</b> Increase diagnosis rates through a single point of access; improve dementia care in acute hospitals; improve co-ordination of post-diagnosis care across multiple agencies, with greater roles for primary care, 3rd sector & peer support.	<b>Improving boundary navigation:</b> Increase diagnosis rates through a single point of access; improve dementia management in acute hospitals: provide a unified approach to care planning following diagnosis.
<b>2. Forms of clinical leadership</b>	<b>Defining new service configuration</b> Clinicians and managers led in establishment of memory service <b>Implementation leadership:</b> doctors and nurses shaped implementation <b>Informal collaboration:</b> Medics and nurses now link informally between related services, with aspirations for a more integrated approach to post-diagnosis care.	<b>Informal collaboration:</b> Informal linkages between geriatricians & psychiatrists led to... <b>Defining new service configuration</b> Clinicians and managers led in establishment of memory service <b>Implementation leadership:</b> doctors and nurses shape implementation of memory clinic network <b>Informal collaboration:</b> Nurses link informally with related services
<b>3. Cross boundary practices developed</b>	<b>Incorporating elements from one area of practice into another:</b> psychiatric liaison and elderly medicine <b>Reworking administrative systems</b> Using EPR to get rapid response from psychiatric liaison in hospitals <b>Reconceptualising the role of users:</b> carers and suffers providing peer support	<b>Incorporating elements from one area of practice into another:</b> elderly medicine and psychiatry in dementia diagnosis <b>Reworking administrative systems</b> Triage system for referral to most appropriate memory clinic; care planning system
<b>4. Practices still needing development</b>	Redrawing conditions for referral from one practice to another. Realigning financial systems	Redrawing conditions for referral from one practice to another. Realigning financial systems. Reconceptualising the role of users.
<b>5. Professional roles and relationships</b>	<b>Significant nurse autonomy</b> in memory clinics; nurses lead on linking between services. <b>Learning between psychiatry and geriatrics,</b> for doctors and nurses <b>Overlapping roles between different professions</b> in community mental health teams.	<b>Significant nurse/community practitioner autonomy</b> in memory clinics; nurses lead on linking between services. <b>Introduction of care assistant roles</b> as Dementia Care Advisors. <b>Learning between psychiatry and geriatrics,</b> for doctors and nurses
<b>6. Development of patterns of sentience</b>	Strong identification with old age services; confusion and frustration at lack of clarity about the larger picture of how acute mental health, primary care and third sector services should relate to one another.	Memory network provides an alternative source of identification, in addition to "home" trusts. Concerns at lack of integration and interface with continuing care services.
<b>7. Performance Achievements</b>	Increased rates of diagnosis within community and within acute hospitals.	Increased rates of diagnosis in the community

## **8.1 Cross Boundary Agendas**

The first row indicates that, in both sexual health cases, the underlying cross boundary agenda was to offer integrated sexual health services rather than separate GU and contraception. In both cases, the solution was to put in place clinics that offered both services, delivered mostly through one clinician. So the fundamental boundary issue was to re-cluster services moving away from existing specialisms, in effect creating a new composite clinical area –sexual health - which required composite clinicians. We will return shortly, in the context of a different row in the table, to the issues in creating these composite clinicians. Here it is worth noting that this new horizontal clustering of services involved simultaneously creating a new kind of vertical boundary, between different levels of complexity of the composite service. The basic rationale for this is to match the complexity of the skills of the clinician involved to the nature of user need in the interests of efficiency of use of resource. Ensuring simple issues are dealt with in one location or queue also ensures that patient flow and waiting times are optimised. In the Greater Manchester sexual health case, differentiation of services was achieved by a decision to differentiate clinics along a Hub and Spoke model. In the London sexual health case, a different model was adopted, involving differentiating queues within the same clinic. In effect, the Hub and Spokes exist together under one roof.

The two dementia cases can be seen as addressing cross boundary issues of a nature different to those described for the sexual health cases, but again share similarities with each other. In both, a key boundary innovation is the introduction of a memory service as a single mechanism by which people with a particular range of conditions – dementias – can enter the system of secondary health care. So the boundary innovation is the creation of a specialist mechanism by which GPs and dementia sufferers can navigate or cross the boundary into secondary services. The theme of helping dementia sufferers navigate the boundaries between the range of health and social care services they may need to access over the course of progression of their condition is a prominent one in both of these cases. The issue is not so much how to merge existing services as how to help users and carers understand how to get the services they need, given that the nature of these needs can vary hugely from individual to individual and over time for a particular person and set of circumstances.

In parallel with the memory service taking referrals from GPs, in both cases there was the development of psychiatric liaison in acute hospitals as an important route by which patients in acute hospitals are identified as having dementia. Much of the debate in the London case is how far the memory service can manage the boundaries between the different kinds of memory clinic already operating, and how far it can help dementia sufferers access the range of services they need after diagnosis. In the Greater Manchester case, the memory service was established several years earlier and the

agenda was arguably already more advanced in terms of having mechanisms in place for referring mild and moderate sufferers on to other services, whether community mental health teams or day care. However, at the time of our fieldwork, new challenges in managing boundaries and their navigation were becoming focal. Clinicians were concerned to clarify routes through the system and to find a smoother way for patients to be referred back into the secondary health system for short periods of treatment, whilst being supported in the community by a combination of third sector support workers, activities and peer networks for sufferers and carers.

The differences and also richness of the issues concerning the nature of service boundaries in these two services undoubtedly only partially illustrates the range of service configuration issues that are currently being tackled or emerging within the NHS. Our analysis suggests that one of the tasks of clinical leadership, working together with managerial leadership, is to take stock of how boundaries between services and specialisms currently function and in what ways boundaries may need to be reworked. A fundamental question is the extent to which new groupings are needed, as opposed to improving how existing groupings relate to one another. Both kinds of issues are present in all four cases, but in very different proportions. These distinctions relate to the literature on the design of complex systems of organising in terms of frameworks for describing various mechanisms for achieving integration of activities, such as administrative, normative, operational and structural integration (ref needed!). In the sexual health cases, the path of structural and operational integration appears most relevant. The dementia cases, the balance of attention seems to be on administrative and normative integration, although the memory clinic is a structural intervention and ensures operational consistency in how memory assessments are carried out.

## **8.2 Local leadership arenas**

The second row of Table 6 summarises the arenas or forms of local clinical leadership involved in each case. Here, three of the cases show broadly similar patterns, with one, the Greater Manchester Sexual Health case appearing rather different. In the London Sexual Health case and both Dementia cases, there is a suggestion of a cyclical pattern in modes of leadership, moving backwards and forwards between informal collaboration and formally planned and resourced initiatives. Informal collaboration between clinicians in related services provides a basis for the formulation of a significant planned initiative to innovate in the configuration of services, with substantial involvement of senior doctors in the definition of the new configuration and the securing of resources for it. Service managers and commissioners are also involved in this definition activity. In the both dementia cases, the new service element took the form of a memory service. In the London Sexual Health case it took the form of a pilot integrated clinic, leading to the creation of further examples along similar lines. This definition work moves into implementation leadership by

clinicians, which involves senior nurses at least as much as doctors. Implementation then moves into further clinical leadership in the sense of making interfaces function effectively around the new service element or configuration being implemented. In the dementia cases, this linking work involves for example the interfaces between the memory service, psychiatric liaison and community mental health teams. In the London Sexual Health case it involves developing exchange and learning between the different integrated clinics that have now emerged. Particularly in this case and in the Greater Manchester Dementia case, there is then evidence of further more formally planned initiatives emerging – respectively, a formal network arrangement between clinics and an overarching team structure for all secondary mental health services focussed on dementia.

In the Greater Manchester Sexual Health case, clinical leadership appears to focus mainly on the work of implementing the integrated clinic principle agreed by commissioners and public health professionals at SHA and PCT levels. However, there was also a kind of leadership role provided by the Manchester-wide network of sexual health services, which acted as a forum for exchange and conduit for learning about how to run integrated services. The significant feature of this case appears to be comparative absence of clinical input in the formulation of the new model of integrated clinics – conceptualisation was led by commissioners and by public health. The case perhaps illustrates that this kind of model may be needed, particularly when there is no critical mass of clinicians who are actively seeking to create a new model. The case also illustrates the importance under such circumstances of carefully engaging senior clinicians to take up a full role in implementation. As a consequence of this successful engagement, we may speculate that the lead clinicians now involved in running the services are becoming heavily involved and pro-active in the exploration and definition of a new Manchester-wide network of services, matching the same kind of role being played by their London counterparts in institutionalising a similar network of clinics on a more formal basis.

We should also re-emphasise here that all of the areas of clinical leadership identified here involve clinicians working with others – above all with managers and commissioners for defining and resourcing new service configurations, and with managers, administrators and IT staff for implementing new kinds of clinical practices. So, clinical leadership involves working and leading jointly within different constellations of professionals at different points. A tentative conclusion is the importance of clinicians taking learning and perspectives from one constellation into another. So clinicians working in the definition and resourcing of a new service element can often make productive use of what they have learned through informal collaboration to improve service interfaces, and clinicians working on implementation may need to draw on what they have learned during the process of defining and winning resources for a new service or unit. The different realms of clinical leadership we have identified may appropriately



involve different clinicians, but there appear to be strong benefits to having some overlapping membership as well.

### **8.3 Reworked clinical and organisational practices**

The third and fourth rows of Table 6 provide an overview of the work that has been done and that is still underway across the four cases in terms of developing clinical practices and other related practices, needed to bring into reality the cross boundary agendas described in the first row. Unsurprisingly a common focus in the two Sexual Health cases has been the development of an integrated clinical practice dealing with sexual health. This has however taken place mainly at the nursing level, since these clinicians have dealt with the lower and middle layers of user complexity, where dual skilling of all clinicians appears more viable. For the doctors dealing with more complex cases, complete dual skilling in contraception and GUM appears not to have occurred. Doctors have kept within their primary discipline, of GUM or Reproductive Health, but have incorporated within their practice a more basic level of competence in the other discipline.

Both Sexual Health cases have also involved a reworking of clinic administrative and operational processes to ensure that patients flow enter the right clinician queue – in the London case – or are referred on rapidly to the Hub clinic, if the need to be, in the Greater Manchester case. In both cases, there has been substantial investment in IT systems to support the kind of patient flow that is needed. So clinical practices have been very closely linked to and supported by new operational and administrative systems. In both cases, further development of the model of integrated care appears to be linked to the development of a tariff system that rewards clinics for activities actually undertaken, as opposed to the existing model of a single level of payment for acute STI testing and block contracts for community-based contraception.

The London case has a further distinctive component: the encouragement of active user participation in the process of care, through self-triage, supported by IT, and through self-service for test kits for straightforward STI screening.

The two Dementia cases show a similar vital role for the development of administrative and operational systems to support new clinical practices. However, the nature of the changes in clinical practices relevant to pursuing the cross boundary agenda for these two cases are rather different from those in the two Sexual Health cases. The emphasis is on incorporating areas of practice from one discipline into another for both nurses and doctors. Elderly medicine nurses have for example learned techniques in dealing with confused patients from their psychiatric liaison nurse counterparts, and nurses and psychologists working on the memory assessment service have learned techniques from one another.

The two dementia cases perhaps differ in the extent to which the way forward for further development of practices has been clarified. In the Greater Manchester case, there is a more developed emphasis on the importance of service users – sufferers and carers – developing peer support networks, facilitated by third sector workers. There is also an emerging vision of developing administrative mechanisms for rapid referrals of patients back into acute care for short periods of treatment. These developments are also being debated in the London case, but are perhaps as yet further from being acted upon.

This survey of the range of practices that need to be targeted in redefining service boundaries reinforces the lesson that clinical leadership is not simply about working with clinical issues, but it is also about reshaping administrative, IT and operational practices, and involves joint leadership with occupations primarily focussed on these domains. Whether developments in clinical practices involve merging previously separate areas or some exchange or overlap between areas that remain distinct has major implications for the kinds of threats that may be posed to existing patterns of professional or occupational demarcation. We now turn to a more detailed discussion of these issues.

#### **8.4 Professional roles and relationships**

Row 5 of Table 6 summarises developments and issues concerning professional roles and relationships across the cases, drawing out issues that are relevant to the exercise of clinical leadership. A feature of all four cases is the significant role for nurses with specialised skills working with autonomy, running their own consultations with patients and making significant decisions about their care. In the two Sexual Health cases, the horizontal integration of services we have described means that nurses are dealing with a wide range of STI testing for both symptomatic and non-symptomatic patients, as well as giving hormonal contraception and in many instances inserting long acting reversible contraceptive (LARC) devices. The services in both cases employ a substantial number of nurses at senior grades who are highly qualified and experienced in both contraception and GUM, with some able to prescribe under patient group directives. Establishing integrated sexual health clinics has presented opportunities for further development of skills and autonomous working for nurses, including providing a significant proportion of the more complex, higher tier, services. The development of nursing roles appears to flow not only from the integration of basic services needed to make them more accessible and but also from the need for related specialised higher tier services.

In the two dementia cases, psychiatric nurses and other community mental health practitioners – such as occupational therapists and social workers – are responsible for working with considerable autonomy in carrying out many aspects of memory assessments and care planning, although final

diagnoses are arrived at in multi-disciplinary team meetings including psychiatrists or geriatricians and communicated to the patient by a doctor. This kind of division of labour is not uncommon in many parts of the mental health system, but the development of memory services in both cases can be seen as providing nurses and other non-medical clinicians with substantial opportunities to develop their roles. The emphasis on the development of non-medical clinical roles can in the two Dementia cases be seen as stemming from the concern to improve how patients are passed from one service to another. Senior nurses and other community practitioners were in both cases involved in agreeing guidelines for referrals, as well as in drawing up care plans for individuals and often in expediting onward referral. The emphasis on improving navigation through different parts of the system of care for dementia confirms senior nurses in both mental health and geriatric care in a pivotal role of linking and coordinating between services.

Our studies of two different clinical areas thus illustrate different kinds of cross-boundary service redesign. But both indicate the growing importance of nursing roles, skills and perspectives. One implication of this is the need for leadership by both managers and clinicians – particularly senior nurses – in putting in place workforce development plans that ensure that nurses working in such roles have the appropriate skills. The development of the pilot integrated clinic in the London Sexual Health case was widely perceived to have been held up due to nursing vacancies, including at senior level within the service. Shortages meant that there were difficulties in maintaining clinic staffing and therefore in releasing nurses for training, and a vacancy at matron level held up progress in defining and implementing training plans so that nurses could all be dual-skilled.

Senior nurses involved in both Sexual Health cases reported that there were no national standards for dual-skilled sexual health nurses to draw on. In fact the areas of skill were uncontroversial, and could be agreed in dialogue with a training and education provider. The current structure of nursing education in England means that there are no national bodies or committees determining standards for specialist post experience training. This may in fact in some ways be an advantage for the purposes of agreeing programmes of skill development for integrated services. As we will shortly discuss, the institutional pulls in defining medical skill development paths are stronger and make dual skilling across established specialisms more complex to achieve.

Formal nursing workforce development appears to have been less of an issue in both Dementia cases. In each, there seems to have been a ready supply of highly experienced nurses to take up roles in memory clinics and community mental health teams, apparently because of retrenchment happening on other parts of old-age mental health services. Knowledge and skills needed to carry out particular cognitive tests for memory assessments were learned on-the-job, building on established more generic skills.

Expanded roles for health care assistant grades are also a feature of both Sexual Health cases and the Greater Manchester Dementia case. These roles can be seen as further development of the principle of dividing clinical work up so that some portions can be carried out with relative autonomy by less skilled staff. So in particular in the London Sexual Health Case, a great deal of emphasis has been placed on developing the Client Support Worker, who can help asymptomatic patients with STI testing, once they have been triaged as not requiring a more highly qualified clinician. The Spoke clinics in the Greater Manchester Sexual Health case appear to have made similar use of care assistants. The equivalent in the London Dementia case is the introduction of Dementia Care Assistants to support sufferers and carers after diagnosis, offering advice on services that can be accessed. An interesting contrast is that the DCA role is promoted and to an extent defined in the National Dementia Strategy, and people in this role in the London case are trained and seconded in from the Alzheimer's Society. So there is a kind of standardisation and wider supervision structure in place for this role and its development. The roles of Client Support Workers or other care assistants in sexual health clinics are in contrast defined locally and supervised by senior clinic nurses. There are no national standards. When care assistant roles are being strongly developed and supervised on this kind of local basis, this has then implications for the leadership responsibilities of senior clinic nurses. Such nurses need to identify how care assistant roles can be further expanded, and the kind of training and workplace development that is needed to provide the competencies needed.

The cases further illustrate a number of issues in terms development in medical roles associated with various aspects of cross boundary service redesign. In both sexual health cases, there appear to some tensions concerning the nature of senior nurse roles compared to those of doctors. These tensions take a range of forms. In the Greater Manchester case, dual skilled nurses were reported as finding doctors engaged to run sessions in Spoke clinics – mostly GPs with Special Interests – depending on them for advice about current hormonal contraceptive options and other matters. This led them to question the value of having doctors without high level specialist skills running clinic sessions. At the same time, these same nurses wanted to be able to have rapid access to more specialised doctors, in GUM or reproductive health, so they could deal with urgent problems with patients whose complications for example put them outside of the PGDs that nurse practitioners can prescribe for. In the London clinic, the a similar issue occurred with nurse practitioners developing some scepticism about the ability of GU registrars to handle complex contraception issues, because they saw such trainees as first and foremost interested in their specialism, and lacking the experience and perhaps the motivation to engage with non GU conditions of any potential difficulty. Access to higher level medical skills was not mentioned as an issue, because the availability of consultants in both GU and reproductive health on site at the teaching hospital where the pilot integrated clinic was located. However, some consultants felt that taking a turn running one-stop-shop clinic sessions was simply not a

responsible use of their skills, given how much the NHS paid them per hour of their time. In such a clinic, they might be spending a substantial proportion of their time dealing with routine contraception or STI testing which someone less costly to the NHS could do as competently.

Both of these cases suggest that the development of senior nurse roles with comprehensive skills that match closely the range of sexual health needs of those attending clinics is already posing challenges that may shape medical roles in new directions. Working as a clinician in a SH clinic providing integrated services appears to be emerging as needing a distinct bundle of knowledge and skills, particularly if most users are to be seen by only one clinician. It is proving viable to equip nurses with this bundle, spanning GU and conception, and so there may be little future for sessional doctors such as GPs who are not working intensively in this particular context. On the other hand, senior doctors may find themselves taking on a more consultative and supervisory role to predominantly nurse led clinics, as more and more nurses master higher levels of GU and contraception competence.

There were, however, divided opinions as to what the implications of integrated clinics might be for the future of GUM and Reproductive Health as separate specialisms. One view was that the national Faculties overseeing the curricula for these two specialisms should simply merge, creating a merged Sexual Health specialism. It would then be possible to have effective medical supervision of any integrated clinic provided by a single specialist doctor. The other view was that both curricula can continue to co-exist, on the basis that they require GUM trainees to take some specialist training in RSH and vice versa, as is already possible. This amounts to creating a substantial area of overlap between the two specialisms. Both solutions appear viable in terms of making specialist supervision available to nurse-led clinics, as well as encouraging trainee doctors working within clinics to develop the range of skills required to contribute effectively to “one stop shop” clinics.

Autonomous working with patients by nurses or other community mental health practitioners – whether social workers or occupational therapists by original professional training – appeared to be more taken for granted in the memory services and community mental health teams featuring in both Dementia cases. Such roles for non-medical clinicians did not appear to raise issues in for medical roles, either in geriatric medicine or in psychiatry. Secondary community mental health services have arguably already made a shift towards a model where psychiatrists take up a role of supervising and setting protocols for the work of non-medical clinicians, particularly psychiatric nurses, who undertake a large proportion of the direct contact work with patients. In memory clinics within geriatric or elderly medicine contexts, it appears that the idea of patients being seen at their first visit by doctors has never been in question. Doctors see themselves as taking responsibility for a comprehensive assessment of physical health and at the same time as administering a set of cognitive function tests. Nurses would

then typically responsible for follow up memory assessments at periodic reviews.

In both the London and Greater Manchester Dementia cases, psychiatric clinicians – doctors and nurses – expressed enthusiasm for having the opportunity to work together and share learning mutually with their elderly medicine counterparts, whether in the context of the a network of outpatient memory clinics or on geriatric hospital wards. This sharing of expertise across specialisms appeared not to pose challenges to established professional spheres, rather to represent the creation of a productive interface where there had previously been little interchange or event contact.

Together, these developments in professional roles and relationships across the four cases suggest the variety of developments that clinicians involved in reworking boundaries in service provision may need to work with. A modicum of sharing of expertise across specialisms may be uncontroversial and enlivening, on the basis that core elements of each specialism do not come into question. In such cases, some fluidity and opening up of the boundaries of what each specialism does not seem to require a counterbalancing reassertion of boundaries in new places. In contrast, more significant overlapping of skills and functions, or even full scale merging of specialisms can pose significant workforce development issues, as well as requiring re-alignment of national training curricula and professional institutions. Under such circumstances, issues are more likely to arise as to what each specialism retains distinctive control over. So opening up of control of knowledge and techniques so that they can be shared with a related occupation or profession needs to be accompanied by new occupational closure. These then represent the range of issues concerning the reshaping of professional roles that members of clinical occupations need to be aware of as they take part in leading service redesign. We will explore this topic further in the final chapter.

## **8.5 Patterns of sentience**

Row 6 of Table 6 outlines the key issues in each case concerning where clinicians identified themselves as belonging – their sources of sentience. Once more, the purpose is to reveal more of the issues that need to be taken into account of whilst engaging in various aspects of clinical leadership for cross boundary service change.

One interesting feature of all four cases is that many clinicians appeared ready to identify strongly with the wider system of care – for sexual health or for dementia – at least as strongly as with their employing trust. So in both Sexual Health cases, clinicians appeared to see their working lives in the context of an emerging network of integrated clinics. Particularly in the London case, doctors in particular indicated that there was a very live debate within the consultant body as to how significant this identification was. Some consultants continued to see themselves as first and foremost

specialists who happened to work in integrated clinics whilst others saw themselves as senior doctors engaged in designing and running integrated clinics, focussed on solving pressing public health problems, who also happened to be members of one specialism or another. The willingness of many doctors and nurses to be open to considering themselves at some point in the future as belonging to a semi-autonomous local network of clinics indicates perhaps the extent to which NHS clinicians have become cautious of forming strong identities around the organisations – currently Foundation Trusts – that currently employ most of them. Many of the clinicians we interviewed could tell how their careers had involved direct experience of a bewildering series of organisational mergers and demergers.

There was a similar willingness apparent in both Dementia cases to consider developing a strong identification with a local network of services that cut across current trust boundaries. In the Greater Manchester case, this identification was perhaps more latent than actually developed, finding in expression in widespread frustration that the overall system of dementia care services was not more transparent and better understood by both users and clinicians. In the London case, there was evident pride amongst the senior clinicians involved that they had achieved recognition for a networked memory service incorporating clinics across three different trusts, but still with a single point of referral from the perspective of GPs. One clinician who had found the struggle to arrive at this arrangement as particularly arduous commented that the Senior Clinicians Group now recognised as running this networked arrangement were the “rebels”, having set in motion an entity that had a life to some extent out with the governance of any of the powerful trusts involved. This remark perhaps illustrates how multiple sources of identity or sentience can co-exist in any grouping, and how new forms of sentience can be mobilised and worked with to develop a collective sense of purpose. The clinicians involved in the networked London memory service matched their mutual learning about approaches to memory assessment and care planning with an increasing level of identification with their collective endeavour. As in the Greater Manchester case, they also showed signs of wanting to draw more aspects of the wider system of dementia care into this sense of belonging and common purpose, but felt frustrated in how to achieve this.

## **8.6 Performance achievements**

Finally, row 7 of the table summarises the performance improvements achieved across the four cases. In all four cases, redesigned services have provided the basis for significantly increasing numbers of patients or users in targeted categories who are able to access services that had previously been characterised by considerable waiting times or which were in some other way difficult to access. So the kinds of cross boundary redesign achieved had effectively created services that represented an easier to access element within secondary health care.

## **8.7 Summary**

In this cross-case comparison chapter we have drawn upon the main framework figure as the conceptual basis for assessing the relationship between clinical leadership and cross boundary service redesign across the four cases.

The nature of service redesign in terms of distinguishing different ways in which boundaries can be reconfigured has been revealed; the role of different arenas of local leadership in bringing about change have been charted; contrasts have been made between cases where clinicians have had deep involvement in service redesign while in others their involvement has been restricted.

We found that cross boundary service redesign in all four cases was bound up with significant shifts in clinical roles – for example, the cross fertilisation between specialisms and a strengthening of nurse autonomy.

We have further noted across all four cases an emerging sense of identification amongst clinicians with some form of local network of similar services, cutting across established NHS organisations. We have seen how such networks are establishing themselves as performing effectively in expanding access to services previously available on a more restricted basis from conventional secondary providers.

In the final chapter of this report, we draw out some broader conclusions as to the nature of clinical leadership in achieving this kind of service redesign and performance improvement, as well as the issues that remain unresolved in taking things forward.



# ***PART 4 DISCUSSION AND CONCLUSIONS***

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## **9 Conclusions**

### ***9.1 Introduction***

We began this report by referencing the many policy papers and other sources which urge the merits of clinical leadership. It is broadly seen as the 'answer' to the many pressing problems of resource constraints and rising demand.

But we found that there is a danger that these declarations, prescriptions and initiatives underestimate the nature of the challenge and underspecify what would be required to make clinical leadership a reality within the context of the NHS.

There is a whole range of obstacles facing any clinicians who might decide to take up this challenge; in this context we took close note of the advice of those researchers in leadership who argued that the phenomenon is best studied in concrete situations (Howieson 2011; Gronn 2002).

Hence, to help clarify what forces are at play and how these might be handled by clinicians we embarked on a study of the two very different service areas of sexual health and dementia in two different parts of the country.

### ***9.2 Answers to the research questions***

The result of the fieldwork has been a series of insights which we have crystallised into a core analytical framework. This was first presented at the start of the Findings section as Fig 2.

This figure identifies the core factors which are involved in the exercise of cross-boundary clinical leadership. We used these as the basis for analysing each of the four cases. These concrete instances of attempts at clinical leadership revealed a rich array of pitfalls and possibilities.

The results of the analysis, shown in summary form in this figure provide the basis for answering the main research question which was first introduced in Chapter 2. In summary form this was:

***What can be learned from the experiences of those enacting clinical leadership in practice and what are the main enabling and constraining factors?***

The four cases provided ample evidence to assist in answering this question and we will recap the answers in this final chapter. We begin by answering the subsidiary questions that were also posed:

***Q1. What general lessons about the nature and practice of clinical leadership can be educed from a series of examples of effective clinical leadership in introducing more integrated models of care? What variations are required when enacting the model in very different service areas?***

The lessons are:

- 1) The redesign and implementation of services that rework existing boundaries is a complex endeavour and can also take different forms.
- 2) Clinical leadership occurs at different levels and in different settings.
- 3) As shown in the 'reworked boundaries' constellation in Figure 2, cross boundary innovation means developing an extensive network and opening-up to new practices. These are both clinical and non-clinical. They include areas such as clinic organisation, booking systems, IT systems and tariffs. This is perhaps the fundamental reason why service design is inherently difficult – it involves challenging established habits distributed across a wide range of occupational areas, as well as a number of distinct organisations.
- 4) Two different kinds of cross boundary redesign were uncovered. One approach, as in sexual health, is to bring together existing clinical specialisms in a new (horizontally) integrated service which is then segmented vertically. This ensures that less complex integrated care is available in some form of community clinic with enhanced roles for nurses and care assistant staff. The other is where the kind of care needed is more variable in nature as in dementia, here the emphasis may need to be on providing a clear route in and then as much clarity as possible in how to navigate around the available options.
- 5) Across all the cases, service redesign of either type can be seen to involve leadership in a number of different forums, both national and local. These are summarised in the first two constellations of Figure 2.
- 6) Clinicians can play a leadership role in any of these forums but to be effective they need to act collaboratively and with different sets of co-leaders. Effective leadership in each arena means reconciling clinical and non-clinical perspectives to achieve joint leadership.

In the three national arenas identified in the Figure, senior clinicians typically collaborate with NHS national senior managers and policy experts, with colleagues in committees of their Royal College or academic Faculties,

or with public health experts and Department of Health officials in drawing up national strategies for particular clinical areas. Across the four kinds of local arena identified in the 'shaping ambitions' constellation, senior service-level clinicians may collaborate with public health officials in defining needs. In addition they will need to work with clinical colleagues, service managers or network managers in improving interfaces with related services. They will also need to work with commissioners, project managers, IT staff and estates staff in planning significant new service configurations.

7) Our findings therefore support but go beyond the widely reported need for service lead clinicians and service managers to work in tandem to bring about change. This collaborative leadership model may need to exist within a number of different arenas if *cross boundary* change is going to be successful. For example, some lead clinicians may need to work with network managers to build consistency across a network of similar services, whilst others work with IT staff on resolving booking and record-keeping systems needed for a different approach to the patient journey. Other clinicians may need to work with counterparts in related services or with primary care representatives in order to influence how GPs work.

8) Hence, one of the key *possibilities of clinical leadership* is for different clinicians to play a wide variety of leadership roles, across these arenas, but always working in collaboration with others. The cases illustrate that effective service redesign can occur without pronounced clinical leadership present in all of the possible arenas. So, it is possible, for example, for managers and commissioners to set the agenda at local level and then bring clinicians in as implementation leaders. We may speculate that this is only viable where there has been effective clinical input into shaping a convincing national strategy that is then taken up by local commissioners, and when clinicians are given substantial autonomy in how it is implemented.

9) *Implementation leadership* appears to be present in all cases – it is arguably the essential minimum in terms of clinical engagement with change. Our cases suggest that clinical leadership in the form of implementing service designs conceived by a combination of commissioners, managers and public health practitioners is an important and valid domain of clinical leadership, independently of whether clinicians were also directly involved in conceptualising these new service designs. It appears that a model of clinical leadership at local level that involves largely working with the national grain in implementation mode is viable; but it is only one part of the possible scope of clinical leadership.

10) It is important to build overlapping membership and synergy between clinicians involved in leadership across the different arenas, particularly at local level. For example, this means involving clinicians who have built informal collaborations across interfaces in developing top down service redesigns and involving clinicians who have defined services in implementation. When clinicians are, for whatever reason, only brought in

at implementation stage, particular effort needs to be made to include those clinicians in the process of thinking that has led up to that stage.

An implication is that clinical and other leaders engaged in service redesign need to make themselves aware of the range of arenas where people are currently thinking and taking action to improve the service, or where further action could be mobilised. Those engaged in formal projects to redesign services need to make themselves aware of who is already engaged in informal cross-boundary collaboration. And those engaged in collaboration across service boundaries who have ideas on redesign need to be thinking about how they can obtain resources and legitimacy to turn their ideas into a recognised redesign project.

11) Regarding the final part of the first research sub-question, there is evidence that different arenas for clinical leadership may need to be accentuated depending on the kind of cross boundary innovation that is being sought. Formal redesign projects with resources for a project team to examine new configurations are important for both integration of existing services and for improvements in how boundaries are made navigable for users. However, informal collaboration between clinicians across service boundaries appears particularly vital for the latter kind of cross boundary change. Both the dementia cases illustrate that it is difficult to include representatives of all services that may be relevant to the total system of care in a formal redesign initiative. Its connection to a wider network of services may need to be developed informally as was the case for the memory services in both of these cases.

## ***Q2. What are the enablers and the blockers of effective clinical leadership?***

1) Change on any significant scale tended to be sanctioned and triggered by national, centre-led initiatives and policy papers. Mobilisation of local effort was much easier when it was seen to be some kind of fulfilment of national level policy. Local sponsorship – including funding – from commissioners and from acute trust top management was much easier when the proposed changes to services were seen to be in accord with official policy.

2) Senior teams at local level were acutely conscious of how they were being measured and so would support clinical leadership which appeared to act in accord with these priorities while discouraging efforts which were not. Thus, the National Dementia Strategy and the National Sexual Health Strategy were crucial in shaping cross boundary service redesigns that were described in the local case studies. Rather than restricting the exercise of clinical leadership at local level, they provided material to work with. The implication is that exhortations for more clinical leadership need to be balanced by continuation of the effort in developing national strategies for particular clinical areas.

3) Funding was also a common feature. Special funding to facilitate change seemed to help significantly in these NHS contexts. The availability of funds enabled project managers to be appointed and it was also used as a lever to overcome resistance and as an incentive to move from conventional practices.

4) The pitfalls awaiting the unwary were shown to be many. The cases revealed clinicians reported that their senior managers rebuffed their attempts to get involved in issues outside their normal job tasks. In other words, the hierarchal and siloed characteristic of the NHS act as barriers to the potential for clinical leadership. The NHS at times can act in a schizophrenic way: it can talk the talk about the importance of clinical leadership while organising itself in a manner which impedes it.

5) In addition to national sponsorship, there are crucial leadership dynamics at local level. This is very evident in that despite national initiatives, the take-up of these across the NHS is hugely varied. Part of the local dynamic is the duality of constructive partnership between a manager and a clinician. In each of the cases when this kind of relationship was forged between effective players then cross-boundary service redesign was much more likely to succeed.

6) Large-scale change appeared to be more easily achieved in the smaller scale areas of Manchester than in the larger scale and more complex environment of London. Informants referred to the obstacles presented by some 'large egos' and the considerable reputational power. These factors made change management more intrinsically complex in these settings and this was the case for clinical leaders as for project and programme managers. The more complex cases required much more leadership effort and much more project facilitation - the London sexual health modernisation initiative, for example, required £5m of funding and 7 project support staff.

7) The cases also revealed how difficult clinical leadership can be at a personal level. Willingness to change by some clinicians and unwillingness by others prompted some fraught inter-personal relationships. Interviewees talked about critical phases of change which were 'dreadful', 'horrible' and led to 'tears'.

8) Collaboration between primary care and initiatives in the acute sector appears particularly difficult, apparently because of the pressure on primary care over the last few years and difficulties for GPs in finding the opportunity to take part in wider initiatives

9) Service redesigns that involve increased *user participation* or self management may involve some rethinking of professional boundaries, implying greater collaboration and input in decision-making from the service user. However, the tendency across our cases seems to be to focus on increasing accessibility rather than self management.

10) Clinical leaders need to be aware of the possibility of threats to professional remits and attentive to the need to find professional “closure” as well as “opening”. Increased collaboration between medical and third sector “care assistant” type staff may pose particular challenges.

11) These developments in professional roles mean that *training and workforce development* are likely to be focal concerns of clinical leadership. Nurses and healthcare assistants who are expected to take on broader roles may need both on the job training and some additional study and competence assessment if they are to be ready for this. This in turn requires sufficient staffing levels to allow staff to be released for training and the timely engagement of some form of training or educational provision.

12) As new models of provider they offer advantages in terms of providing a focus for “sentience” that is closely matched to the system delivering services such as sexual health or dementia services. However, interfaces with specialist identities such as those represented by the Royal Colleges need to be managed.

***Q3. How do effective clinical leaders both initiate and lead service improvements while also engaging constructively with top-down service redesign and improvement initiatives?***

1) The cases revealed the skilful practice of a number of sometimes unexpected competencies and attributes that are not always given sufficient attention in the conventional prescriptions or the literature.

2) Clinical leadership practice needs to maintain its legitimacy and autonomy through demonstrating accountability simultaneously in three directions: (i) to the management of health service organisations, (ii) to a system of professional standards and expectations, and (iii) to service-users and their carers. Health service redesign presented challenges for clinicians in each of these directions.

**Figure 4. Directions of Accountability**



*i) Accountability to health service management*

Cross-boundary service redesign by its nature is likely to challenge established patterns of accountability to existing NHS organisations. The cases revealed clinicians who found themselves caught up in tensions between affinity to their organisational hierarchy and their 'new' cross-boundary network. This echoes the findings of Guthrie *et al* who also found that clinicians involved in clinical networks came into conflict with the management structures and governance arrangements of established NHS organisations (Guthrie 2010).

*ii) Accountability to the system of professions*

Cross-boundary service redesign was found to disturb established patterns of influence, authority and control between different kinds of clinician – hospital doctors, general practitioners, nurses, allied healthcare professionals and health care assistants. Inter-professional dynamics were often foregrounded and consciously negotiated when there were proposals to reallocate aspects of care from one professional group to another. Even subtle shifts in the details of clinical practice can reactivate a continuing process of negotiation of occupational control within what Abbot calls the 'system of professions' (Abbott 1988).

Professional work is, by its nature, about systems of occupational control of techniques and processes used. In attempts to reformulate systems of care we found opportunities for various kinds of clinician – seen, for example, in

the leadership demonstrated by some nurses in both the sexual health and the dementia cases.

These processes of leadership are centrally concerned with both opening up and closing down spheres of knowledge and practice for particular professional groups. This takes place at two different levels – at the macro level of formulation of national guidelines for care, and at the micro or operating level when attempts are made to implement such guidance. Clinical leadership at the macro level takes the form of committees or working parties of clinicians seeking to produce agreed standards or guidelines for treatment

This combination of both *opening up* divisions of labour and finding new kinds of *closure* is crucial. It is we suggest critical in the work of clinical leadership for cross-boundary redesign at the micro level of a particular service. This balancing of openness and closure adds to the work of Hudson who outlined 'pessimistic' and 'optimistic' models concerning collaborative working depending on the degrees of professional defensiveness and/or the commitment to improve care (Hudson 2007).

Working on technical representations of processes of care is not only a way of shaping what clinicians do but also an opportunity for negotiation about who does what. Some areas of vagueness may be as important as precision in finding productive ways forward.

### iii) *Accountability to users*

User-centred service redesign means that clinical leadership must find ways of opening dialogue with users. Increasing accountability to users for improving their experience of care and involvement in care decisions implies both opening up the boundaries of knowledge that is considered to include that of users, and finding new ways of defining professional control and autonomy.

Clinical leadership involves facilitating two potentially contradictory developments: achieving more open deliberations between clinicians and patients, whilst preserving significant aspects of professional control. The London sexual health service redesign case best illustrates how careful, well-planned and serious attention to user concerns and preferences can make a pivotal impact upon service redesign priorities.

### ***Q4. How do service-level clinical leaders in acute and primary care develop and implement service quality improvements through achieving greater integration and how do they go about mobilising other clinicians while also engaging with commissioners and managers?***

This sub-question has been answered in the course of addressing the previous questions. Integration of service offering were found extensively in the dementia cases and in the sexual health cases. In all instances this involved the integration of activities across primary and secondary care



boundaries. The difficulties and the possibilities – including the way commissioners and managers were involved in the process - are clarified in the above analyses.

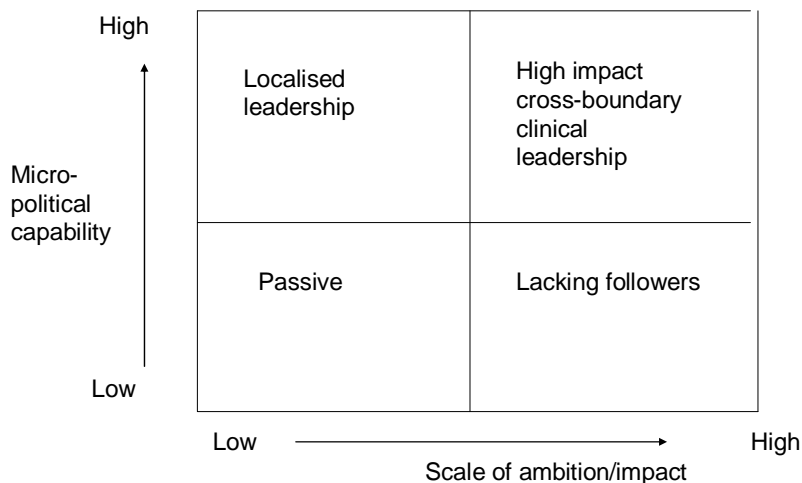
These answers to the research questions allow us to move on to a higher level of reflective analysis. One outcome of this was to rethink the different modes that clinical headship can take. This is explained in the next section.

### 9.3 Types of clinical leadership

The four cases revealed the multiplicity of stances which clinicians adopted in relation to service redesign. We have stressed throughout the report the huge challenges – to speak plainly, the difficulties – which clinicians can often face when seeking to exercise significant leadership in the context of the NHS. We found some had resigned themselves to a relatively restricted, fatalistic and even passive role in the face of brutal experience. Others had settled for a more limited form of local, micro-system or unit level leadership.

But, there were some exceptional cases where, with persistence and with the exercise of the capabilities and skills which we have sought to identify in this report, clinical leadership was seen to be exercised in a high impact way across traditional boundaries. In Figure 5 below we seek to portray this range of ‘types’.

**Figure 5. Types of Clinical Leadership**



The figure cross-cuts ‘scale of ambition’ on the horizontal axis with what we term here, for shorthand, a set of ‘micro-political capabilities’. What we

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mean by this latter term are the full range of capabilities described in this report - most notably in Chapter 8 - but also in detail in each of the case sections.

The bottom left cell shows a 'passive' mode of cross boundary leadership. This is where there is a low level of ambition to try to redesign services and a low level of capability to bring it about results in a passive style in so far as significant service redesign leadership is concerned. (Some clinicians in this category may still offer an excellent one-to-one patient experience).

The top left cell shows 'localised leadership'. This was the mode where the insights and capabilities were present but the scale of ambition was limited. Clinical leaders of this type contented themselves with reshaping, for example, a memory service or an integrated genitourinary clinic with contraceptive services, but made no attempt to take these initiatives any further.

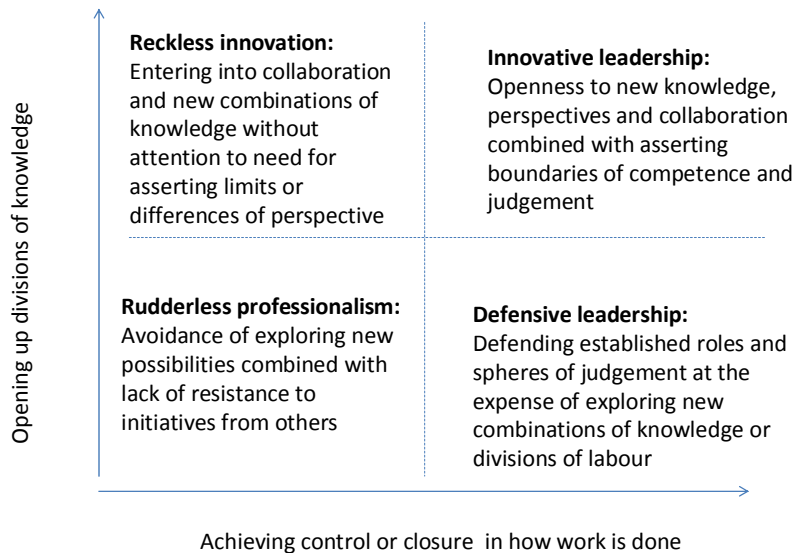
The bottom right hand cell is described as 'Lacking followers'. There were expels in the case where certain clinicians were inspired by an idea and had courage and a scale of ambition but who forged ahead at such a pace and with such little attention to the kinds of skills and requisite behaviours described in this report that they found themselves out on a limb. In some instances they had to withdraw from the leadership role entirely.

Finally, the top right cell shows the 'high impact cross boundary mode of leadership'. This was enabled when the clinicians or group of clinicians (and often with the help of managers too) had a high level of ambition and vision and were also skilful in exercising the capabilities described in detail in the body of this report. These included as each case showed, skills in reworking professional boundaries, recognising the public health challenges, listening to user expressed needs, realigning patterns of belonging and so on.

Thus, when the talk as so often in policy debates is loosely hung around the call for 'more clinical leadership' it behoves us to recognise that this may be a rather rare commodity and that there are many factors which pull clinicians towards occupancy of one of the other three cells in the Figure 5.

Building on these ideas we can further differentiate certain 'modes' of clinical leadership. In Figure 6 below four modes of behaviour are shown. These essentially reflect the degree of skilled deployment of the behaviours we have identified as enabling clinical leadership. They also illustrate what happens when less skilled attempts are made.

**Figure 6. Modes of Clinical Leadership**



The top left cell shows ‘reckless’ practice – these practitioners rush forward with enthusiasm and vision for the end goal but they fail to carry their professional colleagues and they also fail to establish a sense of a new professional boundary. The bottom left cell denotes a closed approach where change is resisted. The top right cell combines an openness to new knowledge with an awareness that some revised form of professionalism needs to be established. The bottom right cell depicts ‘defensive leadership’ where there is high sensitivity to professional identity but at the expense of openness to new combinations of knowledge and ways of working.

## **9.4 Limitations of the research**

It is of course important to remember that the theory building about the nature of clinical leadership which is made in this report is based on just two service areas – dementia and sexual health. A further limitation is that the research was conducted in just two health economies– one in London and one in the north-west of England. Accordingly, it is not claimed that the findings necessarily represent practices in other clinical specialisms, other parts of the country, or indeed other health systems. It might further be argued that as the research took place over a specific time period (respondents were reporting on events which took place mainly between 2004 to 2012), that the findings do not necessarily reflect prevailing dynamics under other time periods and other regimes.

Each of the above points of caution is valid and they certainly need to be borne in mind. On the other hand it seems unlikely that the findings are of relevance only to these particular specialisms, geographies and times. The specialisms and geographies were chosen because they were seen to represent challenging circumstances. They were based on a theoretical sampling approach. Further, despite the significant differences between the clinical specialisms of sexual health and of dementia, the similarity of the findings about how clinicians have been involved in the leadership of service redesign – and the manner of the barriers to this – have been shown to be remarkably similar. Unless this was entirely coincidental, it might be inferred that similar patterns of possibilities and pitfalls may be considered likely in other parts of the NHS. Certainly, none of the informants – including senior managers who had experience and oversight of other clinical areas – ever made the claim that the emergent patterns were peculiar to these specific service areas. Rather, they tended to suggest that these were characteristic of the NHS.

## **9.5 Implications for policy**

An especially significant question is whether, given the complexities of clinical leadership that we have exposed, clinicians are the most likely instigators of big ideas as to how to reconfigure services. It may be important that at least some clinicians operate in the “Innovative Leadership” cell for significant periods during the course of a redesign initiative, but it may also be that this comes about through initial action by visionary and senior health service administrators and policy makers who challenge established boundaries and forms of occupational closure. Research in relation to each of these questions needs to probe more deeply the range of behaviours exhibited in practice by different clinicians and to probe the underlying rationales.

Further policy implications arising from this research concern the need to ensure that the wider patterns of support for systems of care are agile enough to keep pace with innovative ideas and practices. Our cases revealed that the clinicians courageous enough to forge ahead with innovative service redesigns were sometimes stymied by legacy systems which constrained the implementation of new practices. A clear example was the difficulties of the integrated sexual health services in appointing dual-trained genitourinary specialists and reproductive health specialists. The training and development systems and the professional bodies lagged in enabling the provision of such people.

A further policy implication is for the Royal Colleges, the deaneries, and provider trusts to raise expectations of the clinical role. There ought to be a route which enables talented clinicians to aspire to a career or part of a career which involves active engagement in service design as a recognised, legitimate and valued part of the role.

Likewise, there is clearly a need to push once again for better learning across different geographies so that the lessons hard-learned in one domain can be more widely shared by others. In one sense that is a core purpose of this report.

## **9.6 Implications for clinical and managerial practice <sup>†</sup>**

The implications for clinical and managerial practice of the analyses made in this report of our research are far-reaching. We have garnered these into a set of **Practical Guidelines** for both managers and for clinicians (Appendix 1). They can be summarised here as:

- At a very early stage, begin with a review of the broad public health case for cross-boundary service redesign – what is the nature and extent of the unmet need? What is the exciting opportunity or vision for a better service offering? What linkages are there between meeting public health needs and making services more accessible and “user friendly”?
- Find out what other actors – clinicians, commissioners and managers – are already doing, planning or thinking and seek to combine forces with them. Link your joint efforts to current sources of power and resourcing in the shifting NHS landscape. Clinical leadership in reshaping effort is not an individual activity, but a distributed and shared one, spanning different levels within the health service.
- Be aware of the need to ‘open-up’ to new and different ways of thinking about service offerings and to share ideas across professional boundaries. But also be aware of the need to re-consolidate at some point around a new mode of ‘closing’ around a revised service format. Be alert to the idea that what each professional role has traditionally done may need to change: this may require some negotiation.
- Be alert also to the likelihood that changed roles will carry implications for training and development. This is likely to require resources.
- Take account of the range of other practices that may need to change in addition to how clinical work is done. Many aspects of service organisation – such as booking systems, follow up, IT support and tariffs – may also need to be modified for the new model to work coherently. This will mean involving managers and support staff who have responsibility for these areas.
- Give thought to new patterns of belonging and commitment: to what kind of ‘unit’ or body are staff being invited to identify and to mobilise behind? What would entice you and your professional colleagues to do this?

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<sup>†</sup> Note: These practical guidelines have been developed as a result of the research and have been presented, discussed and refined within workshops comprised of managers and clinicians. However, they remain at a pre-pilot stage and they have not as yet been trialled at any scale.

- When planning a formal cross-boundary service development initiative, make sure you and your colleagues take account of the informal links that already exist within the set of services concerned. And if you consider yourself part of an informal cross-boundary group, think with your colleagues about how you might access more formal support and resource for what you are doing.

For further elaboration please refer to Appendix 1.

## **9.7 Implications for future research**

One function of the kind of mapping of the range of responses to the challenges of redesigning services that we have attempted here, alongside the attempt to clarify the nature of the challenges and the requisite skills and behaviours is to bring into focus the contradictions and tensions inherent in clinical leadership. This work can complement and add to the competency models that have recently appeared.

It also suggests an agenda and a structure for future research. One aspect of such research would be an exploration of how and why different clinical groups move between the four cells of Figure 6. Under what circumstances do professional groups depart from a straightforward defence of the status quo? Why might any clinical specialist surrender to a stance of 'reckless innovation' – might this result from overwhelming managerial and commissioner pressure? And what happens when this occurs?

The findings about the dynamics of clinical leadership in the two service areas of dementia and sexual health provoke further questions about the extent to which similar patterns could be expected in other service areas. Services which are more self-contained and which require lesser interface with social services or the voluntary sector may be easier settings in which to exercise cross-boundary clinical leadership.

The two different health economies did indicate some generalisations about power and complexity which merit further investigation. Commissioners in London faced with powerful teaching hospitals and multiple eminent medics seemed to find it much more difficult to bring about service change when compared with the smaller scale of services in the area of Greater Manchester which we studied. In the latter setting, commissioners clearly found it much easier to reshape services. There was, however, a compounding variable in that in this particular area of Manchester there had been a history of positive partnership working between health service providers, the PCT as commissioners and the local authority and the voluntary sector. The extent to which the relative ease of service redesign resulted from the power balance or the culture of partnership is hard to disentangle and worthy of further research in a variety of settings.

The emergent Clinical Commissioning Groups (CCGs) offer the potential for considerable clinical leadership. Following amendments to the original White Paper, these groups are intended to include clinicians beyond GPs. As they

will wield commissioning power these groups have the potential to reshape services across the board. The ways in which they will change the dynamics described here when primary care trusts were still the main commissioning agencies is an obvious target for future research.

The role of special funding to catalyse change as noted earlier seemed to serve three related and simultaneous purposes. First, and most evidently, it offered the resources to aid experimentation – not least by releasing time for the would-be clinical leader to spend time on design issues. Second, it gave a legitimacy to this kind of work. Third, it raised expectations about what active clinicians should be doing. The role played by such special funding merits further research in other contexts. For example, how much funding is required? In so far as the latter two factors are at play the funding might be symbolic and yet still have an effect. On the other hand, large sums, although maybe not strictly necessary for the release of clinicians' time, also served to prompt senior managers of trusts into action and thus helped indirectly to raise expectations.

A crucial avenue for further research which arises from this work is the emergent re-identification that clinicians may have with new 'units'. The sentient issue of commitment and belonging to what service or community appears to be a rich vein worthy of further research.

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# Appendix 1: Practical Guidance Notes for Clinical Leadership †

## The purpose of this Guide

The report has distilled the key elements involved in the practice of clinical leadership of cross-boundary service redesign. The purpose of this practical guide is to clarify some of the practical steps and considerations for clinicians, managers and commissioners who wish to apply in a practical way the lessons to be found in the case analyses.

## Who this Guide is for

This Guide is especially for you if you have some level of responsibility for delivering a particular service within the NHS or a private health provider, and work within a clinical discipline, such as:

- a medical or surgical specialism
- a branch of nursing
- general practice
- an allied health profession, for example occupational therapy, physiotherapy
- a mental health profession, e.g. psychiatry, psychology, psychiatric nursing, or psychiatric social work.
- a manager whether that be for a provider or a commissioning body and most especially if a member of a Programme Board or a Network

When the Guide addresses the reader as 'you' it is usually speaking to clinicians who have some opportunity to show leadership in developing the service they work on. This does not necessarily mean only the designated senior clinician or clinical lead – most clinicians by the nature of their role have some opportunities to lead, even trainees.

But the Guide will also help you if you are:

- someone with a role in commissioning services from clinicians, or
- a professional manager who works alongside senior clinicians, including network managers.

You may also be interested if:

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† As noted earlier, these practical guidelines have been developed as a result of the research and have been presented, discussed and refined within workshops comprised of managers and clinicians. However, they remain at a pre-pilot stage and they have not as yet been trialled at any scale. The contact details for these guidance notes are those of the authors and not an authorising NIHR.

- you hold a key position concerned with change and leadership in the Department of Health, or in one of the Royal Colleges or other related health bodies and institutions.

### **What this Guide will do for you**

As a clinician, it will help you:

- make sense of intuitive acts of leadership so that you can become more conscious about your actions as a leader and the choices you have available to you
- tease out the multiple leadership roles available to you from which to choose according to the context and your circumstances
- distinguish between leadership as an individual skill or competence, and leadership as something that emerges between colleagues in the context of a particular project
- focus your thoughts on particular opportunities for you to take a leading role in cross-boundary redesign
- better understand the wider system in which your leadership is conducted and consider how it affects your leadership options.

### **Building a rationale for change in provision**

A research example from the case study of the London sexual health service shows how a case for change may be made:

‘service redesign work ... is equally imbued with the perspective of the local public health context – reducing sexual health need in the population requires making services accessible and easy to use. This clinically-led insight can be seen as providing an innovative drive and point of reference for justifying new ways of providing services, a way of conceptualising social need independently of the priorities of any particular clinical or managerial group.’ (Report extract)

The clinically-led insight provides a rationale for working across established boundaries.

### **What sort of leadership are we talking about?**

Leadership can take a number of forms. Where should we start? Those in senior positions have the greatest responsibility and impact in how they choose to exercise their leadership on those around them and on the system. For this reason, the research concentrates on senior clinicians’ involvement and their role and perception of service change.

But as the research makes clear, leadership is not the sole preserve of the few in top jobs. Leadership can be more widely distributed. The report points to the lesson that leadership work best in the context of the NHS when it is an inclusive process, something available to many. Indeed, it is vital that appropriate leadership capability is accessed by everyone engaged in a major change project. Liberating such leadership and other appropriate responses and participation therefore calls for enlightened leadership by those in senior positions who can make this happen. And that requires an

understanding of interpersonal and organisational dynamics – something covered in this Guide.

There is no universal agreement on what leadership actually is. There is no leadership best practice that one can teach and predict how leaders will lead. Even if there was an agreed formula, there is no guarantee that two leaders would see their role in the same way or behave in the same way. What leadership looks like depends on where the initiative lies – whether it is something strongly internally driven, or whether there are external stimuli or pressures.

And what is leadership used for? At one level, leadership can be seen as an aspect of the behaviour of someone in a position of authority in how they seek to inspire their teams within their own service. That mode was not the focus of the research nor is it the focus of this Guide. We are taking that personal form of leadership for granted here, though it may sometimes be missing. Instead, we are concentrating on the long-term, chronic, and recurrent conditions that require cross-boundary collaboration across multiple institutions such as primary and secondary care as well as across health and social care boundaries. Simple, within-trust, micro-scale leadership, while necessary is not sufficient to bring about transformational change. So, while the scale may vary, integrated and whole systems change is needed that redefines the 'offer' to patients. And that takes a special kind of clinical leadership.

In the context of major change projects of this nature, leadership is best understood in terms of actions and processes between collaborating parties in a specific context, rather than as a personal skill or as a position of high authority. Leadership is therefore a joint enterprise. Leadership is relational. Its presence is most strongly impacted in the spaces between people and between disciplines and functions. Leadership attracts and bonds – a bit like glue.

### **What leadership roles are available to clinical leaders?**

The leadership roles described below are not necessarily mutually exclusive, but may be seen as building to an increasing level and depth of leadership involvement.

**Level 1:** Constructive engagement with centre-led ('top-down') initiatives that originate elsewhere, particularly with commissioning bodies or the Department of Health.

**Level 2:** Influencing decisions such as how resources can best be deployed.

**Level 3:** Identifying and initiating projects that call for leadership.

**Level 4:** Providing oversight to hands-on leadership by others.

**Level 5:** Taking personal 'hands-on' charge, actively driving through change.

Here is one example of what it might look like:

'Clinicians took their place at leading operational implementation within a formally authorised and resourced service redesign project to establish the hub and spoke model of integrated services, supported by a service manager with a nursing background. They have developed clinical protocols, training programmes for nurses, and models of clinic operation. The conceptualisation of the model and establishing the case for its resourcing were not led by clinicians. They have nonetheless proved themselves to be willing partners in a change initiative of considerable ambition.' (Report extract)

In the example shown, hands-on operational-level leadership followed and then built upon initiating leadership from elsewhere.

### **Initiating leadership**

In the NHS context, high-level leadership might therefore be required to kick things off and provide supervision to others engaged in hands-on leadership and management. Such a 'super-leadership' role may look like this:

1. provides a context, a reason for change and a challenge
2. gives permission for the process and events to happen
3. ensures funds, time and other resources
4. defines a standard of what success looks like
5. ensures readiness for change: a point between excessive stability and excessive anarchy.
6. disturbs or shakes up the status quo for relevant aspects of how the organisation works and moves forward, making clear that the status quo is not an option. In parallel, it maintains stability and continuity of appropriate services (e.g. safeguarding users' confidence during the change)
7. loosens the system, to weaken strictly hierarchical management of change
8. licenses more widely distributed power for others to engage in system-wide improvement activity
9. gives participants a collective and cross-departmental identity
10. makes people's fate rely on inter-dependence, which leads to cooperation, warm relationships, and people taking a share of responsibility
11. sets tight timescales to instil a sense of urgency
12. makes clear how the relevant people will be held accountable, individually and/or collectively, agrees this system of accountability, then conducts a process by which people are formally held to account for the required improvements

You may find yourself engaged at more than one level, in more than one leadership role. This may depend on the scale of the project.



### Where do you stand personally?

You may like to try answering these ten questions about the nature of your engagement in relation to the issues raised above.

1 How strongly are you psychologically engaged with the change agenda?

Don't know	0. Not at all	1. A little	2. Quite	3. Very
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2 How strongly are you practically engaged with the change agenda?

Don't know	0. Not at all	1. A little	2. Quite	3. Very
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3 How strong is your commitment to take on a leadership role and responsibility?

Don't know	0. Not at all	1. A little	2. Quite	3. Very
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4 How well equipped do you feel in terms of your leadership capability?

Don't know	0. Not at all	1. A little	2. Quite	3. Very
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5 How clear are you to what cross-boundary projects you can apply your leadership?

Don't know	0. Not at all	1. A little	2. Quite	3. Very
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6 How clear are you about what your leadership role will be?

Don't know	0. Not at all	1. A little	2. Quite	3. Very
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7 In taking a lead, how well do you expect to be supported by your peers?

Don't know	0. Not at all	1. A little	2. Quite	3. Very
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8 In taking a lead, how well do you expect to be supported by your team colleagues?

Don't know	0. Not at all	1. A little	2. Quite	3. Very
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9 In taking a lead, how well do you expect to be supported by professional managers?

Don't know	0. Not at all	1. A little	2. Quite	3. Very
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10 In taking a lead, how well do you expect to be supported by the wider system you work in?

Don't know	0. Not at all	1. A little	2. Quite	3. Very
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These reactions (scores) are for your own private reflection, but you may want to share them with trusted colleagues.

### **Becoming more engaged**

A distinction can be made between an individual's *desire* to be engaged and an organisation's *encouragement* of involvement.

Hence, there are two scales – one seeks a measure of organisational opportunity (reflecting the conditions that facilitate doctors to become more actively involved in leadership and management activities), and the other a measure of individual capacity (reflecting perceptions of enhanced personal empowerment, confidence to tackle new challenges and heightened self-efficacy).

The two strands – individual and organisational – have to come together if the motivation and availability for leadership is to translate into action, as the diagram below shows.

The organisation provides a purposeful context, important problems to solve, a supportive framework, permeable boundaries, an absence of obstacles and restrictions, the least bureaucracy and protocol, a minimum of needless checks, etc.

*The organisation's facilitation of opportunities*



**(enabled to do)**

INDIVIDUAL (**can do**) LEADERSHIP



ORGANISATIONAL ACTION

**(want to do)**



*People's effort, will, motivation, desires, values, beliefs, perceptions and volition*

The organisation provides a clear vision, goals, challenges, a fear-free culture and positive climate, constructive feedback, good job-person matches, fair recognition and rewards, etc.

## **Influencing perceptions**

Your perceptions are important, as are those of people around you. Along with a person's environment, their perceptions play a large part in explaining their behaviour. For example, do you perceive that there is a gap between how things are and how you think they could be? And what perception do you hold about whether the possibility of closing the gap is something within your control? Or do you see this as 'others in control'?

Organisations and therefore leaders can help shape people's perceptions. That is part of your job as an organisation leader.

As the research results revealed, the role of chief executives of trusts can be critical. They set the tone as to whether clinicians are expected to be part of the leadership effort or are expected to circumscribe their roles.

Chief executives can also take active practical steps to involve clinicians in shared leadership. For example, they may participate in doctors' induction programmes. They may discuss quality, safety and performance, either in regular and formal meetings between doctors and other executives, or simply take advantage of informal opportunities as they arise.

## **The elements needed for clinical leadership – assessing your own situation**

The findings from the research can be summarised in terms of six elements of clinical leadership needed for cross boundary service redesign. These are shown below. Each of them involves clinicians – possibly from several different occupations or specialisms - collaborating with others, including non-clinicians. We want you to use this framework to consider your own current position and capability to get involved in clinical leadership, regardless of how much responsibility you feel you currently have – or lack! Read through the descriptions of the six elements below and ask yourself the following questions with reference to each one:

- 1. What is already in place to help make progress with cross boundary service improvement here?*
- 2. What opportunities or possibilities are you aware for you and your colleagues to make further progress?*
- 3. Which immediate issues need to be resolved?*
- 4. What can you do next in the light of these thoughts? Who else do you need to talk to get started?*

**Figure 7. The elements needed for clinical leadership**



### **1. Clarifying the purpose of care: public health outcomes and user experience**

This first aspect of clinical leadership concerns clarifying the overall goals of service delivery, in terms of the contribution to tackling public health issues and providing what is important to service users and carers. In the research, across dementia services, the public health goal of improving rates of dementia diagnosis was for example widely shared and visibly being tackled. Other goals mentioned included identifying problematic behaviours in sufferers earlier, and providing more community based support and information for sufferers and carers. The idea of a single and consistent point of access for sufferers was however seen by many as a key feature of what users want. There were also a number of ideas of how users could be involved in shaping services. In the studies of sexual health services, there was a clear priority of increasing access to integrated services offering contraception and early diagnosis for sexually transmitted infections, in order to tackle high rates of teenage pregnancy and high incidences of STIs. Making services more “user-friendly” was seen as an important part of improving accessibility.

## **2. Achieving a meaningful scope of authorisation**

Our second aspect of clinical leadership concerns the extent to which clinicians have influence over the system of care relevant to meeting public health goals and the totality of needs of service users. The research found that even those clinicians who have understood how to improve their particular part of the service may feel daunted by the fragmented nature of the wider system of care, and disturbed that such a system is not providing the best possible service for users and carers. Real progress tends to come when some “activist” clinicians find a way of working with managers to establish a project or initiative where they are authorised to review the service on a wider scale.

## **3. Collaborating with service managers to win resources**

Our third aspect of clinical leadership concerns how far clinicians are involved in the resourcing, shaping and continued justification of their service and how it is delivered. Clinicians widely report on being involved in discussions with service managers on developments in their particular services. But becoming involved in an initiative to reconfigure a system of services may well require changing how resources are allocated and finding additional resources for some new components. Which are the centres of power that service level managers and clinical leads can turn to, to make a case for investment? In the research, the National Dementia Strategy was for example widely acknowledged as providing a point of reference for making a case for funding. Which national or regional strategies may be relevant to how you think your own service area needs to be reshaped?

## **4. Tackling the range of clinical and managerial practices required for service development**

This core operational aspect of clinical leadership involves both developing practices needed for improved service delivery and making effective linkages between different areas of practice. So for example, improving sexual health services meant developing new protocols for nurses and health care assistants to take fuller responsibilities for some areas of clinical work. And developing dementia services involved sharing understanding of the roles of psychiatrists, psychologists and nurses in carrying out memory assessments. New clinical practices then required new ways of organising clinics, including IT systems for appointments and recording activity, as well as changes to tariffs so that funding was better matched to actual activity.

## **5. Reworking professional roles and relationships**

Developing a better system of care usually requires developing new and revised understandings of and across professional roles. Each established professional role is likely to need to be ‘open’ to exploring new areas of practice, sharing existing ones and re-evaluating the relevance of knowledge held by oneself and other professionals. An example in dementia care is how far the medical model needs to be brought into dialogue with expertise in building community and social support. So diagnosis of

dementia may need to be closely linked to an assessment of the support networks available to the person concerned and their carers. This is likely to lead to a redefining of professional identities. This in turn implies skilful practise in the appropriate 'closing' around revised professional roles. In sexual health, providing one-stop-shop integrated clinics has led effectively to the need for a "dual-skilled" nursing role, spanning both STI treatment and contraception, and replacing previously specialisms in nursing. There are also implications for more skill overlap between the medical specialisms of reproductive health and genito-urinary medicine.

## **6. Finding resources for leadership and improvement: time, project management and appropriate techniques**

To engage with the other five aspects requires the resources referred to under this sixth heading. In sexual health services in London, service redesign was aided enormously by careful patient journey analysis, transit time etc. Working parties were established which had time allocated to develop these analyses.

### **How leadership sits within a change system**

The rest of this guidance discusses a number of themes emerging from the research which are intended to help you further clarify your thoughts about how to engage further with contributing to cross boundary service improvement.

### **Change management and working on the system**

It might have been expected that the exploration of clinical leadership would show how mainstream HR preoccupations with individuals' competence, skills, behaviour, training, motivation and performance management play a large part in explaining and underpinning service transformation. But the research into cross boundary redesign in the four case studies highlights other additional dynamics. The sum of competent individuals is not sufficient to deliver a competent system. Rational and linear models, theories and frameworks that concentrate on the individual overlook the confused, uncertain, unpredictable, political and messy dynamic of spaces and relationships which were characteristic features of these NHS meso-systems.

What really matters, and what needs to be better understood, analysed and managed is what is going on at the system level of change interventions as they happen. The challenges have a systemic anchor and quality. In the popular change discourse, such detail is easily passed by; the benefit of this research was that it engaged with people's lives at a detailed and practical level. In this section we will draw out these elements from the research and offer practical advice based on them.

### **The system needs to permit change, in itself**

The case research suggests that it is not sufficient for people to be trained; to exercise new skills; to know what to do; or even for them to radically

change themselves or their jobs. All this has a relatively marginal effect on change, on the quality of service delivered, on costs, on productivity. Rather, what needs to change is the way that the whole system in which those people work is designed to work and actually works. This includes how it questions and redefines its purpose and goals, and how it redefines itself in relation to its environment and its stakeholders. Inevitably, leading change means challenging defensive boundaries and taking on vested interests.

The 'system' is also invoked when people seek to blame it. They may cite it as an excuse for their own inability to get things done, or simply be pointing out where the system design and operation is the obstacle. Systems have a habit of thwarting good performance.

### **The part played by individual competence**

You might have expected that the amount of effort put into defining relevant competences would prove that a focus on individual ability and performance does after all hold the key to the success of change projects. This turns out not to be the case, as experience in the NHS in Greater Manchester and London testifies. Of course, it should go without saying that personal competence is vital, but the research shows that in terms of what is going on organisationally during change, competency frameworks receive little mention when compared with a range of other factors.

Nonetheless, it is important to understand competence. Various researchers have identified competences for individual professional performance, and these have their own useful applications when it comes to individuals' professionalism, training and development. In the NHS context the MLCF and CLCF frameworks can be useful in that they act as catalysts to raise the level of a clinician's ambition, to legitimise and normalise the expectation of service redesign, as well as contributing towards the development of the requisite (individual) capabilities.

Both competency frameworks emphasise the importance of working with others across professional boundaries. Competences can signpost an organisation's intended direction, but ultimately they specify how *individuals* are expected to perform, be trained and developed, qualify for certification, and be suitable for a position. If you are hoping for more than that it is wise to bear in mind the stark warnings from the research:

- In the context of leadership, those seeking improvement sometimes conflate leadership with leadership development. But development is just one of several levers. Others that can influence what leadership is actually delivered include how leaders are held to account, the rewards, and what happens to people who show individual leadership. As was evident in the cases despite the high level rhetoric about the importance of clinical leadership in an abstract sense, a number of clinicians who sought to exercise leadership were subject to constraints from numerous quarters



including their colleagues and senior management.

- People's performance is highly sensitive to the context: the way people behave depends on who they are interacting with and the challenges they face collectively when collaborating and conversing. We are still largely concerned with individuals here – the impact of context on their performance.
- The ability to exercise leadership in the organisation depends on how the system is designed and how it operates, including any nourishing or toxic qualities of the waters in which people are trying to 'swim', navigate and survive.
- Organisation performance, change and leadership happen in the space between individuals in dynamic, multi-actor processes in unique contexts. And that can't be specified, published and assessed in cause-and-effect linear form. It is too complex for that.

So, what emerges from the research is how little the subject of formal competency arises once one is immersed in real-live interventions. Competence may best be thought of as necessary but not sufficient, having some effect on whether change succeeds, but not uppermost in participants' minds. It is the nature of what is live about the intervention that matters and must be managed and got right. Researching and specifying competency frameworks is the easiest part of the process. Once written, as far as major change is concerned, they can be left in the background. Many organisations make the mistake of grasping what seems simple rather than what seems messy.

### **Change has an emergent quality**

Detailed planning of change has limited utility. Most change does not follow or go to plan. Where contexts are unclear, and where there are multiple options, multiple actors and multiple viewpoints, then assumptions and plans based on linear thinking may be undone by complexity. Action, events, ideas, directions, solutions and outcomes 'emerge' from interaction between the parts that comprise the system. None of the parts knows or holds the answer, but the system as a whole will be seen to when this emergence process is trusted.

'An overarching lesson is the importance of the counterpoint between formal initiatives intended to redraw the landscape of service provision and the emergent ideas that have been developed between clinicians working within services.' (Report extract)

### **Yet project management is also important ...**

Although as noted above, formal planning has its limitations in the context of the cross boundary service redesigns, the case work did reveal that clinical leadership succeeded best when it was supported and underpinned by competent project and programme management. Clinicians working in

tandem with service and project managers were found to be more likely to deliver effective change.

### **The weakness of exhortation**

Exhortation appears to assume that the blockage, and the route to effective organisation change, is to be found in the individual, indeed in overcoming individual shortcomings and resistance. 'It's them.' But exhortation often points the finger at the wrong target. You may yourself have been on the receiving end of others' exhortations. You may have tried exhorting others. Either way, you will probably have come to realise that exhortation as a means of bringing about change, or even simply engagement, is a weak card to play. Rhetoric needs backing with other pressures, motivations and reasons to change. But mostly, the finger needs to point at the system. It is the system (at a series of levels) that needs to be questioned, challenged and changed: its concept, structure, conditions, politics, etc. This is where leadership energy most needs directing.

'One important point ... is the distinction between leadership understood as individual practice, ... 'distributed leadership' understood as leadership behaviour at multiple points in an organisation and not confined to persons occupying positions of formal authority, and 'organisational leadership' as a more complex array of attributes of the whole system. This last conceptualisation highlights the system-wide conditions necessary for the exercise of leadership, and thus attends to organisational development elements such as identifying obstacles to the practice of leadership. (Report extract)

### **The role of training and education**

Training and education are important in change, not as a driver but in a supporting role. The terms training and education are often lumped together when discussing planned change. The catch-all word 'training' is often used to cover various kinds of learning, information-giving, instruction, exploration and bonding between members. But, strictly speaking, training and education are quite different in their effect. Training seeks to converge learning (narrow the range of behaviour) around an expert view of best practice. That is often important, especially for the technical aspect of jobs. But it requires one to be sure about the conditions in which a particular skill or behaviour would be the right response. Learning to read a balance sheet might take training.

Education, on the other hand, is a divergent learning process. It aims to expand the variety of people's performance; it liberates their potential and increases their choices. This is more likely to be relevant for managers where the best way to handle a given situation may be far from clear, especially where other people are involved in a joint endeavour. The manager needs to be able to choose how to act from a variety of possibilities. (Note that call-centre staff need this breadth of choice in their

responses to variety too, but often what we experience when talking to them is the product of the limiting effects of training.)

This distinction holds important implications for those in positions of leadership. In the context of cross-boundary change, a subtle mix of training and education is likely to be appropriate, as in this example from the Greater Manchester sexual health case:

‘Previous boundaries between two service areas have been dissolved, whilst dual training of a cohort of nurses has allowed the boundary of what most nurses do to be considerably expanded, both in terms of specialism and previous divisions of labour between nurses and doctors.’ (Report extract)

If you are a budget holder and you are asked to make funds available for people’s education, you may have only a vague idea what the learner will do with the learning. They may not know either. Yet that need may be just as important as training people in best practice. So trust, imagination and curiosity become more relevant than trying to predict and control others’ behaviour. Sponsoring such learning calls for many a senior leader to become more comfortable at letting go, not imagining that one can control what someone else learns, let alone control what is going on in their head. Even they may be unclear about that.

### **Managing requisite variety**

From an organisational standpoint, education is a response to a system’s need for ‘requisite variety’ (an important concept in organisation design). What this means is that if an organisation is diverse in what it offers (because it faces an environment that is also diverse in the range of demands it places on the organisation), then the management capability needs to be able to match this amount of variety. Otherwise it will get caught out, unable to handle things that arise outside its expertise and what is familiar, its structure, and set procedures. It follows, of course, that such an organisation needs to adapt its variety to match the demands placed upon it. If the organisation lacks the requisite variety to be able handle all that may be expected of it, then it can choose to attenuate the demands placed on it. One way is subcontracting some services, but this too holds potential risks for both providers and users, but these may not be evident in the short term, especially if decisions are made on cost grounds. Hence we found in the Manchester sexual health case that:

‘The outsourcing of sexual health services by commissioners is seen as a retrograde step both by several managers and clinicians within the main service and by some commissioners. This creation of an additional boundary is seen by many as unnecessary and as damaging to the development of resources and capabilities needed for the further development of the system of integrated Hub and Spoke clinics.’ (Report extract)

Even subcontracted services need certain competence to be retained in-house in order to be able to oversee the service,

especially concerning strategy and costs. This sense of losing control can lead to such services being brought back in house at a later date (notably with IT contracts).

The competency frameworks mentioned earlier may carry a risk of narrowing the organisation's variety; that is, they may suggest a narrowing down of the range of expected responses. They imply that they contain sufficient knowledge about all situations (including future ones) that will call for those competences, and this may not be true. There is a risk akin to that of recruiting in one's own image.

### **Assessing the types of challenge**

Some problems and challenges are recurring and familiar; that is, they are well-understood and the relevant solutions are known. They are sometimes labelled 'tame' problems. As such, they require the kind of leadership called technical, and the role and response needed by followers is well trodden and prescribed.

Critical problems where urgent action is needed are different. The kind of leadership required here is 'commanding' in style. Such problems require compliant followership.

But the kinds of issues faced in cross-boundary design are different from both the above. They have not been encountered before, and they are complex as well as complicated. As such, they are termed 'wicked'. From the Manchester dementia services case we find:

'This complex array of services can at one level be understood as an appropriate response to the diversity of kinds of dementia, the different stages of deterioration that people may present with, the variety of levels of support they may receive from carers at home, and the variety of physical health problems they as elderly people may also suffer from. Dementia patients are scattered across domestic premises, independent sector care homes, GP care, acute hospital wards (for co-morbidities such as falls) and the mental health services which in their turn were split between Community Mental Health Teams, inpatient facilities, a day centre run in partnership with a charity, and an In-Reach Team.' (Report extract)

Wicked problems cannot be separated from their environment, and in solving them they change their environment; indeed, this may be the aim. Such problems may be difficult to solve completely, certainly in the immediate term, and may only be amenable to improvement or work-in-progress. Crucially, wicked problems are defined by the absence of a ready-made answer on the part of the leader; hence it behoves the leader to engage others in addressing the issues. Since the identification of the issue at hand occurs in a contested space, the kind of followership required is dependent on a persuasive rendition of the situation by those in authority.

## How can leadership be more widely distributed?

'[A core issue is] the nature of the relationship between clinicians and managers. Factors identified as associated with productive relations include alignment of priorities, open communication, collaborative leadership styles and shared decision making. Unproductive relationships are said to occur when doctors feel under threat from managers who are focused on financial and other issues that may seem to disregard or even undermine clinical judgements. ... the literature concerned with dispersed, distributed and shared leadership (Gronn 2002) makes no presumption that the manager is necessarily the leader, and the clinician merely in a role where he or she has to be, at best, simply 'engaged.' (Report extract)

Distributed leadership is sometimes called dispersed or shared leadership. It happens when people see benefit in extending leadership activity at various levels. Such leadership may depend on and be sponsored by a managerial hierarchy, or it may be more bottom-up and may challenge or bypass the hierarchy. Both approaches may be helpful for the organisation, though the latter may feel uncomfortable for some and be thought to threaten the comfortable state of the hierarchy.

Distributed leadership is not easy for various reasons. It may be unwelcome and resisted by those who may see it as giving up their privileged status and right to decide. They may resent remaining accountable when the acts of others go wrong. Those who are urged to show more leadership may be uncomfortable with additional responsibility and visibility (but without commensurate rewards). Or they may simply be trapped into their reliance on hierarchical relationships and having a boss to turn to for decisions.

### The significance of incentives

'If clinical leadership for service redesign is such a good idea, why has so little of it occurred so far? According to research by the management consultants McKinsey, there are three main reasons: ingrained scepticism by clinicians themselves, weak or negative incentives, and little nurturing for leadership' (Report extract)

The term 'incentive' is used in two ways. There are what might be thought of as passive or built-in incentives: that is, largely natural, unplanned features of a system that lead people to do (or not do) what is good for the organisation. If the system punishes them when they do the 'right' thing (such as sacking them if they spotlight an embarrassing or dangerous practice) then the system contains dysfunctional or negative incentives. It is someone's job as a senior leader to try to ensure that such 'perverse' incentives are absent.

The other type of incentive – usually a payment (but may include some other expression of appreciation) – is deliberately designed to lead someone to undertake some activity or behaviour that they might not otherwise do or want to do, or simply cause them to work harder. This is inevitable in a

marketplace where there are multiple partners, some of whom are competing (for attention, priority, funds, etc.), and there are clear buyers and sellers, each with separate accounts. Within a close boundary, explicit incentives cause no end of trouble, since it attempts to buy a change in someone's performance (according to someone else's definition of what is right). Such manipulation and implied mistrust may be bought at the expense of goodwill, motivation and loyalty, whether individual, group or institutional.

Under pressure to gain control over national health priorities such as obesity and alcoholism, offers of special payments are sometimes dangled in front of professionals' eyes, or in front of institutions' budgets. Perverse examples have included a PCT offering payments to GPs not to refer patients to its hospitals because of the economics. It is easy to imagine how such arrangements may undermine trust with patients. Rule number one is to try to keep money issues in the background, and not in the foreground, of people's thoughts when they are taking decisions about their work.

Such incentives in the form of pre-specified rewards and payment-by-results schemes are not to be confused with those that merely say 'thank you' for performance *after the event*, sharing in corporate end-of-year financial success, or are part of jointly and willingly agreed personal objectives.

### **Building a collective ethos**

'Clinical leadership has demonstrated a distributed and collective ethos in a number of ways during the evolution of this case. The formulation of the sexual health modernisation initiative grew from informal collaboration between public health, reproductive health and genitourinary specialists, who found common cause in wanting to redesign services to make them more accessible. Tensions between specialisms and between different professional groups are experienced but are worked with explicitly and in a way that preserves mutual respect.' (Report extract)

A collective ethos recognises that differences in priorities and interests are real and need to be taken seriously. This includes acknowledging the way that changes in skills practised by one group or specialism may have implications for the future role of another.

### **Developing a new identity and sense of belonging**

In the above example, the bonding aspect of 'training' is likely to be one factor in helping to develop in people a new sense of identity and of what people belong to and who their new close work colleagues are. The Greater Manchester dementia services case contains the lesson that service redesign can lead to realignments in the sense of belonging:

'Reworking of service and professional boundaries appears to have led to new patterns of group belonging or identification. Nurses

reported that both their clinical colleagues and reception staff identified strongly with the new service and its integrated offering, and were willing to work shifts across the set of Spoke clinics as well as at the Hub. The new employment pattern, based on full-time appointments rather than the sessional work that was characteristic of older family planning clinics, appears to have played a key role in establishing such strong sentience.' (Report extract)

Without close attention and a thought-through strategy, there is a possibility that a specialism may fear that the ethos of another will take them over.

### **Building relationships between professional roles**

A participative style of leadership and a carefully designed structure helps to build bridges across erstwhile prevailing professional boundaries. This lesson derives from the London sexual health case:

'The development of the pilot service has been guided by a pattern of rotating clinical leads working within a collectively engaged consultant body, and a participative management structure that encourages significant input from nurses, health care assistant and receptionist grades in working groups to improve aspects of the service. Leadership in shaping operational practices is broadly distributed, and the resulting patterns of work involve nurses and health care assistants working with autonomy in dealing with patients, based on dual training of all nurses and sufficient cross-skilling of doctors.' (Report extract)

Tensions between specialisms and between different professional groups may be experienced but can be worked through in a way that preserves mutual respect.

### **Balancing leadership with followership**

The act of followership entails its own form of leadership. Clinical leaders who respond positively to centre-led initiatives are themselves exhibiting required followership, and how they take that forward calls for leadership. In any hierarchical structure you can think of positive followership being converted into leadership under the authority of successive levels. There are probably few leaders who don't need to follow another's lead. Responsible and active followership needs working on and arguably is as important to the organisation as is leadership.

### **Good governance and accountability**

It takes a number of things to come together for change to happen. It is not sufficient to have the right person in post, for them to have had the right training, and for them to be well-motivated. It needs a good system of governance to be in place. A cornerstone of good governance is clear accountability.

**First, to whom do people believe they have their major responsibilities or obligations, or owe a duty, in how they perform their roles?** These major responsibilities can be thought of as 'accountabilities'. There needs to be agreement between parties about what these are.



The research revealed a model that conceptualises clinical professional practice as needing to maintain its legitimacy and autonomy through demonstrating accountability simultaneously in three directions: (i) to the management of health service organisations, (ii) to a system of professional standards and expectations, and (iii) to service users and carers.

So, another practical action point is to assess whether this is how you see your own situation. Is this something that you need to clarify?

**Secondly, of the various stakeholders to whom you have your most important responsibilities, who in particular has formal authority to hold you to account for fulfilling those responsibilities?** Ultimately, it is only individuals or bodies that can legitimately impose sanctions if you do not fulfil your key responsibilities that can formally hold you to account. How do these arrangements work in your own area?

In organisational life that there will always be those with either more or with less authority and power, we are not free to do as we please.

Taking one example, individual patients by and large cannot directly hold you to account. They tend to rely on your employer or your professional body to undertake that function on their behalf. But in a more overtly conscious patient-centred health service, and with increasingly better-



informed patients and improved means of communication, doctors are being encouraged to shift their dialogue with patients in the direction of becoming 'an interpreter of information and an adviser, rather than an unquestioned expert'. Such a change begins to blur theoretical and practical accountability, where the more intense dialogue may feel close to being held to account. The government's plans to extend patient choice, for example to change their GP easily, adds to this feeling and strengthens this line of accountability in the diagram.

**Thirdly, how practically do formal processes of being held to account work?** In other words, who does what to whom? Who asks for progress reports, or who calls for appearance before a project board during the course of work, or during a change project, and not only when there is a complaint or where something has gone wrong?

What does the process look like and feel like in your case? It should feel that you are under the spotlight, that this matters to others, that you are not free to do as you please, that others have a responsibility on behalf of your stakeholders to ensure that you, in turn, are carrying out your key responsibilities. It should also feel that others need to know what support or additional resources you need, what you need unblocked etc. This is practical governance at work.

In the case of a change project, it may be sometimes be a team, body or panel that has practical responsibility for holding you to account. And it may sometimes be a team that is held to account. The focus of discussion will include your responsibility for providing appropriate leadership, however that has been defined.

**Overlaying each of the above is the question: how well does the structure assist the perception of who is accountable?** The position of a job in an organisation structure and in relation to those around that job determines how reasonable it is to hold people to account for required actions and decisions. Jobholders need sufficient distance between their job level and those above and below for them to be clear that the action required sits squarely with them at their level. If there are too many levels in the structure, where jobs are squeezed and the difference between them is small (in some cases on the same grade), then a jobholder may feel that responsibility lies either with their boss or with a subordinate.

### **Economies of scale and economies of flow**

A major reason for large-scale reorganisation in the way services are delivered is to achieve economies. These economies may be financial or save on other resources.

'Such a perspective involves leaders in relocating routine services from high-cost specialist jobbing shops to more appropriate settings where advantages can be taken of economies of scale.' (Report extract)

There is a widespread assumption that increasing scale automatically leads to economies. It may do, but this is often not the case. For political reasons some costs may be hidden to show that a particular decision was justified. Moreover, increased scale may make the service more remote or less personal for the user.

Economies of flow, however, are quite different. These arise when a chain of services which a user is likely to need get joined together. Reorganising services around the patient's needs may streamline services, and lead to efficiencies. This may come about when a patient's perspective is taken, when the patients 'pulls' the service, or when the patient may even have an input and play an active role in 'co-providing' the service.

### **London Sexual Health Services Case**

The integrated walk-in service has been significantly shaped by a multi-professional 'patient flow group', which examines how users pass through the service and why delays might be occurring. This has led to a number of refinements in the triage questions put to people through the screens on arrival to make sure that users are directed to the most appropriate clinician.

### **The relationship between clinicians and managers**

Unproductive relationships existed when clinicians felt under threat from managers who are focused on financial and other issues that may seem to disregard or even undermine clinical judgements. In contrast, productive relations emerged when managers and clinicians worked actively to find shared priorities and to contribute in a mutually re-enforcing way.

### **The importance of conversations**

Many of the successful changes noted in the case studies were facilitated by the opportunity and the willingness to engage in conversations. This was seen most notably for example in the London dementia case where psychiatrists and geriatricians who had previously not communicated with each other at all began to converse productively as part of the design of the new memory service. In the Manchester case a similar outcome was achieved in this smaller-scale setting rather more by diktat. But in this case the acceptability of the change was rather less embedded.

Attitudes and perceptions change over time about what activity is considered work, especially what part conversations play in this. If work is thought of as something practised by individuals achieving results on their own, then talking – and other people's conversations – will seem to play only a small role and appear to some as none of their business, or even time wasting. The level of talking in the workplace may be regarded as dangerously informal, unmanaged, and badly out of the manager's control. That view is changing. Complexity science has drawn attention to the frequently unplanned course of change processes, and this has elevated the part that conversations necessarily play in determining outcomes. Indeed,

in some quarters, conversations are now heralded as the life-blood of organisational change. Brokering conversational process (putting others in touch with each other, sometimes without a particular outcome in mind) is now considered to be much more important than it used to be.

### **Emerging from the shadow**

Organisational life may be thought of as consisting of two domains: one broadly formal, official, planned, managed and rational; the other broadly informal, unofficial, unplanned, unmanaged and non-rational.

‘People don’t tend to like to learn from their nearest neighbours. They’re happy to take things from London, Birmingham, Glasgow, anywhere, but they won’t go to Salford or to Bolton. This certainly happens in the early stages of network development; and as time goes by and they become comfortable working together, sharing practice comes easier.’ (Report extract)

The non-rational aspect of organisational life is often associated with the shadow-side (and even the dark side) of the organisation’s personality. It may simply be a case of initially wanting to hide from others nearby a need to seek an external view. Fear of embarrassment may explain this. Fear is a powerful force in organisations.

Conversations (along with networking) are located in this second, non-rational domain – though they are on a journey of gaining greater (rational) legitimacy. The increasing acceptance of the place of complexity theory in understanding and managing organisations, coupled with the increasing centrality of conversations, and the notion of rationality as the driver for decisions becoming seen as illusory, leads some to consider that the division between the two halves is becoming redundant: in other words, the shadow side emerges into the full light; messiness is intertwined with the rational.

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## Appendix 2: NVivo Coding Analysis Methodology and Procedure

Instructions to Coders: note on top of interview transcript:

1. Identifier code, role, other descriptions;
2. Which interview question/case study heading data is relevant to (Location, Disease)

### Codes:

1. **Background:** motivations for change and context: triggers for change and why?
2. **Process of Change:** What happened? Descriptions of the sequence of activities involved in bringing about change or stages of development of the new services
3. **Achievements:** What kind of cross-boundary service redesign has been achieved? Include data on levels of performance achieved, including limitations.
4. a. **Factors that enabled** (helped) shape progress  
b. **Factors that were barriers** (hindered) to progress  
c. **Factors that were neutral** but shaped progress
5. **Role of Clinical Leader or clinical leadership** in shaping progress or outcomes, if not covered by 4/
6. **Unresolved issues** currently being faced (including new developments now possible, or visions of the future)
7. Relevant to study but **Outside** 1-6 codes
8. Coders' **Interpretative insights** of the codes or themes

Code using Bold Key words above in left hand margin

Code multiple codes if in doubt

Do not code extraneous material that has no relevance

Code passages of interest but not within scope of codes 1-6 in 7

## Appendix 3: Examples of emergent descriptive codes used in NVivo analysis of interview data

Figure 8. Examples of emergent descriptive codes used in NVivo analysis of interview data

Name	Source	Reference	Created On	Created	Modified On	Modified
Role in service	6	11	12/10/2011 1	R W	11/12/2011 16	R W
Outside but relevant to study	30	186	03/05/2011 1	KJ	12/11/2011 14	R W
Unresolved Issues currently being faced	27	171	03/05/2011 1	KJ	12/11/2011 21	R W
Ambiguities about what integration actually means	2	2	12/11/2011 2	R W	12/11/2011 21	R W
uncertainties about the future of commissioning	2	2	12/11/2011 2	R W	12/11/2011 21	R W
Loss of appeal to established separate target groups	1	2	12/11/2011 1	R W	12/11/2011 17	R W
Issues emerging with the Camberwell model	3	17	10/11/2011 1	R W	12/11/2011 20	R W
Finding an effective SH role for primary care	1	2	10/11/2011 1	R W	12/11/2011 13	R W
possibilities of wider roles for various levels of nurses and C	2	10	09/11/2011 1	R W	12/11/2011 22	R W
Need for workforce planning and development across the c	2	5	07/11/2011 2	R W	12/11/2011 15	R W
Contraception services in danger of becoming lower priority	1	1	07/11/2011 2	R W	12/11/2011 13	R W
Ambivalence about integrating GSTT and Lambeth commu	2	4	07/11/2011 2	R W	12/11/2011 15	R W
how to increase learning across centres	1	2	07/11/2011 2	R W	12/11/2011 13	R W
possibility of providing more intermediate services related to	2	2	30/10/2011 1	R W	12/11/2011 13	R W
Working on integrated tariff for sexual health services	3	6	30/10/2011 1	R W	10/11/2011 20	R W
need to increase take up of STI testing in an efficient mann	2	2	30/10/2011 1	R W	12/11/2011 14	R W
problems managing demand in relation to finances, capacit	3	11	30/10/2011 1	R W	12/11/2011 14	R W
integratedS across different providers	2	11	30/10/2011 1	R W	12/11/2011 14	R W
need further integrated medical training and collaboration in	4	10	30/10/2011 1	R W	12/11/2011 17	R W
Role of Clinical Leader or Clinical Leadership in shaping progre	29	187	03/05/2011 1	KJ	12/11/2011 21	R W
Formal role in higher level structure for designing the future	1	1	11/12/2011 1	R W	12/12/2011 10	R W
Public health as clinical leadership	1	1	12/11/2011 2	R W	12/11/2011 21	R W
desire to sort the system out	2	2	12/11/2011 2	R W	12/11/2011 21	R W
Taking responsibility for understanding the context and taki	3	7	12/11/2011 2	R W	12/11/2011 21	R W
Lack of resource for clinical leadership roles	1	1	12/11/2011 2	R W	12/11/2011 21	R W
importance of a range of clinical perspectives, including fron	4	6	09/11/2011 1	R W	12/11/2011 21	R W
Complementary role of non-clinical leaders	5	14	03/11/2011 1	R W	12/11/2011 20	R W
Participating in wider forums to establish standards for new	2	5	02/11/2011 1	R W	10/11/2011 20	R W
Resourceful solution of expertise gaps circumventing establ	1	5	31/10/2011 1	R W	12/11/2011 20	R W