

**Creating an Integrated Nursing Team within Primary Healthcare: An
Action Enquiry Approach**

Thesis submitted for the Degree of Doctor of Philosophy,
University of Leicester

By

Susan Allen (SRN, SCM, Dip. Nurs. ED. MSc)

June 2005

© Susan Allen 2005

This thesis is copyright material and no quotation from it may be published without proper
acknowledgment.

Acknowledgments

I would like to thank all the participants at Leicester Terrace Healthcare Practice who welcomed me into their work environment so willingly and freely gave me so much data with which to conclude this study. I hope that the learning for them was as powerful as it has been for myself and has influenced the excellence of patient care delivered by the practice.

Sincere thanks to my husband Steve, and children, Belinda, Paul, and David, who have been so supportive through this long journey, and have encouraged me when family issues and bereavements seemed so overwhelming I would have chosen to give up.

For my work colleagues who encouraged me I thank you and hope that I will be as supportive to you as you complete your own personal research journeys.

Finally, I would like to thank Professor Susan Weil who introduced me to the methodology for this enquiry, Professor Julia Kiely, who as my second supervisor has encouraged me through different cycles of this project and especially to Professor Nada Kakabadse who willingly took me on as a student late into this action enquiry process. Without her expertise and clear and timely advice and encouragement I would not have succeeded.

Abstract.

This thesis is based on a journey towards developing team working within a primary healthcare setting which enabled the NHS agenda for primary care service delivery to keep pace with the government modernisation agenda. (Department of Health, 1997). Initially the focus was on the development of an integrated nursing team which enabled all disciplines of nurses to work towards a patient focussed healthcare service, but it soon became evident that all staff involved in delivering the primary healthcare service were essential to the process and developments of the enquiry if the objective was to be achieved.

An action enquiry approach based on collaborative and participative action research (Carr and Kemmis, 1986; Lincoln and Guba, 1989; Cayer, 1997) was discussed and was the prime method of enabling changes to occur in the healthcare practice. This is represented by the interrelated four main cycles of enquiry that have emerged from the data, and discussed in this thesis.

Key to the success of the developments was an understanding of team working and leadership as it applied within a healthcare setting and also the underlying dynamics, which are evident when different professional groups from different traditions and knowledge base work together. (Schon, 1983) This was explored within the context of a systems approach to organisational development and through reflective dialogue along the principles advocated for creating a learning organisation. (Senge, 1990)

This thesis will demonstrate how confidence developed in myself and the practitioners, especially those from marginalised groups, and how the wider healthcare system made an impact on the developments within the practice. The area of leadership will be discussed from multiple perspectives and recognition that as a concept all stakeholders had a poor understanding of leadership.

The key finding from this study identifies the need for a holistic approach to manage and sustain change, and indeed everyday productive working relationships. This especially identifies the importance of giving attention to the preparation of future healthcare workers, the appropriateness of organisational structures in which services are delivered and support structures available to those in team leadership positions.

Table of Contents

	Page
Chapter 1: Introduction to Enquiry and Structure of Thesis.	1
1.1. Introduction	1
1.2. Background	1
1.3. Chapter Summary	4
Chapter 2: Enquiry's Formative Context	5
2.1. Introduction	5
2.2. Why the Interest in Team Working in Healthcare Services?	5
2.2.1 How did I make sense of this passion to provide direction for the enquiry?	7
2.3. The Policy Imperative	9
2.4. Developing Integrated Working in Primary Care	10
2.5. Where the Enquiry Took Place	11
2.6. My Introduction to the Practice	12
2.7. Practice Development Plan	14
2.7.1 External environment	14
2.7.2 Practice Vision statement	15
2.8. Chapter Summary	15
Chapter 3: Literature Review	16
3.1. Introduction	16
3.2. Policy Directives	16
3.3. Modernisation Agenda and Interprofessional Working	18
3.4. Integrated Nursing Teams and Interprofessional Working	19
3.5. Political influence	19
3.6. Power Relationships within Healthcare Teams and Professional Knowledge	20
3.7. Teams and Team working	22
3.7.1. Team Roles	24
3.7.2. Teams and Organisational Structure	25
3.8. Leadership	26
3.8.1. Styles of Leadership	27
3.8.2. Preparation for Leadership	29
3.9. Organisational Learning	31
3.9.1. Communication and Dialogue	33
3.9.2. Change as an emotional transition	35
3.9.3. Systems thinking	36
3.10. Conclusion to Literature Chapter	38
Chapter 4: Philosophy and Methodology	40
4.1. Introduction	40
4.2. Philosophical Underpinning	40
4.3. Qualitative Enquiry	42
4.3.1. Ontological and epistemological assumptions	42
4.4. Action Research as a means to develop knowledge	45
4.5. Ethical Considerations	50
4.6. Chapter Summary	54
Chapter 5: Data Analysis as Cycles of Enquiry	55
5.1. Introduction.	55
5.2. Cycle 1: New Leadership for the Nursing Team.	58
5.2.1. Introduction	58
5.2.2. Why the nursing team needed leadership?	58
5.2.3. Finding the best way forward to lead change in the practice	59
5.2.4. The direction of travel	59
5.2.5. Uncovering some underlying tensions	60
5.2.6. Setting the scene for the Nurse Team Coordinator.	61
5.2.7. Attempting to clarify the Nurse Team Coordinator role.	63
5.2.8. Introducing reflective practice and my role in the practice.	65

5.2.9.	Developing reflective dialogue	69
5.2.10.	Challenging the practice to define what it meant by leadership	70
5.2.11.	Cycle 1 Summary	71
5.3.	Cycle 2: Team Forming and Norming Challenges.	72
5.3.1.	Introduction	72
5.3.2.	The practice nurse review and related issues	74
5.3.3.	The community (generic nurse) staff nurse	76
5.3.4.	Introducing Phlebotomy into the role of the B grade Nursing auxiliary	78
5.3.5.	Communication	79
5.3.5.1.	Coffee Time	79
5.3.5.2.	Titles of meetings	81
5.3.6.	Mapping current developmental position	82
5.3.7.	Questionnaire	84
5.3.7.1.	Individual nurse responses.	84
5.3.7.2.	Leadership questionnaire	86
5.3.8.	Clarifying the definition of an Integrated Nursing team	86
5.3.9.	Team Processes	87
5.3.10.	Summary	92
5.4.	Cycle 3: Developing a Shared understanding of Leadership.	93
5.4.1.	Introduction	93
5.4.2.	Leadership profile.	94
5.4.3.	Skill development	94
5.4.4.	Questionnaire responses (to Appendix 1)	95
5.4.5.	Interviews with administrative staff	100
5.4.6.	Individual interviews with GP's	100
5.5.	Cycle 4: Developments.	102
5.5.1.	Introduction	102
5.5.2.	More appropriate use of B Grade nursing auxiliary	103
5.5.3.	Appointment of a 'generic' (community staff nurse) nurse working within clear guidelines	104
5.5.4.	Shared Care	105
5.5.4.1.	Menopause	106
5.5.4.2.	Blood Pressure recordings	107
5.5.4.3.	Asthma Care	108
5.5.4.4.	Mental Health Awareness and Depression	108
5.5.4.5.	Contraceptive services	111
5.5.5.	Other developments in integrated working	114
5.5.5.1.	Flu vaccinations	114
5.5.5.2.	Issues in collection of patient information data	115
5.5.5.3.	Trial telephone Triage study	116
5.5.5.4.	Epilepsy management.	117
5.6.	Discussion of Cycles	119
5.6.1.	Introduction	119
5.6.2.	Development of integrated nursing team	119
5.6.3.	Overall practice objectives, to be achieved by end of two year project period	121
5.6.3.1.	Nurse Team Coordinator appointed	121
5.6.3.2.	Integration of nursing	121
5.6.3.3.	Staff working more appropriately	122
5.6.3.4.	Patients getting better care	122
5.6.3.5.	Nurses working more to Grade	123
5.6.3.6.	Offering more services to patients	124
5.6.3.7.	Needs of patients being met by Primary Healthcare team	125
5.6.4.	The way forward.	127
5.6.5.	Team learning	128
5.6.6.	Developing-shared visions	128
5.6.7.	Mental models	128

5.6.8.	Personal mastery	128
5.6.9.	Systems thinking	129
5.7.	Chapter 5 summary	129
Chapter 6:	Discussion of Findings	130
6.1.	Introduction	130
6.2.	The Outdoor Experience	131
6.2.1.	Developing confidence	133
6.3.	The Community Trust	135
6.3.1.	Peer support across boundaries	136
6.3.2.	An autocratic leadership style	136
6.3.3.	Introducing more collaborative decision making	138
6.3.4.	Concerns expressed from a different perspective.	139
6.3.5.	Teamwork assumptions	140
6.3.6.	Influencing the wider healthcare system	141
6.3.7.	Concerns about generic practitioners	142
6.3.8.	A personal challenge	143
6.4.	Developing confidence 2	144
6.5.	What is being marginalised in the enquiry?	148
6.5.1.	Elderly surveillance.	149
6.6.	Leadership and learning and support	151
6.7.	'Problems' and 'Disappointments'	153
6.8.	People versus Tasks	157
6.9.	Whole people and Whole Organisations	160
6.10.	Leadership	163
6.11.	Practising what I preach.	169
6.12.	Conclusion	171
Chapter 7:	Contribution and Future Directions.	172
7.1.	Introduction	172
7.2.	Key Findings	173
7.2.1.	Organisational structure	173
7.2.2.	Uniform issues	174
7.2.3.	Support for middle managers/leaders	174
7.2.4.	Interprofessional Education	175
7.3.	Contribution to Practical and Theoretical knowledge.	176
7.4.	Reflection on Enquirer's Journey	179
References		180
Appendix 1		194
Appendix 2		196
Appendix 3		197
Appendix 4		198
Appendix 5		203
Appendix 6		204

Table of figures

Figure 1 Ranking of perceived improvement in organisational effectiveness	89
Figure 2 Number of blood tests taken	103
Figure 3 Shift of care of patients from doctors to nurses - Menopause	106
Figure 4 Blood Pressure recordings	107
Figure 5 Asthma care consultations	108
Figure 6 Consultations with patients presenting with Depression	110
Figure 7 Comparison between emergency contraception consultations by nurses and doctors.	113
Figure 8 Comparison between general contraception consultations by nurses and doctors..	114
Figure 9 Dimensions for effective teamwork in integrated nursing teams in primary care...	173
Figure 10: Confidence as a key dynamic for ‘performing’ teams in primary healthcare, modified from Tuckman’s (1965) model	177

Creating an Integrated Nursing Team within Primary Healthcare: An Action Inquiry Approach

Chapter 1: Introduction to Enquiry and Structure of Thesis.

1.1. Introduction

This thesis represents a journey of enquiry into the development of an integrated nursing team and is presented in seven chapters. Chapter 1 gives a background of the importance to myself of undertaking this enquiry, and a perspective on the choices made into the methodology used. Chapter 2 describes the context of the enquiry and gives background to the physical context of the Healthcare Practice. Chapter 3 explores the relevant literature and Chapter 4 the philosophical principles that guided action. Chapter 5 describes the findings of the enquiry with illustrative examples, and Chapters 6 and 7 expand these findings in relation to the literature and the current context of healthcare policy, identifying aspects of learning that can be applied to the wider healthcare community.

1.2 Background

This enquiry commenced in September 1997 when I embarked on a learning process initially with SOLAR¹ to complete an action research project and to submit this as a Ph D. At this time I was employed in a large department at Nene College known as the Centre for Healthcare Education, my post was deputy to the Director of the Centre and I was responsible for academic affairs. Much of this work was procedural and related to quality of provision. My main interest in this role was the impact *individuals* had on quality and ways in which human issues such as motivation and job satisfaction could be explored and enhanced.

My background was in the NHS with some experience of the independent healthcare sector. The NHS in 1997 had begun to really grasp the quality agenda and had articulated on many fronts that it would be the NHS workforce that would make improved and sustainable quality care happen.

In late 1997 a two-year project commenced with a local primary healthcare practice, this is the enquiry that is illuminated in this thesis. The main findings from the project were published in a document (Allen, 2000) and are available in the public domain.

¹ SOLAR: Centre for Social and Organisational Learning and Re-animation. Nene College Northampton.

This work seeks to explore in more depth the interrelationships between the people in the practice and the external environment of which they were part, and is done from the perspective of myself as the lead researcher, whilst recognising that in the spirit of collaborative enquiry all were partners in the research process.

The enquiry set out to explore how an integrated team could be created that enhanced the ability of the participants to learn how to learn in the context of change within a NHS primary care context? This question built on the ideas of organisational learning as outlined by Argyris and Schon (1978) Indeed this could be considered the overall aim, with the anticipated objectives relating especially to the development of model 2 or double loop learning (Argyris, 1982) through processes of critical reflection and dialogue (Bohm, 1990; Hayward, 1997; Weil, 1998). A further objective was to develop new ways of working through collaborative change management models and to recognise the barriers, personal, professional and organisational that may enhance or impede the development of primary care services which met the intentions of NHS policy. To enquire using an insider approach to research (Blaikie, 1993) was consistent with my personal perspective and had the potential to contribute to a deeper understanding in answering the 'how' of creating an integrated nursing team in primary care.

This personal perspective has been influenced by my professional everyday role in academia and my involvement with a company providing outdoor development for healthcare teams, which at the time of this study involved me as educational facilitator. For a period of time, at the end of the study but still in the phase of involvement with the practice I was seconded as Director of Nursing to the local community trust for half my time for a six-month period. This provided valuable insight into the context of change from a perspective external to the healthcare practice. Throughout the course of the enquiry I have learned so much that I have incorporated into my everyday professional leadership role and consequently the enquiry has extended to benefit not just the healthcare practice but the organisation I work for by virtue of the development of my personal reflexivity.

Given the nature of action enquiry and the need to write in a linear format some of the content of this study is interrelated. I have tried to only represent the findings in one place and I hope for the reader this does not compromise the overall sense of complex activity and change both within the context of what the practice did but more importantly for the people who were the catalyst for such change. The words multiprofessional and interprofessional may appear to be used interchangeably but in the context of my discussion in this document 'multiprofessional' refers to where professions recognise that the other disciplines have an important contribution to make. (Kenny, 2002). Interprofessional is where practitioners 'make

a commitment to work with each other across boundaries for the benefit of the patient or the client' (Freeman et al, 2000:40). Interprofessional working was a key objective for the perceived success of this project

The work and passion of William Torbert (1991); Fisher and Torbert (1995) gave me an early understanding and commitment to the power of action enquiry, suggesting that social science can be practiced in the midst of everyday practice in the following research environments. All three apply to this enquiry.

First-person research (e.g. observing what I am doing and the effects I and my environment are having on one another, what I am thinking and feeling, and what I really want).

Second-person research (e.g. encouraging mutual testing of attributions and assessments in real-time conversations and meetings, along with transformations toward increasingly mutual control of our collective vision, strategies, performance, and assessment).

Third-person research (e.g. publicly testing propositions with persons not present through measures and publications, as well as through creating learning organizations that interweave first-, second-, and third-person research).

Source: Torbert and Associates (2004: <http://www2.bc.edu/~torbert/>)

Through this process the people who are the 'healthcare practice' have developed personal and organisational confidence and it will be seen that this was the essential element both for the introduction of new roles but more significantly for the team developments in the practice and for the understanding and practice of effective leadership.

This study will initially identify the context of the enquiry and situate myself as the enquirer within the paradigm of action research (Reason, 1988; Lincoln and Guba, 1989; McWhinney, 1992). This will be followed by a literature search that relates to the key aspects, as I understood them at the time in respect of creating an integrated nursing team in primary healthcare. The philosophical and methodological perspective will be discussed prior to the narrative of learning, action and reflection within the context of the enquiry in the healthcare practice. This will conclude with a discussion of conclusions that were owned by all the participants at the end of Chapter 5. Chapter 6 will discuss the findings in respect of the literature and Chapter 7 will relate these findings to the contribution this work has made to the current understanding of team work in primary care and directions for future development.

The study will identify four key areas of findings that should be considered for further research and development:

1. Organisational structures within Primary Healthcare teams which support multidisciplinary and interprofessional working.
2. The role of uniforms and other identifiers in the development and confidence of nurses within multiprofessional and interprofessional healthcare teams.
3. Support structures for middle managers and leaders.
4. Interprofessional education that develops a rigorous curriculum underpinning to develop and create professional knowledge, owned across all healthcare disciplines. This should incorporate a spiral approach which takes into account all levels of the Knowledge and Skills Framework (Department of Health, 2004)

1.3 Chapter Summary

This chapter has provided an overview of the purpose and process of the study and identified some key themes that have emerged from this enquiry. As the following chapters add to this initial overview it will emerge that the development of confidence in nursing staff was key to the development of the healthcare practice and of central importance to me as co-enquirer.

Chapter 2: Enquiry's Formative Context

2.1 Introduction

The formative context for this enquiry needs to be seen in the light of the policy drivers for change in the NHS, the local initiative within Northamptonshire to develop integrated working in a primary healthcare setting and my own perspective as an action researcher. The 'formative contexts' refers to surroundings that are (re) created over time and in turn propagate common social attributes embedded within the institutional arrangements, cultural values, networks, tastes, professional training, background and cognitive frames that shape the daily routines of enquirer, enquiry participants, ideology and equity objectives (Korac-Kakabadse and Kouzmin, 1997).

I will start from the latter as this thesis will represent a journey written from my viewpoint as the researcher exploring the dynamics of developing effective working relationships between people from different professional groups working together to enhance the quality of healthcare provision at the cusp of the 21st century. So I start by exploring some questions that are relevant to myself within this study.

2.2. Why the Interest in Team Working in Healthcare Services?

I always wanted to be a nurse; it seemed to be in me from when I was quite young. I remember having a curiosity about hospitals, the smell, the counterpanes, the bed tables and clinical efficiency. ...It wasn't really to do with the soft kind of nursing skills, the caring element that in later life I have got so passionate about. The uniforms were impressive; they oozed power, status and achieving in life. This is what I wanted to be part of!

Career decisions seemed to be about everybody else thinking that they knew best what I ought to do. I wasn't a rebel and wanted to please others so landed up applying to be a Radiographer, yes in hospital but not the same buzz, I also was totally uninspired by maths and physics. Two weeks before the due date to start, I dug my heels in. I was going to be a nurse. I choose the nursing school on the style of the hat! My childhood dreams were coming true.

Twenty years later in the late 1980's, I had qualified as a nurse and midwife, worked in each discipline as both a staff nurse and a sister and had qualified as a teacher of nursing. My role was currently in a College of Technology teaching nurses and other healthcare professionals. The content was similar, the interpersonal skills the same, the client orientation paramount. Alongside this I worked in the practical hospital situation as a 'bank' nurse as I

had three young children. The areas I usually worked in were the Accident and Emergency department and an Elderly Care unit. In both areas I considered that optimum care was compromised because effective communication between different professionals was significantly limited. The seed for this enquiry was sown.

Around this time I commenced a Masters degree in Educational Studies, like doing a PhD I thought it was something I ought to do, but the learning revolutionised my life both professionally and personally. The Masters degree opened my mind and my practice to the principles and concepts around how adults learn and how reflective processes can enhance the value of experiential learning.

Developing a reflective insight into how individuals act within the social context and developing an awareness that promotes new learning was central to the development of my practice in healthcare education over the next ten years.

So history repeated itself, and the 'ought to' do an MSc, turned into an 'ought to' do a PhD. The Master's experience had been a life changing experience for me and I wanted a PhD journey to do the same, so it was with some enthusiasm that I started on the journey towards a PhD.

The PhD represented the opportunity to validate other values that I had developed over the years; the instrumentalism with which I came into nursing had developed into a real desire to care for other people. Not necessarily people who are in compromised health mentally or physically, but for the healthcare staff who care for them. The principles of caring seemed often to elude the profession itself and the culture of the health service allowed this dysfunction to persist. At the level of team relationships improved communication, empathy and understanding I was sure could lead to greater satisfaction for staff and ultimately improve the care of clients and patients.

So how would this seed germinate, and grow into a research project that would meet the requirements of a PhD, by introducing effective change and provide a new focus for knowledge within the context of interdisciplinary teamwork?

The area for enquiry was influenced by my experiences in my professional life and my observation whilst acting as a facilitator on an Outdoor Education programme. I was aware that the traditional barriers that I had learned existed between different groups in society

hindered my communication. I was aware that this affected both my competence and performance in certain situations and as such it was an affective element of my personality. What I had come to observe was that although I had rationalised my behaviour into feelings of low self-esteem and inadequacy, I came to recognise that this phenomenon was fairly common among other healthcare professionals (Creative Healthcare Management, 1999). Taken on a grand scale these inhibiting factors were a major issue for the NHS. I was also interested in how individual preferred ways of seeing the world were influenced by individual belief, values and attitudes and from the epistemological base on which we interpret information and make decisions.

At the same time as the beginning of my study a new Labour government had come into power and produced a White Paper as the way forward for modernising the health service over the next ten years (Department of Health, 1997).

This paper made assumptions about the nature of team working in interdisciplinary teams to such an extent that the monitoring of the whole quality agenda was predicated on successful working relationships within these teams. This new system to become known as Clinical Governance was to be in place by April 98, just six months away from the publication of the report.

This fuelled my passion to be involved in creating interdisciplinary teams that worked, were able to contribute successfully to contemporary patient care and were satisfying to the team members in both their personal and professional lives.

2.2.1 How did I make sense of this passion to provide direction for the enquiry?

In a session for postgraduate students who were embarking on action enquiry we were encouraged to select from a collection of photographs, scenes that 'we connected with' in four key areas:

A key concern, a respectable passion.

"I chose a picture of a large group of young people at a pop concert; all in one way or another will be touched by healthcare in the future. The key concern is that as individuals they will have a good experience."

Source: Reflective Journal September 1997

At the end of the first two years (1999) this key passion had sustained my interest and focus on the development of teams, with a focus for ensuring a positive outcome for patients, clients, carers and the healthcare staff involved with caring. It is this key concern that

encourages me to help deliver the principles in the current government policy documents, which are patient focussed, committed to an efficient economic and effective service. What has arisen is how I interpret what a good experience is and the judgements I make about what is good and bad. The research over the last two years has enabled an exploration as to what 'good' means in the eyes of healthcare professionals delivering a service. From this exploration has come an interest into the aspects of culture and subculture and how this affects our individual and corporate perceptions of the world. Exploring cultural issues will potentially be a key area for enquiry, especially in respect of how this hinders interprofessional collaboration, which in turn limits the potential for organic change in an organisation to respond to external and internal motivators. These are the core issues that relate to this enquiry.

Something about inquirer

'Quiet thinker, like open spaces. Look to the future – tend to see things clearer in the distance than the here and now. Picture identifies calmness, time and thoughtfulness before action'

Source: Reflective Journal September 1997

The concept of space has been central to my research journey. My interest in this research was stimulated by outdoor courses in Wales. The effect on individuals of the course seemed to be striking. The question in my mind was to 'what extent the course made the difference or the extent to which the environment gave a spiritual opportunity for individuals to explore the meaning around their personal and professional lives'? Two issues on reflection have resonance here. The first is the need for seeking meaning in our lives. This tied up for me with the focus of my Master's research and how space to explore and experiment, to think and reflect on purpose and meanings of life are fundamental to human life. Secondly the way in which people are whole beings and that issues in professional life cannot be separated from issues in the personal life. To find a space psychologically and physically to explore these dimensions has become important to me, as I have worked with in the context of this enquiry.

From this starting point I have also noticed how I get irritated when people want to pay attention to process issues. Exploring issues of effective teams identifies the need for both process and product oriented group members. I also recognise that I am similar in my work life and tend to 'turn off' when certain people whom I have labelled as 'process oriented' try to capture my attention. An outcome of this awareness is an active intention to listen more carefully to these people, to listen for these aspects on the tapes I transcribe, and thus become aware of what I may miss because of what I do not pay attention to.

Anxiety or Struggle

"My family, that they will not be pushed out but still feel loved and supported, and that my intentions will be for the right reasons rather than personal gain and prestige."

This says something to me about the way I like to be perceived in the world. Through the interactions with fellow participants I have faced what it means to be properly selfish. This however is a movable feast depending on the circumstances and relates back to the key passion first identified above. There is something that makes me fulfilled in seeing somebody else being treated properly and consequently this then isn't about being selfish. Later on in the enquiry threads of this issue will emerge in a more tangled way than just relating to the family, but more in the arena of professional and personal identity and what this means in respect of developing interdisciplinary team working.

A leadership effectiveness tool² completed in the year 2000 indicated that I was very high on empathy. This predisposition towards other people produces a tension, as this can be both strength and a weakness in developing this enquiry. People matter more than things.

Something that will matter

"Challenging my present perspectives of self worth, esteem etc. and questioning all my values, but developing new dimensions of being that are acceptable (to whom?). Taking time for new growth and development. Seeing results, waiting for new growth and development... Felt I ought to choose pictures to do with disability, but I want to focus on the average person rather than the special person. Space was a pattern in my choice of photographs."

Source: *Reflective Journal* September 1997

Re-writing these reflections now reinforces the realisation of personal needs that I bring to this research; the way in which the photographs used to stimulate the above thinking articulated the 'me' in the research. This is still grounding and will act as a benchmark to highlight bias in analysis and interpretation of my observations.

2.3 The Policy Imperative

The policy documents from the Department of Health that are explored in more depth in the literature review were all outlining the modernisation agenda for the NHS. This agenda was all about culture change to enable an effective environment for changed services to flourish. Time scales were very short, and my reading and experience was showing that sustainable change needs solid foundations and building solid foundations takes time, the centrally dictated change machine was not prepared to wait! This would be a tension for the team and me in the context of the enquiry. According to a raft of government publications since 1997, integrated health services could be achieved based on a primary care led service. The underlying assumption is that healthcare staff already worked effectively together to achieve a quality service where clinical and financial responsibility is aligned.

² Leadership Effectiveness Analysis: Management Research Group 1992

2.4 Developing Integrated Working in Primary Care

The healthcare practice is a collection of people who work together to meet the healthcare needs of a specific patient and client population. The enquiry was about managing change to develop integration in processes and systems of work. This enquiry had to focus on the products and processes of change within the practice, but the incidental unexpected findings led to the opportunity for real engagement in the dynamics of the change process.

Consequently this became a multi-dimensional enquiry, which developed different foci around issues from a personal nature, and professional issues that impacted however discreetly on meeting the current healthcare agenda that was driven on the premise that interprofessional and interdisciplinary teamwork was a reality.

This healthcare practice was situated in the centre of a south midlands large town. The practice is one of the oldest in the town and had a loyal population of some 10,700 patients. Until 25 years ago it had three branch surgeries, which encouraged registration of patients from all parts of the town. This resulted in increased deprivation and mental health needs in the area, although this is beginning to change with urban regeneration. The practice has six general practitioners and is approved as a medical training practice. The practice was fund holding until the new funding arrangements came into place in April 1999. Nurses are either employed by the practice or the local Community Trust. Nursing staff equal seven whole time equivalent posts plus a link midwife and link community psychiatric nurse.

In the mid 1990's the practice management recognised the need for the nursing staff from the disciplines of practice nursing, district nursing and health visiting to be integrated as a cohesive body within the practice. The doctors had a forum for discussion and representation as did the administrative and reception staff, the latter having team leaders. The direction ahead for the co-ordination of the nursing team and what their function should be within a changing health service was uncertain and unclear. The partnership had considered many different models to develop the nursing service, which included the development of a specialist nurse practitioner and increased communication with nurse managers from the Community Trust. Regular meetings took place involving all the stakeholders.

Early in 1997 the practice recognised that despite many discussions and models being proposed no clear pathway for the future was emerging. Consequently an independent consultant was appointed to produce a report indicating options for the way forward. This

project referred to internally as the Glyn Jones Report (1997) focussed mainly on the task activity of the practice and made recommendations for change. One of the key recommendations confirmed the preference of the practice, that a nurse team coordinator be appointed to lead the changes as proposed. This report was accepted as the blueprint for the way forward and a nurse team coordinator was appointed in November 1977 initially for a two-year period.

2.5 Where the Enquiry Took Place

The practice is situated on the outskirts of the urban part of Northampton and is the oldest in the town. As new practices have developed the practice population has become increasingly local and this has further increased the deprivation and mental health problems seen in the practice population. The policy of the practice is to keep patients registered if they move to other parts of the town if they wish, and also to accept additional members of the family unit as this facilitates the continuity of care. The demography of the population as evidenced in the Practice Development Plan PDP (1998) demonstrates a high proportion of elderly patients (11.75%) in comparison to the National average 8.8% (1991 Census). The practice is situated in a relatively run down part of the town and lies between two wards attracting deprivation payments (PDP, 1998), the unemployment rates are amongst the highest in the Northampton Borough at 21% compared to the national average of 10.9% (1991 Census data). Deprivation and unemployment is associated with higher morbidity and workload for general practice. (PDP, 1998). The practice population in April 1998 was 14,956.

The practice operated with 6 General Practitioners, each with a lead for specific areas of the operation and organisation of the practice. One GP had lead responsibility for nursing, and this became an interesting relationship as the project progressed. Each of the General Practitioners had significant external networks; this was an asset in externally benchmarking the activity within the practice team.

The practice was 'managed' by the practice manager, with three team leaders,

- Reception: 6 staff,
- Administration: 8 staff
- Nursing: 4 practice employed staff and 11 attached staff that were employed by the Community Healthcare Trust.

In addition the following services allied to medicine were provided on contract from the community trust. All positions in this category were part time/sessional.

- Counsellors 2
- Physiotherapist 1

- Continence advisor 1
- Chiropodist 1
- Diabetic podiatrist 1
- Dietician 1

For the purpose of this enquiry all the participants (i.e. staff mentioned above) were the 'Primary Healthcare Team'. The building was originally an old shoe factory. Northampton was famous for its Boot and Shoe Trade starting after the Boer War when special boots were designed and made in Northampton for the soldiers. This started declining with the import of cheaper shoes from Asia in the early 1970's. The building had been converted with a new front added which was the reception and patient waiting area. Consequently the building naturally divided into two areas. This managed to separate two of the nursing teams; the practice nurses and district nurses were on one side of the building and the health visitors on the other. This became significant in the development of a cohesive team. The nurse team coordinator had an office in the part of the building, which was close to the practice nurses and district nurses. Many of the one to one interviews took place in this office. The practice prided itself on the morning coffee meeting. This took place away from some of the key nursing teams and it became an observable fact that this at times hindered attendance. On the top floor of one of the buildings was an area set aside for meetings, a small library and computer room attached. The majority of the staff meetings that will be included in later chapters happened in this environment. Although the core team based at the practice was made up of doctors, nurses and administration staff the team was complemented by visiting personnel as identified above. These people had dedicated space within the building and any reference to dialogue with these individuals took place within the building. On a couple of occasions the nurse team coordinator visited my office on the university campus, on these occasions we either talked over coffee or discussed issues as we walked around the campus.

2.6 My Introduction to the Practice

I would visit the practice two or three times per week, this was not always prearranged and as the enquiry progressed I felt welcome and comfortable to drop in. Access was available to all parts of the practice and I respected the rules of confidentiality under which I am bound as a registered nurse with the Nursing and Midwifery Council (NMC). This confidentiality has not been breached in this work.

Gaining acceptance in the practice was really important for me to ensure that the enquiry was not overshadowed with tensions and that an educative culture developed.

'Relationships within an organisation define its culture: the relationships are the culture. An educative culture is one in which relationships foster learning'

Source: Mc Niff (2000.81)

Axelrood, (1990) explores the basis of education being care; recognising that care is not sentimental; and in its strongest form it implies respect, recognition and acceptance. The following extracts from my Journal illuminate this process of acceptance in to the practice.

'My insecurity surfaced, my next meeting was with the practice manager and the lead GP's, and perhaps I should do something a bit more academic for that meeting. That nearly became my downfall!'

Source: Reflective Journal December 1997

A further meeting was with the practice manager, at the first meeting he had been very dominant in the discussion, in fact I thought he was the senior partner. The meeting was scheduled for an hour in his office. He refused my request to use a tape recorder, and bombarded questions at me. I had produced initial steps in the research process based on a structure that was not a match for his style and he saw it as far too touchy feely. I sat on a chair, aware of my controlled body language and feeling that I was being grilled far in excess of what was necessary.

'Reflection in action was a concept I was familiar with in the repertoire of reflective skills that I had developed post MSc. At a point about 20 minutes into the discussion, it certainly was not a dialogue; I recognised that the balance of power needed to be challenged. Consequently I relaxed my body language and moved forward, and on the next question responded by putting his question back to himself and asking his opinion. This worked well; he relaxed more too, and then started doing all the talking. The interview finished on equal and friendly terms. The practice manager also commented that he could work with me and he escorted me of the premises.'

Source: Reflective Journal December 1997

The next stage was to inform and engage all the practice staff of the process of evaluation and research working alongside the change process. A set of ground rules was negotiated and the methodology of participative/collaborative action research explored. The meeting for this purpose was well attended, but I did see all the practice staff individually that could not be present. This did reap benefits in developing a sense of common purpose in achieving the changes that had been outlined in a previous report.

This seemed to be my rite of passage into the organisation, they had acted as if they had selected me and consequently owned the approach I was going to take. This did not mean that over the next two years we would not have differences in opinion, but that conflict would be managed in a way that was adult in relationship.

'Being accepted as part of the team was commented on by several people. It was evidenced by when I arrived at reception I was allowed to take myself to the various venues and see myself off the premises when I had finished; the unspoken norm was to always escort visitors!'

Source: Reflective Journal March 1998

As a student I had been struck with the work of Maslow (1943) on motivation theory especially that the issue of 'belongingness' was foundational for achievement.

2.7 Practice Development Plan

This chapter has attempted to illuminate the context of the enquiry both from my perspective and the perspective of the practice. Two remaining aspects require comment. Firstly the external environment, and how the practice saw it impinging on its practice and secondly the 'Vision' of the practice as identified in the Practice Development Plan.

2.7.1 External environment

Developing the understanding of the context in which the enquiry at the practice was to be situated demanded consideration by all players of the key external drivers. Some of the challenge in the discussion was to focus on the macro environment rather than the micro politics within Northamptonshire. The following key aspects would impinge on the developments at the healthcare practice;

- Political

"In December 1997 the Department of Health published the White Paper, The New NHS, Modern, Dependable, swiftly followed by other papers relating to the implementation of the proposals, e.g. saving lives - Our Healthier Nation (Department of Health 1998). A First Class Service (Department of Health 1998); and latterly, relating to the strategy for Nursing, Midwifery and Health Visiting Making a Difference (Department of Health 1999).

This political direction affects the strategic and operational planning; implementation and delivery of care patterns locally and requires a team who is able to accept emerging healthcare policy. The uncertainty of the future is destabilising and affects practice planning. Additionally staff do not necessarily view being up to date with present ever changing healthcare policy a necessity in delivering everyday patient care"

Source: Allen (2000)

- Economic

"Fundholding practices ceased to exist with the advent of Primary Care Groups. Consequently budgetary control was not within the control of the Practice. Rationalisation of health visitor posts in the Community Trust had an impact in the service able to be offered by this key group of nursing personnel. The review of the District Nursing service by the Community Trust may have similar impacts as the Health Visitor review. External funding issues in respect of obtaining essential resources impact on the smooth delivery of an effective service. For example in the early days of the project the district nursing team spent considerable time in obtaining sufficient syringe drivers to aid pain control for the significantly high case load of terminally ill patients."

Source: Allen (2000)

- Social

"Government agenda for more flexible access to care across a longer time frame. Opportunities to share good practice, e.g. Beacon Awards. Opportunities for external accreditation. Better partnerships in care across traditional health and social care boundaries. Global changes in respect of Social status, the family, employment patterns. Changing expectations of patients as 'consumers of healthcare'"

Source: Allen (2000)

- Technological

"Increasing use of the Internet for patient access to information. Use of a paperless record system in the Practice. Issues around different monitoring systems for nurses employed by the Community Trust. Development of seamless systems between primary and secondary care.

Accessibility of 'high tech' equipment. Advanced technological skills required by healthcare workers, relating both to specific healthcare interventions and information technology impacts on time and cost for staff development."

Source: Allen (2000)

Awareness of the impact of the external environment was crucial for an informed way forward for the organisation.

2.7.2 Practice Vision statement

'The practice will provide high quality, consistent and accessible services with an increasing range, in appropriate surroundings and in a cheerful manner by a well trained team of people. The service provided will be based as far as possible on the needs of our patients and on evidence of effectiveness'

Source: Practice Development Plan (1996: 6)

The purpose of this enquiry was to enable the practice to achieve the Vision statement, with the focus on staff and organisational development to provide people and processes to deliver excellence of care to patients.

2.8 Chapter Summary

This chapter has attempted to illuminate all the different threads that initiated this enquiry, external policy drivers, and effective, economic ways of working to meet the needs of the healthcare community. Central to this enquiry is the belief that change will happen if individuals are motivated and rewarded in intrinsic ways to act and learn differently. This was so for myself as co-enquirer, and the practice as a group of people who aspired to being a fulfilled integrated team. Guidance to achieve this has been sought from the literature.

Chapter 3: Literature Review

3.1 Introduction

The purpose of this review is to explore the current literature relevant to this enquiry. Initially I will outline the policy documents relating to teamwork in the healthcare sector and especially within the primary healthcare setting.

Teamwork as a concept, and in primary healthcare will be reviewed and literature will be sought to support the concept of integrated nursing teams.

From this perspective the challenges and barriers to effective teamwork will be explored, including the current understandings of effective leadership, moving on to literature which promotes the possibility of effective growth and learning within organisations that lead to improved patient care and morale and well-being of staff. This will include aspects of how organisations learn and communicate.

3.2 Policy Directives

Since the Second World War attempts have been made by governments to shift the focus of provision of health and social care from large institutions to the community. Improving patient care, was an explicit intention, and it was also assumed that care in the community would be a cheaper option. In 1963 the Gillie report (Standing Medical Advisory Committee, 1963) recommended the attachment of district nurses and health visitors to GP practices. Practice nurses have worked in GP practices for many years, and twenty years ago in 1985 the Royal College of General Practitioners (RCGP, 1985) recommended that different professionals in primary care should pool their skills and work together not only for the benefit of patients but also to increase their own job satisfaction.

The creation of primary care teams did not necessarily ensure effective and harmonious team working. The majority of community nurses functioned separately within their set, inflexible roles resulting in a great proportion of professional skills being unused or not used to their full potential. (Cumberledge, 1986). Difficulties in team building so that all members of the team understood and respected each other's roles, functions and responsibilities was also identified as a problem (Harding, 1981). Dongas (1982) recognised that in the field of learning disability good collaboration between agencies and professionals was a necessary component of improved patient care. This recognition was not new, as it is evident that

communication between teams was problematic. (Jenkins, 1979; Harding, 1981; Audit Commission, 1986) the latter report criticising the slow transfer of funds to the community and the lack of preparation for professionals in the community in general. Several government reports emphasising the need for interprofessional co-operation were subsequently published (Department of Health, 1987; Social Services Committee, 1987; Griffith, 1988).

The 1990 NHS and Community Care Act (DHSS, 1990) introduced the market economy into healthcare; the intention was to improve value for public money and improved patient choice by introducing competitive tendering for all aspects of health and social care. The reality was to develop a sense of competitiveness and mistrust between professional groups and between potentially competing organisations, some of this mistrust still is evident today, and deeply rooted in individuals and organisations. The act took some time to be implemented and the report 'New World New Opportunities' (NHSME, 1993) suggested that poor communication, rigid role demarcation and vested professional interests led to misunderstandings about responsibility. Primary healthcare should be centred on the GP practice and multidisciplinary teamwork would be essential. Financial issues although not mentioned extensively in the report were a significant barrier to moving forward. Indeed soon after the reforms, at least two audit commission reports (Audit commission, 1982, 1992a) identified the problems of developing a co-ordinated approach to care. There was perceived to be a lack of incentive to collaborate. Health and social care boundaries were different, as were structural and procedural arrangements, and difficulties were evident with joint funding. Managers responsibilities for managing tight budgets led to tensions in professional relationships. A further audit commission report (1992b) reported that the potential for multi agency work was limited due to different payment systems which led to suspicion over motives and lack of trust and respect for different professional roles:

The Roy report (Department of Health, 1990) had identified a set of key principles that seemed to underpin those community-nursing services that were more effective and better managed than others. These included having a shared vision of care, based on the desire to work together effectively in a patient focussed service, that met the needs of the local population.

Glyn Jones et al (1998) suggests that at the heart of the NHS reforms is the belief that the contribution made by primary healthcare will increase and that the sector will steer the direction of healthcare delivery towards a primary care led NHS (Department of Health, 1994). The engine for this change will be the ability of primary care teams to adapt, to share

care with other professionals as a means of reducing individual workloads (Marsh, 1991) whilst expanding the range and quantity of its services (Department of Health, 1996).

3.3 Modernisation Agenda and Interprofessional Working

The drive towards tangible multi-professional working may have a long history in primary care, but the current modernisation agenda for the NHS advocates interprofessional working as a means of achieving the agenda, for a first class modern, dependable and quality service across all sectors of the NHS (Department of Health, 1997; 1998; 1999). These policies have in common the shared vocabulary of collaboration, meaning moving away from historical contexts of working which may be described as 'uniprofessional', where the activities of professionals are confined within their own discipline and 'multiprofessional' where professions recognise the other disciplines have an important contribution to make. (Kenny, 2002). Interprofessional is where practitioners make a commitment to work with each other across boundaries for the benefit of the patient or the client (Freeman et al, 2000) The intention for working across boundaries to meet the modernisation agenda has taken on an instrumental approach with the development of National Service Frameworks for specific client groups such as the elderly, (Department of Health, 2001) and to reduce the incidence and improve the treatment of patients with mental health problems. (Department of Health, 1999) Cancer care is an area that has been given a lot of attention to try and achieve an improvement in mortality and morbidity rates, through improved multi and interprofessional team working. This too has a history. In 1987 the Council of Europe established a select committee of experts to consider the interprofessional care of cancer patients, the terms of reference extended to a review of interprofessional training of healthcare professionals. (Council of Europe Committee of Ministers, 1989) This has resulted in cancer care being one of the target areas for strategic development and results are now being reported from the work of 'cancer collaboratives' set up across organisational boundaries within health care economies.

So it can be seen that the policy intention to promote collaborative interprofessional action and decision-making has a fairly long history and yet considerable effort needs to be made to make this a consistent reality. Vaughan (2002:295) notes:

' Increased funding, albeit for salaries or services, is only part of the equation. In traditional management terms, dealing with structural 'hygiene' factors may help to relieve some poor morale but will not necessarily lead to increased productivity, higher motivation and better job satisfaction which are all crucial elements in developing good practice.'

If history is not to be repeated in that policy advocates interprofessional working but nothing appears to change then there is a need to explore why the rhetoric does not become a

reality and what can make effective action towards professional working be achieved. This is the purpose of this study.

3.4 Integrated Nursing Teams and Interprofessional Working

Before exploring concepts that may guide the action enquiry, I chose to search for evidence from the literature of the formation of successful integrated nursing teams. This literature was sparse and mainly anecdotal at the beginning of this study, this is probably as the first projects had really only taken off in the mid nineties (Bull, 1998; Black and Hagel, 1995; Morgan and Hanson, 1996). Gerrish (1999) described an evaluation study, carried out eighteen months after 28 integrated nursing teams had been introduced across a NHS Trust. Whilst opinion differed as to the extent to which teamwork should be central to the functioning of team members, peer group support, ability to resolve conflict among team members, and the decision making ability of teams were considered to be important. Black and Hagel found that health visitors found the greatest improvement in the perception of team function followed by the district nurses.

Owen, (1998) reported on an evaluation study of a pilot project in West Berkshire, which aimed to develop competent and confident nurses working as full members of the primary care team. However no data appeared to be collected or conclusions reached on how the approach to team working actually enhanced both confidence and competence of the nursing staff in primary care. Sibley, (1997) reports on a questionnaire that identified two issues for the development of collaborative care in Dorset, the first that staff working geographically away from the practice were less likely to communicate effectively and the second that there was a strong impression that GP's spent most of their career in one location, community nurses often stay for many years and yet social workers tend to move on rapidly. Sibley (1997) relates this to a study by Pritchard (cited in Owen et al, 1995), which suggests that the length professionals' stay in an area is very relevant to teamwork. What is not discussed in the context of developing organisations is whether new people with creative and dynamic ideas can invigorate teams to develop new ways of thinking and working.

3.5 Political influence

Kenny (2002) suggests that politics is first and foremost about ideas and that understanding the ideas that underpin policy is essential if professionals are to appreciate the context in which they work. He goes on to suggest that the thinking behind government policy that has generated a new commitment to interprofessional working in the context of the modernisation agenda is based on the philosophy of the '*Third way*' as expounded by Giddens (1998) as it

seeks to strike a balance between the historical preferences of the political left and right that have traditionally driven the management of the NHS. The main tenet for the modernisation of the NHS is replacing the competition of the internal market with co-operation and partnership, with the aim of improving communication and working practices across professional and organisational boundaries. Interprofessional working tries to replace existing power structures through a commitment to equality and collective responsibility. In the words of Tony Blair (cited in Barr, 2000: 81)

'The new NHS is finding the 'third way' based upon partnership and driven by performance, which will replace the inequities and inefficiencies of internal markets by integrated care'

Successive governments concentrate on the Nation's health and education as prime drivers for both campaigning and policy development. The organisation and philosophy of healthcare has changed over the years as has been demonstrated from the focus on competitive market approaches to more joined up approaches. This can have the effect of implying that healthcare workers can feel pawns in a disempowering system, and consequently do not always practice in the sense of team accountability. Team accountability is not necessarily recognised in the same way that personal accountability is identified as essential by all the Professional Bodies. Rawson (1991:38) suggests that this came to a head in the wake of child abuse scandals such as in Cleveland where child victims were seen to fall through the professional net. Again with the Climbiere case in 2002, it would appear that little has really changed to harmonise over and under lapping practice areas. (Astrachan and McKee, 1965) The impact of staff conflict on patient care and behaviour can also not be underestimated (Bond and Cartlidge et al, 1987; Gregson et al, 1991).

Rawson (1991: 38-39) proposes the foremost reasons that inhibit interprofessional working are:

- *Poor communication and language differences*
- *Conflicting power relationships*
- *Ideological differences*
- *Role confusions*

The assumption that conflicting power relationships result from the traditional professional elitism that has focussed organisation power in the hands of doctors and managers may prove more difficult to effectively identify, challenge and change than the policy makers may believe!

3.6 Power Relationships within Healthcare Teams and Professional Knowledge

McIntosh et al writing in 1978 suggest the potential futility of promoting interprofessional collaboration without giving different primary healthcare professionals equal status, prestige

and power, and Davies (1979) has suggested that working relationships in primary care reflect the broader social divisions of class and gender as well as the hospital-centred experience of health professionals in which medical power predominates.

Exploring the underlying knowledge base from which professional knowledge has arisen helped attempt to understand some of the reasons for conflicting power relationships within healthcare teams. Schein (1974:43-44) proposes a threefold model of professional knowledge:

- *An underlying discipline or basic science component upon which practice rests or from which it is developed.*
- *An applied science or 'engineering' component from which many of the day-to-day diagnostic procedures and problem-solutions are derived.*
- *A skills and attitudinal component that concerns the actual performance of services to the client, using the basic and applied knowledge.*

Glazer (1974: 363) suggests that:

'in Schein's view these components constitute a hierarchy which may be read in terms of application, justification and status. The application of basic science yields engineering, which in turn provides models, rules and techniques applicable to the instrumental choices of everyday practice. The actual performance of services "rests on" applied science, which rests, in turn, on the foundation of basic science. In the epistemological pecking order, basic science is highest in methodological rigour and purity; its practitioners superior in status to those who practice applied science, problem solving or service delivery'

From this perspective I was aware that medicine was seen as one of the 'purer' professions and acknowledge that in working interprofessionally the professions such as nursing and nurses are caught in a:

'Hopeless predicament and have tried to substitute a basis in scientific knowledge with traditional reliance on experienced practice'

Source: Glazer (1974:363)

In the context of this work that aims to extend and develop the nurse's traditional role, care would need to be taken to recognise the importance of scientific knowledge. The current debate at a political level to professionalise nursing, conflicts with being seen to absorb the traditional roles of doctors. Glazer (in Schon 1992) related some of the difficulties to the potential problems inherent in the perceived lack of systematic scientific knowledge, which prevents the application of scientific knowledge to instrumental problems, and consequently a perceived lack of a rigorous curriculum of professional education in nursing.

Medical dominance on nursing has been the topic of a number of studies (Seymour and Buscheroff, 1991; Kenny and Adamson, 1992; Bucknall and Thomas, 1997) that confirm that health professionals are aware of dominance and negatively evaluate their lower status and lack of autonomy relative to doctors (Gair and Hartery, 2001)

The aim of the enquiry with the healthcare team was to be grounded in the expectations of organisational learning and recognition that the developments that were required could give rise to considerable anxiety and uncertainty, such that defensive group patterns could emerge. Vince (1996: 47) would suggest this is a political process, and that it is possible that transactions between individuals:

'serve to act out or restimulate power struggles, and intense emotions associated with power and differences... The intensity of these emotions, and anxiety about how to deal effectively with power relations in groups and organisations, means educational or learning groups have an interest in defending against and avoiding these issues'.

But these issues would need to be surfaced and dealt with rather than hidden or ignored if the collaborative intentions of integration were to be achieved to match the literature aspirations of effective teams.

3.7 Teams and Team working

Katzenbach and Smith (1993) asserted that teams will become the primary unit of performance in high-performing organisations, and Partington and Harris (1999) identify that team working is becoming the structural norm, suggesting that a critical determinant of team performance is the quality of the human resource that make up the teams, suggesting that attention needs to be given to the expertise, personality and aspirations of team members.

Within primary healthcare Ovretet (1993) suggests that the term primary healthcare team is a convenient way of describing a nebulous network of associated disciplines, and advocates that teams are really more like network associations. This network association team is a voluntary grouping together of service providers who cross-refer or meet to coordinate work. This for me gives limiting potential, as development within a team towards a shared vision is the essence of effective team working. Writing again in 1996 Ovretet suggests five ways of describing a multidisciplinary team in primary care and the importance of defining which kind of team is developing and operating (Ovretet, 1996). He suggests a continuum where (Ovretet, 1996: 163):

'At one end is a loose knit association, which some people would not call a team at all, because membership changes and the team is voluntary. At the other end is a closely integrated team where team members workload and clinical decisions are governed by a collective multidisciplinary policy and decisions made at team meetings'

Others would suggest that it does not matter how the term team is used, that we all know what we mean by a team and local circumstances will determine a team's composition (Baly, 1995), although others would suggest that (Glynn Jones et al, 1998: 191):

'There are so many factors which militate against teamwork developing in this context, that the team is in danger of becoming an unmanageable arena of professional conflicts, struggling to provide an ever fragmented service'

They go on to identify how a lack of shared premises, diverse lines of professional management, poor communication, lack of team meetings, lack of team objectives and lack of feedback on performance influences the potential failure and suggest that at the heart of it all are deep historical divisions, not helped by gender differences (West, 1995).

The importance of effective communication structures and strategies is woven throughout this literature chapter and the representation of the cycles of enquiry. Hobden-Clarke (1997: 140) exploring the difficulties of primary care 'teams' who have members employed by different organisations and situated in different geographical settings notes:

'Belonging to the practice team is a good way of developing relationships and avoiding failures of communication. People who do not 'belong' remain outsiders and do not see themselves as members of the team. They do not function as part of the team and are a potential source of conflict.'

Defining what is a team within the primary care setting, seems to be characterised by a group of people of a manageable size who have collective responsibility for achieving shared objectives. (West and Poulton, 1997). This has been linked to effective and cost effective outcomes for patients, especially when teams audit their activity and learn together from the outcomes. (NHSME, 1993).

A good example of the importance of integrating the people perspective in teams is described by Powney et al (HSJ, 2000: 47) in relation to setting up a rehabilitation unit for older people:

'The critical influencing factor was the integration of the lead personalities. We have not always agreed and have very different ways of working, but we decided early on that it was right to trust and respect the other and to search for the value in all that was said'

Jones (1992), building on the work of Lawrence (1970), suggests that the difference between a group of people and a team is the level of respect and trust, which is the covert agenda which concerns relationships and shared agendas. The overt aspects of the team's work will concern the organisation and management of the task.

Looking outside of the healthcare arena for guidance in developing high performing teams Guzzo and Shea (1992) make a series of research-based recommendations for developing effective teamwork. These include ensuring all individuals feel important to the success of the team, have meaningful and intrinsically rewarding roles, which can be individually identified and evaluated, and are clearly set within the context of clear team goals and targets.

However some scepticism exists about the benefits of teamwork, and these are not confined to healthcare.

Multinational companies have begun to question their benefit. (Donnellon, 1996). Glynn Jones, Rapport and Kinnersley (1998) identify that only tasks that require continuous integration of knowledge, experience or perspective, which cannot all be found in one individual are appropriate for shared work within a team.

Consequently a team that brings together people from different disciplines can only add value to patient care, provide new insights to more creative care and provide a richer working environment for all staff. Achieving this is an exciting challenge, promoted by team members and leaders who are motivated and open to change as opportunity for personal and professional learning and development.

3.7.1 Team Roles

This is an important issue when the development of new ways of working for a team is at the heart of a change management process and gives justification for using collaborative action enquiry as a mechanism to develop team roles, which harmonise with personal qualities and aspirations. Many different team roles have been identified from 'harmoniser', 'initiator contributor' and 'energiser' Benne and Sheats (1948,41-49). Woodcock (1989) proposed 12 roles; Margerison and McCann (1990) identified nine. Davis, et al (1992) proposed five team roles subdivided into 15 while Spencer and Pruss (1992) argued for 10 roles. Bales (1950) proposed categories for analysis of the interactions in small groups dividing between two main types of behaviour, task oriented and social emotional.

One of the most extensively used methods for identifying team roles derives from the work of Belbin. Partington and Harris (1999: 698) explore this concept well and also comment that:

'In the contemporary social context the meaning of team 'performance' is far from clear cut, and needs clarifying here. It is possible that managers apply several inter related criteria in assessing overall team effectiveness, including the extent to which:

- *The teams output e.g. decisions, products, and services, meets the standards of those who have to use it.*
- *The team experience contributes to personal well-being and development*
- *The team experience contributes to organisational learning*
- *The team enacts the values of the organisation*

These criteria reflect the close relationship between team working and other contemporary management themes such as employee empowerment, organisational learning and visionary leadership. Nevertheless for many managers the key criterion of team effectiveness remains the teams output or performance against a measurable task.'

This was a focus for the nursing team at the healthcare practice and presented a tension between developing the capacity and relationships within the team versus the drive to get things done as measured against the recommendations of the Glyn Jones report (Appendix 1)

3.7.2 Teams and Organisational Structure

In a significant study carried out by West and Poulton (1997) primary healthcare teams scored significantly lower than other teams except on task orientation. This study measured four aspects of team climate: participation, shared objectives, task orientation and support for innovation. 68 primary healthcare teams, 24 oil company teams, 27 NHS management teams, 20 community mental health teams and 40 social services team participated. The study concluded that (West and Poulton, 1997: 205):

'a restructuring of the organization of primary health care is required if primary health care teams are to develop clear shared objectives to facilitate the co-ordinated approach to the delivery of care, long urged by practitioners and policy makers.'

Ovretteit (1993) recognised that organisational structure is also important to achieve this and comments that certain problems and behaviours will remain if the structure is wrong, however much effort is put into developing a group into a team.

Glynn Jones, Rapport and Kinnersley (1998) suggest that the historical approaches to teams in primary care settings need to be challenged and reengineered to achieve coordinated approaches to care. In June 2002 the NHS Executive published a paper entitled ' Making a Difference: Integrated working in primary care,' and was based on a review of the literature, a scoping exercise of current practice and a consensus workshop involving a wide range of interested people. They suggest that Teams work well when:

- *There is a high level of participation by members*
- *There is clarity of vision for the team*
- *There is mutual understanding of roles within the team*
- *The team feels cohesive*
- *There is a sense of ownership and belonging amongst team members*
- *The emphasis is on member's competencies and skills and not their traditional roles*
- *There are flexible working practices*
- *There are opportunities for shared learning*

Barriers to team working are:

- *Organisational boundaries with traditional hierarchies*
- *Professional tribalism*

- *A lack of clarity about roles*
- *Separate managerial lines*
- *Status and gender issues*
- *A lack of commonly accessible data*
- *Lack of training for team working and people management.*

Source: NHS Executive (2002:3)

Challenging the why, how and way in which teams work in primary care was starting to be explored. Recognising that trying to change *what* tasks and functions individuals carried out in teams without giving attention to the other dynamics was central to this enquiry. Groups to teams seemed to be identified in the literature as a way to improve both the efficiency and effectiveness of function. New language in organisational development was beginning to take the groups to teams concept a bit further suggesting that in a whole systems approach to change creating communities of practice was important. Wenger et al (1998: 4) define communities of practice as:

'Groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their understanding and knowledge of the area by interacting on an ongoing basis',

The list of recommendations (Appendix 1) was the blueprint; the challenge for this enquiry was to develop a community of practice to develop sustainable change, within a health service that wanted to see quick results.

3.8 Leadership

Leadership is a concept that along with team working features significantly in the policy literature on healthcare development. (Cunningham and Whitby 1997; Allen, 2000; Cook 2000;). Indeed Bolman and Deal, (1991) point out that leadership is offered as the solution to problems for organisations everywhere, and that nursing is no different. Within the Health Service significant investment has been made in the National Leadership Centre managed by the Department of Health and yet confusion over what is effective leadership and management prevails within all sectors and not just within healthcare (Kakabadse, 1999:5).

Wall (in HSJ, 2000: 8) identifies that 40 early terminations of Chief Executive contracts had occurred over the past five years. Medical Directors who assumed a significant leadership role in the new NHS considered they have been '*poorly prepared*' for their roles (British Association of Medical Managers Cited by Millar in HSJ, 2000: 38).

But what is leadership, what is its purpose and potential? Alimo-Metcalfe (1998) recognises that leadership theory has moved on from models based on personality types,

behavioural styles, or situational styles. This is helpful because it identifies the evolution of leadership and management thought especially as it relates to the public sector.

Whilst it is recognised that management and leadership may be two sides of the same coin, the specific goals of each are differentiated by getting things done in the short term (management) to developing a long term sustainable view and direction for the future (leadership). Ackoff, (1998) adds another term of administration and suggests to use them interchangeably is a waste, as it misses the opportunity to reveal important differences, he defines them in a way that is directed at improving leadership and bringing about more important organisational transformations:

'Administration, consists of directing others in carrying out the will of a third party, using means selected by the same party. Management consists of directing others in the pursuit of ends using means both of which have been selected by the manager (Executives are managers who manage other managers)

Leadership consists of guiding, encouraging and facilitating the pursuit by others of ends using means, either both of which they have either selected or the selection of which they approve'

Source: Ackoff (1998:24)

Ackoff goes on to state that leadership is poorly understood because it is primarily an aesthetic function, and he links this with the four aspects of development identified by Ancient Greek philosophers all when taken together are sufficient for continuous development, these are the pursuits of *truth, plenty, the good and beauty/fun aesthetics*. This interpretation is as valid for organisational leadership as it is for personal leadership that is alluded to in this study.

3.8.1. Styles of Leadership

In the last decade there has been significant emphasis in what has become to be known as Transactional and Transformational leadership styles. Transactional styles lean more to the management side of the continuum of getting things done, whilst transformational styles enable the transformation of organisations to keep pace with the changing culture. Within the context of nursing most of the leadership posts also have a significant management function and consequently an effective leader will have a range of behaviours that meet both functions. This differentiation however is not that simple, as we go on to explore, the differences in styles of leadership relate to how things are done rather than what is done, and it's the relationship with other people that matters. Conveying this message is important if previously learned assumptions about what leadership is are to be challenged:

'The single most important factor in creating high quality service is leadership. We heard that, on promotion to front line management positions, staff received little or no associated leadership training, nor much guidance on what was expected from them in their new role. It was also often unclear as to who held responsibility for the quality of the service delivered.'

Source: Mackenzie (2000:24)

Within the context of this study it will be identified that a lack of clarity existed as to what leadership was and lack of preparation for it. However preparation for leadership programmes tend to concentrate on skills required to do the job, especially from the management perspective and the writing of strategies and business plans. Goleman et al, would suggest (2002a:4) that research in to the field of emotion has yielded key insights into how a leader's emotions impact at work, and that leaders who have found effective ways to understand and improve the way they and other people handle their emotions has an impact on the leadership function.

'Understanding the powerful role of emotions in the workplace sets the best leaders apart from the rest – not just in tangibles such as better business results and the retention of talent, but also in the all important intangibles, such as higher morale, motivation and commitment'

Source: Goleman et al (2002a: 5)

This was reinforced in a different publication in the same year exploring the concepts of 'emotional leadership'

'Breakthroughs in brain research show why leaders moods and actions have enormous impact on those they lead, and shed fresh light on the power of emotionally intelligent leadership to inspire, arouse passion and enthusiasm, and keep people motivated and committed. Conversely we sound a warning about the power of toxic leadership to poison the emotional climate of a workplace'

Source: Goleman et al (2002 b Preface: x)

Within the literature (Tannebaum and Schmidt, 1958; Bennis, 1980; Peters and Waterman, 1982) the consensus appears to be that a leadership style that is transformative in nature, is the most effective in developing and maintaining sustainable organisations, so can transformational leadership be developed and learned?

In exploring the literature, different writers argue the qualities of a transformational leader but not all would agree on the same set of behaviours. What does seem to be consistent is that the real success of transformational leadership comes in the ability to inspire others towards a goal that is not limited by traditional ways of seeing the world. The large amount of growing literature on 'Learning Organisations' would suggest that one of the key tasks of a leader is to ensure that the organisation functions as a learning living organism (Senge, 1990, Arie De Geuss, 1998). Bass et al (1996) identified four components of transformational leadership that focussed on the personality/behaviour of the leader, such as charisma, the ability to inspire and intellectually stimulate others, while considering them as individuals.

Charisma refers to the quality some managers have of embodying role models that followers strive to emulate and align around a common purpose and mission. Inspirational motivation provides meaning and optimism about the mission and its attainability.

Intellectual stimulation is about enabling people to see things in new ways, to explore different ways of responding to problems and being able to challenge each other in an environment of mutual trust and respect. This is the individualised consideration aspect of the model and relates to the fundamental belief in the value of each other.

Peters and Waterman (1982) would draw similar conclusions from work with top multinational executives, which suggest that their success lies in the ability to deal with people effectively and meaningfully. Indeed Ackoff (1998:27) suggests that:

'Visions that induce others to pursue them must be inspiring. An inspiring vision is the product of a creative act of design. Inspiring visions are works of art, and those who formulate them artists'.

Cook (2001:33) reports on a qualitative study to determine the attributes of effective clinical nurse leaders. He identified five attributes of effective clinical nurse leaders: *'highlighting, respecting, influencing, creativity and supporting,'* and five distinguishing typologies of effective clinical nurse leaders, *'discoverer, valuer, enabler, shaper and modifier'*

A transformational leader therefore has the capacity to transform an organisation by working with people in an effective way; this challenges our traditional views of leaders:

'Our traditional view of leaders – as special people who set the direction, make the key decisions, and energise the troops – are deeply rooted in an individualistic and non-systemic world view. Especially in the West leaders are heroes – great men (and occasionally women) who rise to the fore in times of crises. Our prevailing leadership myths are still captured by the image of the captain of the cavalry leading the charge to rescue the settlers from the invading Indians. So long as such myths prevail, they reinforce a focus on short-term events and charismatic heroes rather than on systemic forces and collective learning. At its heart the traditional view of leadership is based on assumptions of people's powerlessness, their lack of personal vision and inability to master the forces of change, deficits which can only be remedied by a few great leaders.'

Source: Senge (1990: 340)

The emphasis on a style of leadership that at the core respects and values people appears to be significant. Leadership although a concept that can be learned is a continuous learning process and depends on the potential of the leader to be self reflective in the process of enabling and facilitating others to succeed. It is the function of current leaders to provide an environment in which such capacity can grow and develop safely.

3.8.2 Preparation for Leadership

This significant component of organisation development can be easily overlooked and assumptions made that people with certain talents mature into the role. The previous section has started to identify the importance of developing emotional awareness in leaders but at sometime or other all are leaders whether within a personal or professional capacity.

Sims (1991) quotes Dumas (1986:4) who in a paper presented at the Leadership conference in Ann Arbor Michigan stated:

'We will fail in the preparation of leaders if the focus of our attention is limited to the roles of those whom we designate leaders. For we cannot fully comprehend the nature of leadership by focussing only on a single individual whom we would give the title leader. This provides only half the picture. The behaviour and success of leaders is influenced as much by the needs, demands and actions of followers as by the leader's own knowledge and skills, character and personality traits, needs and leadership style. Thus, preparation for leadership necessarily includes serious attention to the inextricable linkage between those whom we label leaders and those whom we label followers'.

Charles Handy accords with this and yet indicates that the dominant culture may also have some impact

'Machiavelli writing in Italy in the early 16th century, described a theory of leadership akin to manipulation. It was based on the assumption that leaders have and should have, much more power than their followers (a large Power Distance Culture) Thomas More writing in England at the same time, described a Utopia based on consensus, where ideally power is distributed more equally (a small Power Distance Culture) Leadership theories in the sixteenth century were, therefore, heavily culture based.

They still are argues Hofstede (1984). His research suggests that Italy still is more comfortable with large power distances. So are France, Mexico and Brazil. Denmark Sweden Austria, Israel and New Zealand, on the other hand prefer much smaller power distances and so would look for a consensus type of leadership. Britain, the United States, Canada and the Netherlands are in the middle, which might explain the more ambivalent contingency-type theories, which emanate from these countries.

Leadership is about Followership. You can only be the leader your followers are comfortable with. What works in Scandinavia may well look weak and wet in Mexico'

Source: Handy (1990:109)

Personal or individual leadership as well as effective co-ordinating leadership at a more senior level is also a theme developed within a concept of effective leadership. Covey (1989:217) suggests that three individual character traits are essential to develop the win/win mentality of leadership. Integrity, maturity and an abundance mentality,

'It is difficult for people with a scarcity mentality to be members of a complementary team. They look on differences as signs of insubordination and disloyalty.

An abundance mentality flows out of a deep inner sense of personal worth and security.'

Or as Senge (1994:22) writes

'Good ideas drive out bad ideas'. Most companies have no good ideas, are driven by ideas of 'the name of the game is climbing the corporate ladder, says former Hanover CEO Bill O'Brien. Or do 'whatever it takes to win personally.' Like a bad ecology these ideas pollute the organisational climate and become self-reinforcing.

Fortunately guiding ideas can be developed and articulated deliberately. Indeed this has long been a central function of genuine leadership'

Senge (1994:14) advocates that learning is a primary task of leadership and that it is:

'Perhaps the only way that a leader can genuinely influence or inspire others... eventually people come on board themselves'

This can be linked to voluntary 'followership' a quality that according to Block (1993) is important for successful companies of the future. Block (1993:231) would indicate that this is most likely to occur when executives:

'Have stepped over the invisible psychological line to interpersonal leadership – as servant steward and teacher. When it is time to develop strategies they ask" Who will our actions impact" How will we involve them in the decisions and planning?'

Elliot 1991 suggests that an effective leader should be able to achieve goals through his or her team members by instilling in them feelings of worth and the leader should be a link and buffer between different management levels, whilst having the ability to work with and to take instruction from other team members.

Within a learning organisation leaders are stewards, designers and teachers and consequently leadership is everybody's business. Eddy (1985) links this to the concept of 'Organisational Commitment' whereby members of the organisation identify with the purpose and goals of the organisation and expect to obtain rewards by cooperation with the leadership. Clarification of issues around team working and leadership were important at the beginning of this enquiry for the individuals concerned but it was also recognised that the organisation itself is a living entity (De Geuss, 1998) and organisational learning is central to this enquiry.

3.9 Organisational Learning

The concept of organisational learning was formally introduced some forty years ago (Simon, 1976) and has expanded rapidly in recent years (Easterby Smith, 1997, Easterby Smith, Araujo and Burgoyne, 1998) and yet no single theory or model is widely accepted, although Easterby Smith (1997) from a review of the organisational learning literature identifies six disciplinary perspectives that currently contribute to the theorising of learning. Organisational learning appears to have at its core the process of understanding and gaining new insights (Argyris and Schon, 1978; Fiol, 1985; Senge, 1990) For the purpose of this review I will concentrate on those areas of organisational learning such as that of 'Double Loop' learning (Argyris and Schon, 1978) which involves a change in the values of an organisations "*theory in use*". This results from organisation members cognitive change as a result of learning 'how to learn' as a result of reflecting and enquiring into their previous learning experiences. According to Argyris and Schon, 1978, an organisation learns through the learning of its individual members. Many organisations within the healthcare sector have expected this to occur through supporting individuals through a myriad of different training and educational programmes, and whilst the benefits may have been evident to the individual's practice the impact on the organisation has often been negligible. This is not just a phenomenon in the Health Service and studies have shown that real change can result from training but most of

the time the change doesn't seem to be sustained (Goleman et al, 2002a: 99). Consequently I searched for a different perspective as experience has shown over the years that vast amounts of money have been invested in individual learning that has had a minimal impact on the way that healthcare practice is delivered. Schein (1993) and Senge (1990) suggests that although learning at an organisational level may follow the same processes it is fundamentally different and that the ability to transfer individual learning to organisational learning is through shared mental models (Schein, 1993). This will be embedded within the cycles of enquiry and the developments within the context of a Learning Organisation. (Senge, 1990).

Others would link personal learning to organisational learning through decision making, thereby challenging the concept of a 'learning organisation':

'If decision-making is learning, then all companies learn all the time. There is no need to 'build' a learning organisation. You already have a learning organisation'

Source: De Geuss (1998: 77)

Although implying that decision-making means action is taking place, this does not explore the effectiveness of the decisions made for not just the bottom line of the organisation but the fulfilment and motivation of the staff.

Easterby Smith (2002:136) explores the conceptual distinction between Organisational Learning and the Learning Organisation, stressing that the

'Learning organisation is an ideal, towards which organisations have to evolve in order to be able to respond to the various external pressures. Organisational learning is the activity and processes by which organisations eventually reach this ideal of a learning organisation'

Source: Easterby Smith (2002:136)

Whilst the work on Learning Organisations gives a useful framework for organisations wanting to embrace change especially within the NHS, and is increasingly popular as a model to develop structures and systems that nurture innovation (Peters and Waterman, 1982; Kanter, 1989; Senge, 1990), there is little hard evidence of the effect of organisational learning in practice. Argyris and Schon (1996) state, that they are unaware of any organisation that has fully implemented a double loop learning system. However system thinking promotes the thinking of seeing cause and effect relationships rather than single snapshots or linear relationships.

Griffin (undated) identifies the two main approaches to management thinking today, common sense, rational constructivist arguments and the

'Number of popular management theorists (who) speak of changing 'mental models' 'perceptions' 'paradigms' or systems of belief, implying that this can be done in an intentional and thus designed way. What managers are being challenged to do is not only redesign and re engineer their companies, but also their selves'

They go on to challenge the assumptions on which some of the claims for change are made.

'Many of the writers who imply this ability to intentionally design changes in thought structures draw on systems theory and increasingly employ the language of complexity. They point to how small changes in ways of thinking and acting can lead to much larger shifts in the whole organisation'

Source: Griffin et al: Undated

This starts to focus on the importance of collaborative approaches to change which start to challenge the power structures within an organisation. Tension is surely evident when it is a mechanism for manipulation but the potential for both individual learning and organisational learning, especially in the healthcare field, is certainly worth a try.

Learning seems to be at the centre of sustainable approaches to organisational development although change can seem to occur without learning, and some writers would suggest this is the kind of change that is not sustainable but responsive to external drivers. This may be the predominant kind of change that has previously been seen within the Primary Care sector of the NHS, especially when change is focussed on task rather on other variables and is achieved through coercion and draconian discipline and grievance policies. Several types of learning approaches are identified from the literature, Learning Climate, Learning Company (Pedler et al 1991, 1997) and Learning Organisations. (Senge et al, 1990; Mc Gill, Slocum, and Lei, 1993; Nevis, DiBella and Gould, 1995; Davies and Nutley, 2000)

It is the latter concept of the Learning Organisation that I have chosen to develop in this work, and the co-enquirers within the healthcare practice were motivated, enthused and excited around the potential to develop around the Five Discipline model (Senge, 1990) The attractiveness of this model in response to Cycle 1 and 2 of the enquiry, was the focus on reflective practice to develop a knowledge base for learning and the potential of dialogue to move the practice forward from some of the 'stuckness' it was experiencing toward the latter end of the first year of the enquiry.

3.9.1 Communication and Dialogue

Katz back in 1955 identified three areas of communication skill that were essential to organisational well being, identifying these as technical skills, human skills and conceptual skills. Technical skills would be communicated mainly through training sessions on a Wednesday afternoon and also specialist educational opportunities to develop key skills for the development and implementation of new ways of working. Given the perspective taken in respect of organisation learning and development the human communication skills and the

communication of conceptual analysis leading to action in this enquiry required consideration. Indeed if communication failed then the collaborative nature of this action enquiry itself could be considered to fail. Communication is about interacting with other people and changing the way individuals interact was at the centre of this enquiry. The following quote identified the potential vision of a dynamic organisation:

'In the end, the premise that organizations are the product of our thinking and interacting is powerful and liberating. It suggests that individuals and teams can affect even the most daunting organisational barriers. These barriers didn't appear on the landscape like natural formations, like mountains and rivers. They were created by peoples' wishes, expectations, beliefs and habits. They remained in place because they were reinforced and never challenged: eventually they became invisible, because they were so taken for granted'

Source: Senge (1994:48)

Much has been written about models and theories of communication (Berlo, 1960; Mortenson, 1972; Schramm, 1972; Rasberry and Lemoine, 1986) and yet several fundamental characteristics are inherent to communication. Communication is dynamic, irreversible, proactive, interactive and contextual (Mortenson, 1972). Rasberry (1986:33) identifies three significant areas of hurdles to overcome for successful communication, each of the three are significant in the context of this enquiry:

' Perception, the filter through which we take in stimuli and understand the world, Language can become a barrier to communication among people who do not share a common understanding and organisational structure, the climate, networks, and channels in which communication occurs in an organisation help either to facilitate or to deter meaning and understanding'

In the context of an action enquiry I would need to determine effective strategies to aid communication that had the potential to achieve the expectations we had set for ourselves.

Argyris and Schon (1974) assert that people hold maps in their heads about how to plan, implement and review their actions, and that few people are aware that the maps that they use to take action are not the theories they explicitly espouse. This was an important aspect of perception to explore within the context of the study and integrated with the development of reflective practice as attempting to understand the '*theories of action*' of espoused theory and theory in use. (Argyris et al 1985:82).

It would seem that a process of dialogue could also help achieve this. Senge (1990) makes the distinction between the two different types of discourse of dialogue and discussion which I found later a useful explanation to the groups in the practice. This explanation included Senge's (1990:242) views that '*in dialogue people become observers of their own thinking*' and

'Dialogue that is grounded in reflection and inquiry skills is likely to be more reliable and less dependent on particulars of circumstance such as the chemistry among team members'

Isaacs sees dialogue as

'A sustained collective inquiry into the processes, assumptions and certainties that compose everyday experience. Yet this is experience of a special kind, the experience of the meaning embodied in a community of people'

Source: Isaacs (1993:25)

Communicating the principle of dialogue and using this as a communication strategy to ask questions, clarify understandings and to move forward with shared understanding was crucial to the development of the enquiry from both personal, team and organisational perspectives

3.9.2 Change as an emotional transition

Many of the approaches to organisational change found in the literature give the impression that change is (or can be) a rational, controlled, and orderly process. (French, Kast, and Rosenwieg, 1985). In practice, however, organisational change is chaotic, often involving shifting goals, discontinuous activities, surprising events, and unexpected combinations of changes and outcomes (Cummings et al, 1985; Dawson, 1996). Accordingly, change can be understood in relation to the complex dynamic systems within which change takes place. Northcott and Dolan (2002) identify the differences between linear organisation that manage change as a bureaucratic process and organisations which use emancipatory processes more aligned to chaos theory, recognising that the *'price for this open-endedness may be extreme uncertainty and loss of self-control'* (Northcott and Dolan, 2002: 357)

Successful change involves an emotional transition from the old ways to the new. Bridges (1995) suggests that this emotional shift involves a process not unlike grieving. Even a welcome change unsettles the familiar, and the loss of that familiar way has an impact (Bridges, 1995:48) Consequently the successful support of a change process requires attention to this emotional response, the opportunity for appropriate expression and time.

Handy likens groups within organisations to *'Tribes'* (Handy, 1990:145) and implies that the different meanings between tribes are challenged and worked through in change processes. This is linked to the culture of the environment (Johnson and Scholes, 1999). Positive links have been established between a constructive culture and the morale, staff retention, service enhancement and even decreased mortality of patients. (McDaniel and Stumpf, 1993). Managing change effectively is most effective in a culture that promotes learning and development (Pedler, et al 1991, Senge, 1990). Recognising that doing things differently involves risk and yet this potentially enhances creating such a culture. The way in

which risk is managed in organisations has the potential for proactivity and learning, but needs to be managed in a way that is as emotionally stabilising for individuals as possible. Drucker (1989) emphasises the importance of maximising opportunities rather than maximising risks, and indicates the importance of considering the organisation as a whole, rather than in parts when assessing risk. Northcott and Dolan, (2002:363) suggest that:

'Risks assessment should seek to eliminate them by anticipating them. However, if mistakes occur they should become the focus for learning and not a trigger for reaction or crisis management. Mistakes should not be pathologised towards individuals, but as part of a 'no blame' culture, be part of learning'

Individuals in many organisations may experience risk as disabling and threatening, leading to uncertainty and lack of control.

3.9.3 Systems thinking

Finger and Brand in Easterby Smith (2002) distinguish between the strategic definition of a learning organisation and the processes and activities of organisational learning to achieve it, and identify two approaches, the systemic and the psycho-sociological. These again differentiate between three conceptions of learning on which they build, the cognitive, humanist and pragmatic.

For the purpose of this enquiry the focus has been on the systemic approach to building a learning organisation as this is the predominant approach taken in the policy directives from the government which clearly identify the models encapsulated in this study i.e. Senge 1990. Iles and Sutherland (2001:16) provide a useful summary of systems thinking that originated in the 1920s within several disciplines, notably biology and engineering, and grew out of the observation that there were many aspects which scientific analysis could not explore. Whereas scientific method - summarised by Popper (1972) as the three Rs: Reduction, Repeatability and Refutation -increases our knowledge and understanding by breaking things down into their constituent parts and exploring the properties of these parts, systems thinking explores the properties which exist once the parts have been combined into a whole. A system is a set of elements connected together which form a whole, thereby possessing properties of the whole rather than of its component parts (Checkland, 1981). Activity within a system is the result of the influence of one element on another. This influence is called feedback and can be positive (amplifying) or negative (balancing) in nature. Systems are not chains of linear cause-and-effect relationships but complex networks of interrelationships (Senge, 1990).

Systems are described as closed or open. Closed systems are completely autonomous and independent of what is going on around them. Open systems exchange materials, energy and information with their environment. The systems of interest in managing change can all be characterised as open systems. In terms of understanding organisations, systems' thinking suggests that issues, events, forces and incidents should not be viewed as isolated phenomena but seen as interconnected, interdependent components of a complex entity. Applied to change management, systems theory highlights the following points.

- A system is made up of related and interdependent parts, so that any system must be viewed as a whole.
- A system cannot be considered in isolation from its environment.
- A system that is in equilibrium will change only if some type of energy is applied.
- Players within a system have a view that a system's function and purpose and players' views may be very different from each other.

Kesby (2002) explores the issues in cross boundary communication for patients from primary to secondary care, despite improvements to service availability and financial resource. Kesby referring to the work of Pratt et al (1999) who concluded that 'living systems' theory was preferable to 'hierarchical' theory in enabling new ways of collaborative working:

'Living system structure is characterized as bringing people together on an equal basis according to their contribution and role in working towards the shared goals and objectives of the organisation. It is dependent on looped feedback information and communication system whereby everyone knows the consequences of their own actions and the corporate performance of the organisation. In this way people at the strategic and practice levels know and inform one another. A living system built on trust, knowledge of and respect for all stakeholders, and pays attention to connections, relationships and meaning.'

Source: Kesby (2002: 359)

This reflection of the metaphor of a living system was put into practice by Pratt et al 1999:14 who asks the question:

'If you look at an organisation, or collection of organisations, using the metaphor of living systems, what would stand out? First you would notice whether it struck you 'as alive' – the sort of information you often get from first contacts. You would notice the quality of the relationships and the way that people are connected; whether conversations go beyond 'if you can't find it on the shelves we don't stock it'"

This metaphor of being alive was helpful in clarifying my role in the enquiry, my natural tendency would be to resuscitate 'dead' organisations, stale relationships etc, but the healthy approach is to facilitate individuals and organisations to become more alive. This is the core of action research and the challenging journey I entered into.

3.10 Conclusion to Literature Chapter

This literature chapter has attempted to identify the issues that were pertinent to the development of an integrated nursing team in primary care. Within the paradigm of action research choices have to be made as to what to include and what to exclude in the narrative of the enquiry process (Reason, 1998) and this may include reflection on the literature and its sources committed to paper that ground the enquiry in the social context in which it is undertaken. This was a difficult decision as it is an important quality measure in action research that practical knowing and action is conceptually grounded in theoretical knowledge (Reason and Bradbury, 2001). I could have chosen to commit to paper the reading on organisational culture, motivation, management and leadership styles that I had undertaken and had informed by preferred view of management and leadership theory. This was not followed through as the intention was to develop a culture of learning and leadership by the process of action enquiry and indeed was central to the whole personal purpose for me of the research, to determine the 'how' of creating teams that were motivated and demonstrated a positive culture of living and acting in the public healthcare sector. The theoretical knowledge expounded in this and the following chapter built on my previous knowledge base as my career has developed and as Torbert (1991) identifies the first person stance of action research reflects a lifelong enquiry. This enquiry reflects midlife in my journey through life and has been significantly influenced by educative models of development, empowerment and leadership. (Lindemann, 1926; Lewin, 1946; Freire, 1972; Knowles, 1973; Jarvis, 1987; Rogers, 1993; Brookfield, 1994; Mezirow, 1990). As the enquiry developed and cycles of enquiry evaluated additional literature was sought to support developments. The literature represented was actively discussed within the process of the enquiry; care was taken to contextualise excerpts as to not make assumptions about the situational knowledge of the literature. This was especially important in the dialogue and discussions around developing an understating of critical reflection and the five disciplines of a learning organisation (Senge 1990).

The exploration of the literature from my perspective did focus on the NHS from an insider view, but also from a view of learning from other organisations that could guide the development of effectiveness in the health community for example:

'For the NHS to become truly customer focussed, it will need to be designed around the needs of its customers and adopt and display the strategies, common to all top service organisations. Front line staff need to be flexible and empowered, staff and management have to be accessible,

there has to be an open style of management with less bureaucracy and customer complaints have to be actively encouraged and acted upon. The NHS culture is more than 50 years old and changing culture is the hardest part of any change programme.'

Source: Mackenzie (2000:24)

Key to change was the concept of leadership, and its effectiveness. The situational context has to be understood in a collaborative system, and the power of the culture in the prevailing system must be taken into account. Goleman et al, (2000b: 232) suggests that programs of change may well fail when leaders fail to do the following:

'Ignore the real state of the organisation, assuming that if people learn what they should do and be, systems and culture will automatically support them in the change process.

Attempt to change only the person, ignoring the norms of the group they work in everyday and the larger surrounding culture in play

Drive the change process from the wrong place in the organisation. Leadership development that transforms people and organisations must start at the top and be a strategic priority

Fail to develop a language of leadership – meaningful words that capture the spirit of leadership by symbolising ideas, ideals, and emotionally intelligent leadership practices'

So in summary the literature reflected here attempts to ground the enquiry in both the propositional knowledge, or theoretical knowing (Heron, 1996) that would influence the decisions taken to enhance the likelihood of successful action and also the experiential and practical knowing that influence the actions and reflections of the development of effective teamwork.

Within this type of enquiry the ontological and epistemological aspects will be evident and guide from a leading perspective the nature of the enquiry. The next chapter identifies examples of literature that influenced the 'worldview' that influenced all aspects of the cycles of enquiry.

Chapter 4: Philosophy and Methodology

4.1 Introduction

This chapter will outline the philosophical perspectives that have influenced the choice of methodology relevant to the enquiry I have chosen to explore. Initially I will explore general philosophical concepts and relate these to the ontological and epistemological perspectives that have influenced the choice of action research as a methodology. Finally the concepts and differences in respect of action research, as a means of qualitative enquiry, will be addressed.

4.2 Philosophical Underpinning

Fromm (1968:17) suggests that many philosophers have developed metaphysical systems that have had a profound influence on the development of human culture. What makes human culture special are two fundamental questions of human existence, which men have explored since life began '*Why life?*' and '*Life what for?*' Metaphysics attempts to answer these questions and tell us what the conduct of man should be in the process of living. Consequently Fromm (1968:17) would suggest that '*metaphysical speculation is vital, not idle speculation*'. These 'meta' questions are also asked at a community and personal level. In the context of this research these questions are asked in respect of the organisation - the primary health care team, but also require enquiry at both community and personal level. This leads to other fundamental philosophical considerations namely the philosophical concept of 'freedom'.

In the context of my study autonomy and freedom of individuals was assumed to be a prerequisite of achieving successful outcomes around the development of a patient centred service. These assumptions came from both the literature around teamwork and the contemporary political focus on the effectiveness of transformational leadership strategies. To most philosophers freedom has been interpreted as a more fundamental concept i.e. the capacity of a) choosing freely between two options; and b) liberation, that is to say, the capacity of freeing oneself from irrational passions (Fromm 1968: 12).

Thus freedom of the individual should lead to a sense of meaning shared by the group, but this is a naïve assumption and as the journey of my enquiry will show many individual agendas come into play in developing freedom and autonomy. Consequently early on in the enquiry developing a sense of common meaning, goals and measures of what would be deemed success was underlying much of the discourse, whether spoken or unspoken.

But this freedom must be seen in the organisational context, and develops the direction of questions around what organisational freedom means, how it is achieved and what it means to 'be' part of such an organisation. Critics of utilitarian philosophies would suggest that instead of focussing on life as a process of 'being' life has been eroded by a culture of 'having'. Within the context of the primary care practice this tension surfaced because of the financing, resourcing and political ideology of the NHS although the journey revealed that by developing ways of 'being' often the 'having' followed too.

Authenticity is another philosophical concept that has influenced my approach and especially around the use of reflective strategies for managing change that results in organisational learning. Fromm (1968: 17) states that the meaning of life is precisely rooted in the question of authenticity and the authentic man is the one who adheres to the spirit. He goes on to express that

'materialists in as much as they search for authenticity, in as much as they search for enlightenment, harmony and salvation are spiritual.'

This search for authenticity transcends any particular religious perspective but opens up the exploration of the spiritual component within organisations. So the exploration of meaning relates to exploring the opportunity for learning about 'being' as an individual within the context of an organisational community. This can then lend itself to creating an organisation that is capable of having a spiritual as well as a social identity. Heidegger (1962) identifies that man is essentially a 'being with others' or that sociability is an essential attribute of man. It is not because society exists that each of us exists; society exists because otherness belongs to each of us individually. Man in his very nature is a being for others (Feuerbach and Machado, in Fromm, 1968: 18-19).

Underpinning the conceptual approach to the research question is expounded by Fromm (1968: 21)

'We are only capable of knowing, understanding, and caring for the other if we are also capable of understanding, caring and knowing ourselves'

This leads to a discussion on the nature of the development of (self) knowledge; Kant (1787) revived a distinction, found in Aristotle (1946) between theoretical and practical knowledge. Theoretical knowledge refers to states of affairs whose existence can be checked, tested and accepted. Practical knowledge, on the other hand, refers to decision-making. Can humans ever know what to do, with the same kind of certainty that they know the truth?

This suggests that the capacity of human beings to make decisions suggest they can play a part in their own self-determination and decision-making presumes human freedom. Kant (Denzin and Lincoln, 1994:63) therefore suggests that

'Practical reasoning is applied social research and related to the application of moral judgements in the realm of human action'

Source: Denzin and Lincoln (1994: 63)

As a representative of the dialectical strand of neo Kantian thought, Habermas (1972: 310) holds that,

'Unreflected consciousness could, through self reflection serve, emancipatory cognitive interests such that knowledge and interest are one'

From the Habermas (1972) perspective, social research is an interactive rather than a controlling process. Participants aim for mutual understanding over the co-ordination of their subsequent action. Applied research, therefore, is not about social conformity but about social justice (Denzin and Lincoln, 1994: 97).

Midgely (1992:147) advocates that

'Methodological pluralism is essential for the continued legitimation of systems science...our traditional view of complexity focuses the 'natural world' of object relations and thereby excludes complexities of moral decision making and subjectivity'

He goes on to suggest along with others (Jackson and Keys, 1984) that to cope adequately with the many problems in the modern global world, different methods are embraced to help and understand the complex world in which we live.

4.3 Qualitative Enquiry

This study is therefore within the realm of social science. Research in social science attempts to explain social behaviour. The interpretation of social behaviours from the study of the empirical world depends on assumptions about the nature of human action (ontological assumptions) and how the nature of human action can be revealed through research (epistemological assumptions) (Wass and Wells, 1994:2)

4.3.1 Ontological and epistemological assumptions

Recognition of the roles of scientific communities is related to the issue of the source of ideas relevant for enquiry. These ideas can be drawn from what Inkeles (1964) has called 'models', Cuff and Payne (1979) and others have called 'perspectives' and Kuhn (1970) has called 'Paradigms'. Although there are differences in the meaning of these various concepts, they all recognise that social theorists and researchers operate in the context of a set of abstract

ontological and epistemological assumptions about what society looks like, what its fundamental units are and how they are related etc.

A paradigm encompasses three elements. *Ontology* raises basic questions about the nature of reality. *Epistemology* asks how do we know the world. What is the relationship between the enquirer and the known? *Methodology* focuses on how we gain knowledge about the world. (Lincoln and Denzin, 1994: 99) Blaikie (1993:155) expands this further by suggesting that:

'Two main perspectives or paradigms (a basic set of beliefs that guide actions) drive the view about the nature of human action. The Positivist perspective or paradigm based on a realist ontology that suggests that individuals respond to external stimuli and that both the stimuli and response can be observed and measured objectively. Critical of positivism Kant proposed, in effect, that perception is more than seeing. Human perception derives not only from the evidence of the senses but also from the mental apparatus that serves to organise the incoming sense impressions. Kant therefore broke sharply with Cartesian objectivism. Human knowledge is ultimately based on understanding, an intellectual state that is more than just a consequence of experience. Thus, for Kant, human claims about nature cannot be independent of inside-the-head processes of the knowing subject. Kant's model of human rationality therefore built on the process of knowing and the emergence of knowledge upon an epistemology that transcended the limits of empirical enquiry. In turn the transcendental perspective opened the door to epistemologies that allowed, if not celebrated, cognitive processes'

A Kantian (1933) view on the creation of knowledge, therefore, must take full cognisance of the investigator. It must concede the significance of interpretation and understanding (Denzin and Lincoln, 1994:63). This naturalist perspective or paradigm takes the stance of social reality existing within the consciousness of individuals and consequently the external world is subject to individual interpretation. Therefore naturalistic research studies people and phenomena in their natural settings. (McNiff, 2000:161) Interpretative approaches grew from this perspective as social researchers sought not just to describe what was observed but to make sense of and explain the meaning behind observations.

My methodological choices are based on the ontological and epistemological perspectives that align with interpretative naturalistic enquiry. This is consistent with the qualitative research process behind which:

'Stands the personal biography of the researcher, who speaks from a particular class, racial, cultural and ethnic community perspective. The gendered, multiculturally situated researcher approaches the world with a set of ideas, a framework (theory, ontology) that specifies a set of questions (epistemology) that are then examined (methodology, analysis) in specific ways'

Source: Denzin and Lincoln (1994:11)

McWhinney (1992) claims that when we move from knowledge of the external world to knowledge of the meaning of experience, we move up a step in the hierarchy of knowledge. In addition to relying on the observation from our senses we also need to use language, logic,

values, ideas, images, and symbols. (Wilber, 1995) To verify meaning, we have at some stage to enter into a dialogue with people. Therefore, in intersubjective enquiry, the main research instrument is the investigator herself or himself. Just as investigators in an empirical science have to learn the use of their instruments, both material and conceptual, so those in qualitative enquiry have to prepare themselves rigorously for their work. This requires rigorous self-examination, as well as the mastery of interpersonal skills and techniques of text analysis. (McWhinney, 1992) This will lead to the creation of multiple truths because people are all different, and have their own perceptions and interpretations, so the aim of interpretative practice is to achieve intersubjective understanding of a particular situation (Habermas, 1971, Gadamer, 1975).

This rigour must extend to the ethical principles of doing no harm and relating to the philosophical principles of freedom and authenticity as referred to earlier, and consequently research cannot be separated from practice. This view is expanded as follows,

'First late twentieth century democracies should empower all citizens' not just privileged elites. Second liberal social practice can never be morally or politically disinterested and third; the managerial separation of conception (research) from execution (practice) is psychologically, socially and economically inefficient.'

Source: Denzin and Lincoln (1994: 67)

This accords with the views expressed at the beginning of this chapter and will act as personal benchmarks for the integrity of this research.

This in itself represents a challenge of integrity in recognising what is hidden and how my personal biography will influence my decision-making. Ensuring that I develop mutual respect for participants, without coercion and manipulation, based on moral and ethical decisions that support democratic values, in the context of the enquiry, (House, 1990; Smith, 1990) will be key to exploring my assumptions and being true to the research process.

Blaikie (1993) states that scientific research is about answering questions by means of controlled enquiry, suggesting that controlled enquiry begins with four main research strategies which infer the importance of logic: inductive, deductive, retroductive and abductive. Each of these strategies aligns closely with the epistemological positions referred to earlier. Although the deductive and inductive strategies are predominantly used in positivist approaches to enquiry Bacon in Blaikie (1993:134) recognises that observation in any mode can be corrupted by four 'idols' These can distort the mind and inhibit the acquisition of true knowledge.

'Idols of the tribe' are tendencies to see things from our points of view rather than letting nature reveal itself. 'Idols of the cave' refers to differences in personality and experience which lead

individuals to approach the facts in different ways and not see them as they really are, 'idols of the market' which are the result of imposing on nature concepts which do not stand for anything and 'idols of the theatre' in which philosophical systems influence our mind and hence predetermine what we see in Nature'

Choices of what to see and hear are further illuminated by Hayward in Cayer (1997:45)

'our beliefs and our perceptions, form a tightly interlocking system of mutual feedback and support so that we could just as easily say "I will see it when I believe it" as "I will believe it when I see it" We perceive only what we already believe to exist, and we perceive it the way we believe it to exist.'

This distorting and filtering effect brought about by the content of our memories and beliefs also, according to Bohm, affects our thoughts. Bohm, suggests Hayward in Cayer (1997) considers that there are difficulties with 'thought' and that the first difficulty lies in the bad use we make of our capacity for abstraction, which has degenerated into what he qualifies as *fragmentation*. He would suggest that the propensity to fragmentation has invaded every aspect of human life, leading to a wide range of negative and destructive results that correspond to our individual fragmentary self-world view.

The second difficulty with the functioning of thought is that thought is participatory. Bohm identifies this as thought creates things but denies that they are its creations. Thought maintains that it is only reflecting what things are in reality, it asserts that we are the ones who decide what we want to do with the received information, but according to Bohm this is not true. He argues;

'Thought is not just reflecting whatever is there, but on the basis of what is known from the past, it helps to create the impression of what is there. It selects, it abstracts, and in doing this, it chooses certain aspects, which then attract our attention'

Source: Bohm and Edwards (1991:17)

Developing and capturing the thought processes involved in reflection on reality lead to consideration of approaches to maximise this possibility from a methodological perspective.

4.4 Action Research as a means to develop knowledge

Several research traditions have emerged from the perspective of the Interpretivist approach. Each of these traditions has different views on the proper focus of enquiry. Phenomenology suggests that individual's own interpretations of their life worlds are the truth (Garfinkel, 1967). Ethnomethodology suggests that the accounts that people give of their own experience leads to an understanding of everyday practical reasoning (Mc Niff, 2000)

McNiff (2000:168) states that the *products of Interpretivist research are used to add to the body of "propositional knowledge" about organisations* and this is now as respected a form of organisational theory as the scientific tradition (Clegg and Hardy, 1997:), yet propositional knowledge is relegated to a subordinated position when first order engagement with experience means reflecting on experience and learning how to do things differently (McNiff, 2000: 170) This is central to the concept of action research as

'simply a form of self reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own practices, and the situations in which the practices are carried out'

Source: Carr and Kemmis (1986:16)

Maurice Punch (1986:89) identifies how evolutionist and interventionist work, or '*action research has developed to a phase where 'subjects' are seen as partners in the research process*'. To dupe them in any way would be to undermine the very processes one wants to examine. Rather they are seen as '*respondents, participants, stakeholders*' in a constructivist paradigm that is based on avoidance of harm, fully informed consent, and the need for privacy and confidentiality. If 'action research' actually seeks to empower participants, then one must be open and honest with them.

Key to this approach is the use of a reflexive research practice. The concept of reflexivity is not new, Smith in (Richardson, 1996:194) comments that reflexivity was central to Mead's (1934) conception of the person;

'After a self has arisen, it in a certain sense provides for itself its social experiences, and so we can conceive of an absolute solitary self...who still has himself (sic) as a companion, and is able to think and to converse with himself as he had communicated with others'

Source: Mead (1934: 140)

The perspective of the self in research in the orthodox (positivist) approaches to research consider that reflexivity can be a hindrance to the research endeavour, in that participants having a complex and iterative set of views of what the research is about, what their own role in it is and how the researcher is responding to their behaviour would be considered a contaminating factor, as would the researcher not taking a neutral role in the research. The opposite approach has been taken in this study. Reflexivity is an inevitable consequence in engaging in research with people and that it can be harnessed as valuable part of the research exercise itself. The emphasis for this research has been on the participant, using collaborative enquiry and capitalising on the propensity towards reflection and reflexivity as co-researchers in the research project, involved at every stage from its inception and construction through its execution to its dissemination. (Reason, 1988)

Easterby Smith (2002:59) would suggest that political influences on management research relate to growing acceptance by social scientists of the need to be reflective and less reliance on and therefore challenge to traditional 'linear' models of scientific progress.

The work that most influenced my methodological choices was that of Professor Susan Weil, who at the time was also my supervisor. Weil (1998) explores the relationship between critically reflexive action research (CRAR) and organisational learning and systemic change, and this gives a basis for developing a methodology that is able to validate both processes and outcomes. She talks in her paper of those involved in social and organisational change as needing to manage ambiguity, uncertainty and complexity in a dynamic way that enhances the ability to pay attention (Weil, 1998: 14)

If critically reflexive action research is to be achieved that meets the criteria of honesty and truthfulness then this awareness is important not just for the 'researcher' but for the co participants in the research. Many co-participants come with a professional background that value positivist ways of enquiry and work within a healthcare system driven by performance targets and short-term results. So to be truly reflexive, challenging taken for granted assumptions must be from an individual and community perspective. Hayward (1997:9) would suggest that this requires '*both recognising and staying with the anxiety created when our belief systems fail*', and this creates the possibility for change beyond expectations.

In the process of generating theory, considerable thought needs to be attached to the ways in which methods of data collection are generated. In collaborative models of action research the interpersonal skills of participants play a crucial role, leading to success (or failure) of the change process.

Senge (1990) describes the skills of reflection, which concern slowing down thinking processes to inform understanding of how mental models influence our actions, and the skills of enquiry required of action science practitioners.

'Inquiry skills concern how we operate in face to face interactions with others, especially in dealing with complex and conflictual issues'

Source: Senge (1990: 192)

Dialogue is central to the development of generative and creative enquiry. Bohm (1990:1) gives a helpful description of dialogue as "*a stream of meaning flowing among and through a group of people*"

According to Argyris, (1982) different problems need different ways of thinking. In exploring people's 'theories in use' for problem solving they have found that virtually all human beings have programmed themselves with the same 'master programme'. The purpose of this master programme is to avoid threat, embarrassment and feeling vulnerable or incompetent. This 'master program' Argyris and Schon called Model 1 theory or single loop learning and is efficient to deal with simple problems and routines which do not require questioning and changing our governing variables. They suggest that using this approach to solve complex problems will produce unintended and counterproductive consequences. They suggest that we learn Model 1 early in life through socialisation and consequently we are unaware of our reasoning process involved in performing highly skilled actions (Argyris, 1982:474.)

To deal with complex problems Argyris advocates adoption of another master program called Model 11 theory or double loop learning, these have four key governing variables; relating to accurate information, free and informed choice and a personal willingness to be committed to and be involved in conscious reflection on the process and outcomes of the choices made. The process in the first cycle of research intended to create a culture for double loop or Model 11 Theory in use.

Schon (1991) spent much of his life exploring issues around the crisis of professional knowledge and the pursuit of an epistemology of practice. One of his major contributions to the development of professional knowledge centred around the processes of reflection in and on action and how these processes were in conflict with the academically defined processes of technical rationality.

Schon refers to Schein's (1974) view of professional education as a hierarchy, which may be read in terms of application, justification and status. Recognised is an epistemological pecking order, with basic science being highest in methodological rigour and purity resulting in its practitioners having superior status. This has to be challenged for practical knowledge to develop and to gain professional recognition (Argyris and Schon, 1992)

Argyris and Schon (1992:50) identifies that the technical rational models of professional education emphasise problem solving, but the most urgent and intractable issues of professional practice were those of problem finding. The literature search would suggest that the policy of the reality of integrated healthcare and collaboration between professionals was both an urgent and intractable problem.

Consequently a methodology which would achieve the outcomes of problem finding were central to this work and the development of new knowledge was more likely to result in processes to identify and then solve complex problems in what Argyris and Schon (1992:42) would call the 'swampy lowlands' of professional practice.

'In the varied topography of professional practice, there is a high, hard ground where practitioners can make effective use of research-based theory and technique, and there is a swampy lowland where situations are confusing 'messes' incapable of technical solution. The difficulty is that the problems of the high ground, however great their technical interest, are often relatively unimportant to clients of the larger society, while in the swamp are the problems of greatest human concern'

Chenail and Maione (1997) point out that instead of constructing theories like their researcher colleagues, researching clinicians (or insiders!) must face their previous constructions i.e. sensemaking from experience, create methods which allow for deconstruction (i.e. sensemaking challenged) and then work towards building reconstruction's (i.e. sensemaking remade).

Zuber Skerritt (1996:73) argues that emancipatory action research is organisational change 'best practice' and that it fosters organisational learning and the development of the 'learning organisation'. This is helped by action research that is collaborative, critical and self-critical enquiry by practitioners into major concerns in their own practice (Zuber-Skerritt 1996:84). Zuber-Skerritt (1996:85) states that team working and open and symmetrical communication is essential for emancipatory action research that develops participant's empowerment and self-confidence. From the experience of my research this concept took time to develop and tracking this process will be a key element of recording the journey of my enquiry.

As the process of the enquiry at the healthcare practice developed we 'found' the concept of the 'Learning Organization' (Senge, 1990). This represented a turning point in the development of the community that was the healthcare practice and yet the discovery came about by following the action enquiry process. I don't believe we would have moved to this potentially transformational process if we had concentrated on a model of 'single loop learning' i.e. focusing on the technical, functional and short-term oriented aspects within the practice by 'the detection and correction of error that does not require change in the governing values' (Argyris, 1980:14)

Consequently the development of the enquiry was emergent based on the self-evaluation of the participants in the enquiry. I intend to show that shifts in the development of the organisation started to take shape at the end of the first year. This is consistent with the stages of the CRASP model for management and organizational development (Zuber-Skerritt

1996:85)

'Action research is: Critical (and self critical) collaborative enquiry by Reflective practitioners, being Accountable, and making the results of their enquiry public, Self Evaluating their practice and engaged in Participatory problem- solving and continuing professional development'

Kelly (1963) suggests that the critical attitude towards the status quo in practice and context is mainly based on individual's intrinsic values and aims related to their personal constructs of effective and ethical professional practice. This was so true within the healthcare practice that undertook this enquiry and a considerable part of the journey was taken up with articulating and deconstructing these internal constructs. Hence the concept of the Learning Organization as described by Senge 1990 became an effective tool for sense making.

McNiff (2000:201) would suggest this is an interpretive approach to action research, and suggests that a multiplicity of approaches to action research have developed (McNiff 2000:200) Another approach she refers to as '*Living Educational theories*' (McNiff 2000: 201) which is an approach that enables individuals to clarify the value base of their work. The intention is to try and understand contradictions enabling the researcher to work more productively and help others to do the same. So parallel to the interpretive approach within the healthcare practice I was also reflecting on my own performance, and developing my own living theory which would then be tested out within the context of my everyday experience both within the workplace and my life.

4.5 Ethical Considerations

'The personal values we bring to research both shape and are shaped by the nature of work we do. A more rigorous and honest account of our own ethical stand-point, with all the contradictory and unresolved elements which this entails, is an important pre requisite in establishing our academic integrity, our purpose, our goals and our means of attaining them'

Source: Wass and Wells (1994:277)

Winter (1989) states that action researchers need to develop their understanding of situations rather than aiming to change situations. He suggests that moral political issues are involved here around taking the high ground of making judgments on other's situations until they have shown how they have worked to improve their own. What this implies is honesty about one's own motives and intentions in bringing about social change. Within the context of the enquiry at the healthcare practice I was aware of political drivers both within and without the practice that could have influenced the (manipulative!) process of social change. I tried to remain conscious of these tensions and attempted, through the use of a journal, to recognize the influences upon me to act in ways that may have misused the power bestowed on me as

'researcher' in this situation. For me establishing relationships, which reflected dialogue, was essential to the ongoing integrity of the enquiry.

The first meeting was planned with the Nurse Team Coordinator. I recognised it was important to set up an open rapport with her so issues could be discussed in an open reflective and developmental manner.

'Working within this research paradigm is intended to illuminate the deeper meaning of everyday experiences, the meetings that emerge from this illumination and then consequent actions that could be taken. I recognised the skill required in developing reflective dialogue to allow deeper issues to be surfaced for exploration. I would have to be very sensitive as to when to probe further or when to leave alone. I was really grateful for the development opportunities that I had had in developing this ability to explore within the context of clinical supervision. However I did recognise a potential difficulty that would need to be handled and this would be the fine line between reflective dialogue and counselling'

Source: Reflective Journal December 1997

I prepared a series of questions for this meeting, this was a safety net and yet I was aware that what I really hoped was that we would talk on a more informal basis and start to develop a mutual respect and understanding. My questions really centred on strategic direction and yet in reality all merged together in a naturally flowing conversation that did yield for me all the information I required. The Nurse Team Coordinator was a key player in this collaborative enquiry and she had some concerns at this point, which would act as boundaries for the future. The main concern was about my agenda, would I try and influence where they would go?

*'The Nurse Team Coordinator said she could work with me,
She said I was not too academic, and I used everyday language'*

Source: Reflective Journal December 1997

My next meeting was with the Practice Manager, at the first meeting he had been very dominant in the discussion, in fact I thought he was the senior partner. The meeting was scheduled for an hour in his office. He refused my request to use a tape recorder, and bombarded questions at me. I had produced initial steps in the research process based on a 'for me, for them and for us' framework, this was not a match for his style and he saw it as far too touchy feely. I sat on a chair, aware of my controlled body language and feeling that I was being grilled far in excess of what was necessary.

'Reflection in action was a concept I was familiar with in the repertoire of reflective skills that I had developed post MSc. At a point about 20 minutes into the discussion, it certainly was not a dialogue; I recognised that the balance of power needed to be challenged. Consequently I relaxed my body language and moved forward, and on the next question responded by putting his question back to himself and asking his opinion. This worked well; he relaxed more too, and then started doing all the talking. The interview finished on equal and friendly terms. The Practice manager also commented that he could work with me and he escorted me of the premises.

This seemed to be my rite of passage into the organisation; they had acted as if they had selected me and consequently owned the approach I was going to take. This did not mean that

over the next two years we would not have differences in opinion, but that conflict would be managed in a way that was adult in relationship.

This was as much about me as the Practice Manager and the Nurse Team Coordinator. It was evident from the research that parent child and adult child relationships existed in the practice, some of which would be challenged in the two years and in so doing lead to more effective communication'

Source: Reflective Journal January 1999

Zuber-Skerritt (1996) identifies the paramount importance of action researchers paying attention to the ethical principles that guide their work, recognizing that the action of the researcher is deeply bedded in the existing social organisation. Therefore, it was an ethical consideration for me to understand these subtle dimensions, so that my actions did not jeopardize either improvement or the value of existing valuable work (Zuber-Skerritt 1996:16). This may be seen as even more important in the NHS for as Binney and Williams identify (1995:29) people in an organisation become bewildered by the range of change initiatives which often seem inconsistent and imposed. Indeed

'Managers who are the victim of change initiatives imposed from above become persecutors of staff below them; in Britain's NHS we have found feelings and actions at one level which reflect exactly those of managers below and above'

Source: Binney and Williams (1995:30)

This is reflected in the Executive summary of the Leicester Terrace report (Allen, 2000:4) as follows;

'Key messages of relevance not just to Leicester Terrace but to similar integrated team initiatives in the NHS have been identified.

- *The impact of external political, economic, social and technological influences cannot be underestimated.*
- *The development of shared objectives and shared visions of the future take time to be developed.*
- *The clear understanding of each other's roles within newly created teams takes time to develop.*
- *The role of the leader in an integrated team needs to be explicitly stated, and reflected in job descriptions and person specifications.*
- *An open non-judgmental environment has to be created before staff are able to take risks in sharing ideas, misconceptions and problems.*
- *Personal confidence when communicating across professional boundaries takes time to develop.'*

This tension was recognized in the practice with a focused discussion around the Political, Economic, Social and Technological (PEST) changes that were external drivers for change. This helped identify and articulate the need for good communication around the principles

guiding the work and the informed consent of those taking part. (Allen 2000:10) As the journey will show a steering group representing the practice signed up to the principles. Ownership, involvement and expectation were evident in the energy of this group. Some significant others did not actively block or sabotage the process of change, but could be observed not to be totally present (Lundin, Paul and Christensen 2000:67) in the activity. Continuous reflection before, in and on my actions helped to hold this ethical principle as a central concern.

Other core ethical implications were adhered to during the study, namely ensuring the development of the work was visible and open to suggestions from others, ensuring permission was given to access records or appropriate documents, and ensuring descriptions of other's work and points of view were negotiated before being submitted for publication. (Allen et al, 2001,2002; Zuber-Skerritt 1996:17; Steering group minutes July 23rd 1988).

The initial meetings on a one to one basis at the healthcare practice surfaced the main concern of the practice.

'This was 'what was my agenda? Would I try and influence where they would go? This is probably at the heart of the issue of validity and rigour in this type of enquiry'

Source: Reflective Journal January 1999

And this links to the ethical considerations discussed previously.

This also led me to the literature. At this point, I too was very suspect about the validity of the research (as I called it and understood it at that time) that I was an integral part of. I took quite some time to work through this dissonance, perhaps bringing critical edge to times in the process where I had the impression that the healthcare practice was expecting my leadership in certain elements of decision-making. Fortunately this I challenged for the integrity of the enquiry.

At times throughout this writing I struggled with considering this approach as 'real research'. I could handle it as change management, but my past experience of the mystery of the research approach was difficult to reconcile with this approach. This was the same difficulty for some of my co- enquirers in the healthcare practice but as the proposal seemed to promise change they seemed to accept my reassurances as to the validity of the research methodology earlier on. Whilst I was able to sell the approach to others I myself was quite uncomfortable on two accounts; the first being about the potential power and influence I could exert; and secondly about the validity of the approach.

Yvonna Lincoln (1995:39) considers the present status or '*fourth moment*' of qualitative research as a '*moment of representational crisis*' she suggests that

'in its most succinct form this crisis of representation embodies profound anguish about truth, method and the narrative processes embedded in the anthropological project.'

This starts to redefine truth as a multiple entity, which is both dynamic and fluid. Consequently Lincoln (1995) goes on to justify that validity, generalizability, objectivity and reliability relate to old positivist criteria. Within a qualitative collaborative approach the value lies in the worthwhileness, the value, the truth, and the merit of our activity.

Lincoln (1995) suggests that the fourth moment leads to the '*fifth moment of qualitative research*' and the brewing crisis of ethics in respect of the '*grey areas*' such as face-to-face contact and the development of meaningful relationships in this mode of enquiry.

'Qualitative research puts people in touch with people in very sensitive ways. It has the power as Shulamit Hertz (1979:) suggests, to move us from a 'rape model' of research – where researchers take what they want and leave - to a lover model of research, where individuals interact with mutual trust and regard, and where lifelong friendships may be forged. But in those very friendships and relationships of trust and regard lie all the problems which beset intimate human interaction... ..another problem that we face, whether we like it or not, is that it becomes increasingly difficult to manage anonymity and confidentiality when we are using qualitative data to tell our stories. Qualitative research relies heavily on natural language – a kind of catch all term which means we can eschew the stiff, stilted jargon... and utilize the actual words of our respondents to tell our stories, and to make our research cases'

Source: Lincoln (1995:45)

Truthfulness as opposed to Truth seemed to emerge as the essence of the process of this enquiry. Truthfulness as I perceived the process, tested out by others in the enquiry which resulted in a collaboratively owned view of the process. This I have attempted to write in these pages respecting the confidentiality, friendship and sensitivities of identifiable participants in the process.

4.6 Chapter Summary

This chapter has outlined the sense of meaning that threads through this enquiry and situates it within a qualitative research framework. The importance of learning from reflective strategies to change the way I act, live and make sense in the world and so enable this enquiry to be developed in a participative emergent way with the healthcare practice who wish to explore and enquire into new ways of working.

Chapter 5: Data Analysis as Cycles of Enquiry

5.1 Introduction.

Senge (1990:139) likens the concept of Personal Mastery to the 'Spirit' of an organisation and goes on to explore the views of Kazuo Inamori (Senge, 1990:140) who states that

'The active force in successful organisations is people...if people are not sufficiently motivated to challenge the goals of growth, there will simply be no growth.'

Imamura goes on (cited in Senge, 1990:140) that

'tapping the potential of people will require new understanding of the 'subconscious mind', 'will power' and 'action of the heart' ...a sincere desire to serve the world'

'Personal Mastery' is the phrase Senge (1990) and his colleagues use for the discipline of personal growth and learning, it goes beyond competence and skills, although it is grounded in competence and skills. It goes beyond spiritual unfolding or opening although it requires spiritual growth. It means approaching one's life as a creative work, living life from a creative as opposed to a reactive viewpoint. (Senge, 1990:141).

This concept will be developed as the journey at the healthcare practice, and starts to represent the values of the action enquiry process for this research. This too situates my values and myself as the researcher in the process and my journey towards personal mastery will be incorporated in the data that is shared. This will help to illuminate the '*holding of creative tension*', which Senge (1990: 152) suggests can be reduced by pressure to lower one's vision. The following is an example from my research journal.

"Barriers to professional role seem to act as security in performing the professional role, the safety net of job descriptions, professional first qualification and professional development add to the culture that gives permission to working in traditional ways. Both the safety within this tradition but also the opposition that they create to develop newer and more efficient and satisfying ways of working. To go against this learned culture for the nurses needed a lot of time, discussion and dialogue to work through, knowing what was expected was key to feeling valued in the role and being able to create one's own role was at times nearly overwhelming for some of the participants. But was the nearly overwhelming different for different people? Is there something about people's temperament and life experience which make them more or less able to work across traditional boundaries, even if it was in a discipline for which they were qualified, but perhaps not formalised by a rigid job description "

Source: Reflective Journal April 2003

This text will hopefully demonstrate the development of the two underlying movements towards the development of 'Personal Mastery'. The first is the continual clarification of what is important to us, and the second is to see current reality more clearly. So the forthcoming chapter will be centred on the creative tensions that arise when the vision and the current

reality are in juxtaposition, and the learning becomes *"Lifelong generative learning. Expanding the ability to produce the results we truly want"* (Senge, 1990: 142).

From the beginning of this enquiry I wanted the reality of reflective practice to be central to the day to day actions as well as being the main driver for key decisions on directions which were to be taken as the practice moved further towards the goal of an integrated nursing team. So the approach in this chapter will be to identify 4 cycles of enquiry, which themselves are made up of multiple mini cycles but together identify the key aspects or critical cycles which resulted in clarification of issues and thus action for the practice and are focussed around the development of personal mastery in an individual or team context. Each cycle will use data from the two years of events as recorded by myself in a reflective journal, and the evidence from interviews, observations and a vast range of documentary material. The four areas have been identified by reflection on all the above evidence and the critical stages of the leadership of change within the practice. The four cycles that are presented are not necessarily a linear presentation of the way that change evolved in the practice. Indeed several of the cycles were occurring simultaneously but illustrate more clearly the developments and issues than if they were represented together. Cycle 1 and Cycle 2 were happening in the same time frame and cycle 4 was longitudinal across the whole two years of the study and impacted both on the other cycles as did the other cycles impact on Cycle 4. Cycle 1 had a clear time frame which was identified retrospectively as about the first 6 to 9 months of the project and the outcome of that cycle brought about the enquiry which is represented here as Cycle 3. In fact in the true spirit of this kind of research I doubt that Cycle 3 would have emerged as an issue if other forms of methodology had been adopted. Cycle 2 links more closely to Cycle 4 and yet again they influenced each other.

Consequently to represent this enquiry I have determined the following 4 overarching cycles to demonstrate the change and dynamics that occurred within the healthcare practice.

Cycle 1. New leadership for the nursing team.

Cycle 2. Team forming and norming challenges

Cycle 3. Developing a shared understanding of leadership

Cycle 4. Implementing changes in clinical practice.

Each cycle will be introduced with some background information, followed by data taken at the time from interviews, documentation or observed behaviour. Reflection 'on' the action and planning for collaborative intervention, thus action will be represented in each cycle. In

some of the cycles a linear connectedness or cause and effect may not be initially evident and so the concept of a patchwork text will be utilised.

My struggle to write down multiple realities and to represent the multiple perceptions, paradoxes and influences developed a way forward as I read a book by Winter, Buck and Sobiechowska, (1999)

Patchwork texts are a series of loosely linked pieces illustrating a theme or gradually building up a set of perspectives. Winter et al suggest this is not new, going back at least as far as Chaucer's Canterbury Tales, and other significant writings, which present general themes by means of an amalgam of stories and analytical reflections.

So according to Winter et al (1999:66), a patchwork text is constructed so that it presents the voices of others as well as the voice of the author, *'assembling a plurality of voices concerning an event but without explicitly claiming to include those voices within the single authoritative voice of the author'*. It thus expresses recognition that any given voice (presenting an interpretation of events) is informed by other prior views (expressing different views of those events.)

Everyone constructs their own reality from the voices they have heard, and since no text can include all possible voices, the reality constructed by any author, narrator/observer must be presented as both incomplete and questionable. The purpose of the patchwork text, then, is to express directly a sort of cognitive "*modesty*" bias on the part of the author, since it makes explicit the uncertainty of our understanding and its inevitable subjectivity.

Ambiguity is made explicit, the author is but one voice among many, the text remains a collection of fragments, in spite of its efforts to synthesise it does not set out to present a single compelling vision of 'the truth' but admits that in the end it can never be more than a set of allusions to possible plural truths.

So to Cycle 1.

5.2 Cycle 1: New Leadership for the Nursing Team

5.2.1 Introduction

This cycle is made up of many 'mini' cycles which related to the multiple perspectives and experiences of a different approach to leadership of the nursing team. The cycle commenced before I joined the practice and in the time frame of the first six months of 1998 I gathered both documents which provided insight into the decision-making process and spoke with staff that were part of the formulation of the direction for the new role. What appears is illustrative examples from the variety of data taken. This included one to one interviews, group discussions within the practice team, the nursing team and the individual groups of health visitors, district nurses and practice based staff. Documentary evidence from both meetings that I did not attend, and information to the practice from the health authority that was directive of the way healthcare services should develop. During this period of time I spent the equivalent of two days a week in the Practice for the purpose of the project. This was not necessarily on the same days each week and often it included having a presence for a short time perhaps every day of the week. I also visited and interviewed key external stakeholders in the Community Trust. My thoughts and personal observations and reflections were maintained in a journal that will be referred to as appropriate to illustrate the challenges being overcome.

The examples or patchwork that follows attempts to identify the different voices which contributed toward the perspective that leadership for the three teams of nursing would create one cohesive nursing team and drive the developments forward that were required to modernise the services.

5.2.2 Why the nursing team needed leadership?

It was very soon evident to me from a variety of sources that the approach to nursing leadership had been a carefully considered development. Notes of a meeting held in March 1996 to 'develop the progress in practice nursing' identified proposed changes in clinical practice which would require being 'driven' Three areas were discussed which related to the assumption that current ways of nurse deployment was not as cost efficient as possible for the practice.

'Inefficient utilisation of skills'. For example; Blood tests currently done by registered nurses could be done by less trained staff and blood pressure checks currently done by doctors could be done by registered nurses

Issues practice nurses would like to do, but they are not doing. For example; implants, family planning, chronic disease management, minor ops and minor ailments

Issues nurses may anticipate that we would like them to do, which they do not want. *There were no topics under this heading, which was a positive statement of the trust that exists between the practice nurses and the partnership in developing collaborative care rather than 'dumped on care'*

Source: Meeting notes 12th March 1996

This extract from a document two years prior to the project signalled the development agenda. Whilst the explicit statement around trust was linked to collaborative rather than 'dumped on care' this would become a tension in the development of new ways of working.

5.2.3 Finding the best way forward to lead change in the practice

It would appear that the desire by the doctors and practice manager to develop these changes in workload management just didn't happen and so issues of leadership started to emerge. In April 1997 the practice management decided to employ a consultant to get an external view.

"This led us more and more to having a lead nurse. Discussed this at length many many times over a period of 18 months, decided to go to an external consultancy, he did it I think very well, everybody was interviewed, everybody filled out a questionnaire and from that came an agreement from everybody that delegation would be shared and it all pointed, well we can do all this once we get the NTC (nurse team coordinator) in post, well the lead nurse, but the nurses wanted a coordinator not a lead nurse."

Source: Peter.98

Potentially using an outsider to get an external view was a source for discussion. What was the real purpose of using a consultant? Would this carry more status and power? Did this avoid confronting the issue in a collaborative manner? Some of these questions were answered during the course of the study. The action learning approach to managing change would lead to reflection on the decision to choose an external consultant.

As I entered the practice in late 1997 this consultant's report was referred to as the blueprint for the future by the spokes person for the practice, but examples from my interviews, documentation, and personal reflections indicates that this was not quite as shared, as it would seem! In addition the report by the external consultant had key objectives attached to it. The practice manager at the time was closely involved in the development of the report and gave me the strong sense that this was very much a collaborative view from the practice. However it soon emerged that his views were the most dominantly expressed in the practice and not necessarily a totally shared viewpoint.

5.2.4 The direction of travel

16 main findings/ recommendations came from the report (appendix 1) the intention seemed to be to implement all 16 key recommendations using a project management approach. To achieve this a nurse leader should be appointed

"While there are a number of concerns, it is recommended that a Lead Nurse is appointed with suitable qualifications and experience to lead the nursing team and to facilitate the process of change."

Source: Recommendation 9 consultant's report 1997

The key words 'While there are a number of concerns...' made me wonder whether this was such a unanimous decision as I had been led to believe. Early on I started to get an insight into what some of these concerns were, although the concerns were not necessarily explicit within the culture of the practice, more an undercurrent that was palpable and to do with different ways of working rather than a new post of Lead Nurse.

"We have had to clarify ownership of the external consultants report, there have been some tensions but these have all been discussed...delegation of doctor's role to nurses. We had an issue to do with a previous appointee who was a nurse practitioner, she had qualified under her own initiative but the partnership felt a bit under threat. Tension to do with medico-legal, but also if I get rid of all my easy patients? But that is the focus of the report, we can build on that, we don't have to go and re invent the wheel."

Source: Peter 1998

Consequently I was alerted to difference in management and leadership styles and how they might affect growth and development within an organisation.

5.2.5 Uncovering some underlying tensions

Resistance to change is a well-documented phenomenon and so it was not surprising that some doubt and resistance was evident during the enquiry process.

"I am not happy about shared care. Didn't want it in the first place. I can't bring myself to do it."

Source: Angela 98

And yet such views were not openly expressed to the management of the practice, as this may lead to conflict and threat to personal wellbeing and job security as alluded to as follows;

"Well that went down like a lead balloon, Peter at that moment came downstairs, Paul excused himself from the meeting, you could tell he was agitated"

Source: Angela 98

This became more explicit in a dialogue between us,

"Angela is enjoying nursing but does not want more than her part time commitment, we discussed how she felt about refusing to attend courses put on by the practice i.e. that she didn't want them to think she was not committed, but she had different priorities and was happy just doing her job. Talked about how she resented all the extra hours that she had to put in of her own time to complete one course even though she really benefited from the learning experience. Felt the nurse team coordinator was very approachable and a good way for the nurses voice to be heard in the practice. Enjoyed working at the practice but felt the pace of change was quite threatening especially the expectation for the future that nurses should run clinics traditionally held by doctors...lots of issues to do with training, responsibility and accountability surfaced, as did the letting go of tasks currently undertaken by registered nurses to unregistered staff"

Source: Sue 98

Angela wasn't the only nurse concerned about the changes.

"I came into this job from outpatients because I wanted to be with patients in their own homes"

Source: Penny 98

And on exploring this forward I noted.

"Penny said she didn't really want to be taken away from the patients to take bloods, but felt it was the expectation of the practice, which she felt if she refused, would be seen to be deviant."

Source: Sue 98

The tension of the 'delegation of doctors roles to nurses' remained an issue, often hidden throughout the process of the enquiry.

"Decrease mundane work by members of the PHCT possibly by delegating to other members of the team who may find it interesting, also questioning if it is mundane work then decision making is likely to be low and whether the work needs to be carried out anyway,"

Source: Memo, understanding health need and demand August 1998

This was an example of some of the dialogue on everyday work and what was actually done, hidden in the following cycles are some things that changed but also what was determined as mundane by some was fulfilling work for others.

5.2.6 Setting the scene for the Nurse Team Coordinator.

The agreement to appoint a nurse team coordinator did appear to have significant support, different reasons being given by different individuals depending on their own role in the team.

"The nurse team coordinator was a good idea, felt committed to the role...saw it really as a reflection of the (practice) being quite pro nursing development and seeking the view of nursing. One of the things I felt was that nurses were not represented at a higher management level, although I think the practice knew that and they had long been talking about the tripartite thing of practice manager, lead GP and this nurse whatever, coordinator role. Felt that at regular partners meetings it would be good to have somebody there representing the nursing side"

Source: Ruth 98

This provides an insight into the different perceptions of what the nurse team coordinator would do, for the nurses it was to provide a voice to management and for management to enable change to be driven. This initial tension took time to surface and much of this chapter will explore how the post holder managed this tension whilst developing reflective ways of thinking and acting and starting to implement change by collaborative working.

The practice was aware that the potential for this project to be of interest to the wider community was influenced by the current external reality that has been referred to in the chapter setting the context for this study. Working in new ways for all staff was a vision for delivering the future in Primary and Community Care and so following due process the practice was funded by the Health Authority to appoint a nurse team coordinator, and for the developments to be evaluated. 10 applicants applied for the post and the successful candidate, new to the practice and from outside of the geographical area began this new role.

Reflection on the process of appointment and how the job description was generated did not really occur until two later points in the project; however it soon became evident that defining the role challenged both the appointee and the management team of the practice. The learning from reflection with respect to this appointment process will be referred to later, but reflection 'on action' of the current situation and actions taken to define the role and its purpose is exemplified as follows

"Ann started on 3rd November, she had an office but what does she do? Either she dons a practice nurse uniform to help out there, that's the question. She has started to have her own meetings and meeting some barriers but is starting to deal with them, able to get people alongside and she has been welcomed."

Source: Peter 98

Within the context of the above quote it was apparent that tension existed between the perceived need to make change happen quickly and the time processes would take to ensure it was accepted and sustainable. This became a hidden dilemma for the nurse team coordinator who evidently felt at times that she wasn't getting results quickly enough. So for the nurse team coordinator identifying her role was a learning process.

"Half term week hence my services required in treatment room each day. District nurses also short staffed as Sarah had taken special leave. Have tried to be unobtrusive about working as a district nurse from 8am-10am then practice nurse for rest of the day.... mainly because of jokes from 'reception' about my 'wardrobe' changes of uniform! Practice felt it was important to wear the appropriate uniform for the job required...fair comment...but oh! For nurses in mufti. Why on earth do we need to wear them when a plastic apron would do for protection.... most patients see the person behind the uniform nowadays, even the older generations who one might expect to want a nurse in uniform. Having educated patients out of calling us 'sister' and using first names, why do we reinforce the barrier by wearing special clothing to set us apart?"

Source: Ann 98

Determining what to do was difficult for the appointee as the job description identified broad intentions; this included working 50% of the time in a clinical role. The implicit purpose emerged that the role was to implement all the 16 recommendations from the external consultants report. Not surprisingly developing the role against mixed messages was not an easy process for the nurse team coordinator.

On 24th February 1998 the nurse team co-coordinator gave a presentation to a 'consortium of nurses' across the geographical area. The post holder was quite nervous about this meeting as this practice was seen to be more entrepreneurial than the rest, and also able to attract more funding for new initiatives. The anxiety was increased by the current view that doctors were 'dumping' their work on to nurses and that nurses who accepted extended roles were somehow being unprofessional.

For this meeting the nurse team coordinator had to define her role and purpose and did so as such;

"Role of Nurse Team Coordinator

- *Jack of all trades*
- *Focal point for management*
- *Facilitator of all matters nursing*
- *Link with community Trust management."*

Source: PowerPoint transparency 98

"I see my role within the practice as a focal point for all matters of a nursing nature, to coordinate the practice third team. Research has proved that one of the main barriers to effective team working is the fact that we all come from different cultures and have different employers. Posts such as mine will bridge that gap,"

Source: Ann 98

I noted that Ann as a core function of her role did not identify delegation to nurses of roles carried out by doctors, and yet I picked up that from the perspective of the practice management this was essentially the prime purpose of the project.

5.2.7 Attempting to clarify the Nurse Team Coordinator role.

Ten months into the role the opportunity arose during the annual appraisal review process.

"A lack of clear direction was identified by Ann as her main constraint. We discussed this and agreed that in hindsight, more direction could have been given. However the lead nurse post has the autonomy and 'flexibility' to choose which subjects to concentrate on as long as they are for the benefit of our patients. That said it was suggested that Ann may wish to consider concentrating on Family Planning/Menopause clinics, epilepsy, and elderly surveillance. It will be for Ann to decide the priorities she wishes to place on these subjects and then advise the partners accordingly. Following this she will have the opportunity to update the partnership on these subjects at partners weekly meetings."

Source: Annual performance review 98

This was explored further in a dialogue between us

"Ann often talked about feeling deskilled in her new role, even meeting her two years after the end of the project this is the aspect she remembered most. What did she mean by being de-skilled? Her professional background had been as a district nurse; she had taken a postgraduate diploma to enable her to be a specialist practitioner in this field, and then completed her study to degree level. Her expertise had developed in district nursing and in the terms of current thinking she had become an 'expert practitioner'. Expertise brings a sense of self worth to the individual, a sense of knowing a body of knowledge, confidence in one's own decision making a sense of autonomy and personal comfort. The role of the nurse team coordinator was a leadership role. Ann felt a novice, and all her pre and post registration training hadn't prepared her to be a leader. An assumption had been made, as often is, that as she had been a ward sister consequently she had the knowledge, skills and attitudes to be able to lead and manage. In many ways she probably had, although experiential learning is not always valued, and the mechanisms are not always in place to enable people to develop the learning from experience. This is what was going to be different about this project at every stage the learning could be explored in the context of the individual and the team. But learning from experience itself can be threatening, and expose a vulnerability that isn't always welcome, reflecting on experience to illuminate learning has to be a learned as a process without the emotional baggage that learning from poor performance or mistakes can engender."

Source: Reflective Journal 98

During this time I had to challenge myself and clarify my role, between action researcher, change agent, clinical supervisor, counsellor or friend? In written reflections it was obvious the Ann was grappling to make sense of the role she was in.

"Has been good for me to visit patients at home again...it has a grounding effect! Really highlighted the positive aspects of the NTC post and how my skills are utilised. For instance, on visiting patients in a residential home that Jo had identified as needing nursing care I was able to use my district nursing interpersonal skills to detect some reservations on behalf of the staff and manager toward an individual in the district nursing team. Jo is already aware of the problem but because, in my NTC role everything and everyone is relatively new I sometimes miss the more subtle nuances within the practice team. I have felt that my awareness of the relationships and the dynamics has been dulled by the weight of so many new situations. My feelings were akin to those I experienced when I made the transition from G grade ward manager to full time district nursing student. Although, in that case, the movement was, in terms of other people's reaction to me, a downward one, people saw the student uniform and treat me in a different way to that which I experienced in the navy ward manager uniform. I was in a totally new environment with new networks and new goal posts; this had a curiously deskilling effect. It emphasised to me how important the networks and support systems that come with local knowledge are. How naïve of me! Or is it rather the opposite...was I so confident in my interpersonal skills I felt I could just function equally as well in a totally new environment as I had in my past post. Either way wasn't realistic. Writing is ...cathartic, is that the word? Reflection really clarifies the muddy water.

Source: Ann Feb 98

And also of the autonomy to do things in her way and style that had been asserted as key to the role.

"Whilst I was on leave Joan presented the nurse's suggestions for shared care to the partners meeting and they had identified lead GP's for each section. The community staff nurse pilot for May had been discussed but when I eventually received the minutes of the meeting the way in which it been discussed made me momentarily angry and frustrated at the language used."

Source: Ann April 98

This potentially negative situation led to discussion and resolution of some of the conflicts but proved an opportunity for growth.

"Have several items to discuss with Joan – trying consciously to involve her in nursing decisions by running ideas past her initially. I feel we are working together more closely, on a personal basis, as well I feel confident in my dealings with her. Recently this has been a recurring feeling, of being accepted as part of the general practice environment. It's a real confidence builder. I think much of my feelings of concern were self induced, I wanted to be as effective as possible as quickly as possible"

Source: Ann May 98

A lot of the work around the norming and forming stage of the project was around developing appropriate professional relationships that were true to individual values and identity.

Developing professional relationships with the nursing team also had some undercurrents, which were often observed with abrupt mannerisms rather than actual words. A pattern that will emerge through this work is how the nurse team coordinator through her leadership style was able to promote more open and accepting working relationships.

"Beth's manner has been warmer and softer recently? cause,

- Has finished course with excellent marks*
- She applied for the NTC post. I felt she possibly saw me as a threat to begin with, especially as my first task was the practice nurse review!, she may now feel more comfortable with me. She has suggested we go to Yoga together*
- Did I feel threatened by her? I don't believe I did but her sharp manner provoked a reaction in me. I was very conscious of 'guarding' because the last thing I wanted to do was mirror her behaviour. Recently I've taken the line of 'you seem a bit distracted this morning, have you had a bad clinic? Etc.*
- Have tried to develop more of her management skills, as she is a G grade, encouraged her to take on, or rather keep, some aspects of the Practice Nurse role she seemed to want to hand over to me. Double edged sword! But I felt it may make her role more definite and rewarding, I believe G is a very real management position. Also defines my NTC role more clearly, i.e. the day to day running of the practice nurse team is the G's responsibility"*

Source: Ann February 1998

Changes in behaviours were the emerging result of changes in professional relationships within the nursing team, and the development of trust and respect in the team and its leadership. This could be developed further by raising the awareness of why changes in behaviour were occurring and the positive impact on team well being.

5.2.8 Introducing reflective practice and my role in the practice.

This represents my concern that reflection and informed decision-making needed a 'kick start' in the practice. This was important to me because of my deeply held belief that change that was sustainable would only be achieved through collaborative dialogue, and the research method selected had so much potential to achieve positive outcomes both personally and professionally for all those involved. This also required me to reflect on my role in the practice and what is now evident as my wish to see the nurse team coordinator succeed!

"Ann I thought it would be helpful if I wrote down a summary of what we discussed on Monday.

You will keep a fairly accurate journal detailing your activity. The content of what you did is more important than the time it took you to do it. Part of the evaluation is to try and explore the reasons behind your actions, why you did things, where did the knowledge come from, was it risk, intuition, because of the outcomes from a similar previous experience? To do this you need to be aware of issues to do with reflection in action, and try to 'capture' those 'moments' so that you can reflect on that action later on, either on your own in reflective writing or with me or with anybody else you wish, it is up to you to decide. The idea behind it is to look at what is expert practice, in line with Patricia Benner's work, and will give some validity to the appointment of an H grade. The discussions will also help to develop your role, so it can be moulded to use your expertise and in turn redefine the activities of the other nurses and personnel in the practice. To help with this I suggest you use a Dictaphone to try and capture things as they happen. Don't bother about the language, because the way people use language to help interpret thought is also useful, so consequently it is better to be entirely natural and to resist temptation to tidy things up!!!

Source: Sue May 98

This was followed with a multi disciplinary nurse team meeting on 17th June 1998, where I gave a presentation on "Reflective Practice." All the nursing team were present, one GP and

the community manager. I took the opportunity to discuss the principles behind the idea of 'Learning Organisations' (Senge 1990) and the discussion of three models that could be used to apply a reflective framework to everyday activity. This included structured reflection around critical incidents. Following this meeting I was asked to do the same presentation on Learning Organisations to the whole practice team, this resulted in a new enthusiasm for development in the practice.

This intervention by myself seemed to have much more of an impact than the early meetings I had had with the practice to share my research methodology. I believe this is because I had been through a process of norming and forming my action and role as I developed understanding of the dynamics within the practice. My confidence had grown and my developmental journey within the context of the enquiry requires to be articulated to fully appreciate the developments and changes which came about through 'New Nursing Leadership' Looking back to the first meeting at the Healthcare Practice on 21/12/97 just before Christmas. I went to the meeting with my agenda strongly influenced by the importance of getting my methodology accepted as demonstrated by the text from my reflective journal

"This was perhaps one of the first major choices I made, I was aware that I was acting out of role for myself, I know that I want to please people and be accepted. Here I was with a group of GP's and I recognised that the cultural and power issues were as real for me as any of the other health professionals I would be working with. This would normally have the potential to intimidate me and defer to their presumed superior knowledge backing down easily when challenged. I struggled enough in this respect to cope with challenge and not back down when I knew the subject matter well, but in this research paradigm I was very much a novice. In some ways this meeting was a take it or leave it approach to the practice. Another HEI had also been asked to express an interest and the Health Authority was to make the final choice. So there was a bit of safety here, I had pushed the boat out with a full-blown account of how I would conduct the research. If they didn't like it, they could always go to the other party...and I would escape! Or if they accepted our proposal it was very clear how we intended to run the project. I soon found I would have to be on my guard to ensure that the project was not steered back into more traditional ways of working."

Source: Reflective Journal December 1997

The meeting went reasonably well, one of the GPs was fairly challenging hostile and aggressive but I held my ground, all the time 'reflecting in action' on my behaviour so as not to give away too easily my nervousness and personal doubts both about my personal competence and my belief at the time in the research methodology. Later on this GP became a real convert to this way of working, very supportive of the developments and a catalyst for developing more collaborative activities in the local healthcare economy. An extract from my journal evidences the above statement.

"Paul was the key GP behind this initiative, he struck me at the first meeting as the academic thinker of the practice, who used big words and solemn looks to try and make others feel inadequate. He had a very positivistic approach to research and believed that evidence could

only be supplied in positivist terms. He seemed rather young (to me mid 30's) serious and hungry!

The initial meetings were to explore the ways in which the integrated nurse team project could be evaluated, the assumption being that before and after statistics would be collected and shifts demonstrated. I was opposed to this approach and the background has been fully explored in a previous chapter. For the first year of the project I continued to feel quite threatened by Paul who I believe saw little value in my approach.

However things changed roughly at the end of the first year and Paul became one of my greatest supporters in the practice and a new convert to this type of research. He would also fit my category of a member of the practice whose life outside of work was closely interrelated into his values, beliefs and passions at work. Paul and I found that we shared some of this and consequently this is interesting in the research as to how individuals develop individual capacity to survive grow and develop in organisations. Especially linked to the concepts of belongingness and alignment with strongly held views and purpose. What was interesting was that Paul and I were some way along the journey of joint enquiry when we both had the confidence to share some of our deepest personal beliefs with each other and to value and challenge them in the light of the activity at the practice.

Suddenly for me I had a frame of reference in which I could understand Paul's behaviour but that was because I had a similar thought collective. The challenge for me was in recognising and challenging my thought collective or personal construct so that my way of seeing the world prevented the research from being presented and analysed in as unbiased way as possible. It would be interesting now in hindsight to have focussed my research on illuminating the different thought collectives that contribute to a multiprofessional team."

Source: Reflective Journal August 2000

When considering 'new nursing leadership for the nursing team' and reflecting on all the data collected it is evident the key personnel in the practice had a very significant impact on what in reality happened. The dialogue referred to above in the text indicated some of the communication given out by one of the GPs but he was not the only powerful person in the practice.

"First impressions count for everything, or so it seems is the general thought collective, that's perhaps if you're not reflective enough to challenge those first impressions and make more sense out of them in the light of new knowledge. The way we see the world can be so conditioned by the unconscious boundaries we put around things and the ladders of inference we then make. The work on mental models interacts here, mental models about the practice that I will challenge if I am to be a challenging catalyst for change within the environment.

Well Peter fairly well built guy, wearing striped shirts and busy ties, quite attractive in a funny way, middle fifties with a persona of being the boss. I found this quite interesting, a lot to do with authoritarianism and the impression of power, a useful tool in a practice that was talking about equality of individuals and yet deeply ingrained were the traditional power relationships. You soon found out that Peter had an army background, not just the army but the SAS, that gave him legitimacy for being up there with the partners and also as being a public servant, not just an ordinary public servant, but the Paymaster for the main SAS establishment. Retirement comes relatively early in the army and then career choice may be difficult, Peter had sought out the job of practice manager, he was determined to make a difference and put it on the map, but his part in that needed to be made clear and explicit. Was it achieving the outcome that made him move on! Possibly this influenced his decision but then like so many things in life work cannot be seen in isolation from relationships and personal growth and identity. All issues contributed as it did to the complexity for other individuals.

Peter had perfected his stance of using power; his body language was laid back but with piercing aggressive eyes, with the sense that even if he wasn't actually looking at you, he was. Going into the building you could sense his presence and I was oddly on my guard, I recognised that I always checked the car park to see if he was there. It became apparent that others did that too, the atmosphere was different when he was there, but in some ways it was a healthy fear built from respect and a desire to please and to be recognised to be competent. This became just as much an issue for me as it did especially for the nurses, receptionists and the administration

staff. The partners handled it differently, they seemed more secure in their professional knowledge base, being a doctor credentialed them, they didn't see him as a rival, but certainly at times as a force to be reckoned with as he blocked their ideas, or vetoed the spending plans, but nevertheless they recognised that his tactics worked when getting money out of the health authority and subconsciously recognised that his advantages outweighed his annoyances. In fact he became the leader of the organisation, the natural leader although he interpreted this as his role. He was not the named leader this was a senior partner whose leadership role in action was negligible, but then did he need to exert the leadership role when it was ably done by another individual who then became the focus for the complaint and challenge that goes on in any organisation.

Peter had the charisma to be a leader and in some ways was transformational in his approach but he wouldn't admit to this, certainly in the early days. He had traditional views of management, and reminded me in many ways of tendency towards the Macgregor X theory. He was well grounded in his perspective of women's roles in organisations and sometimes this did not sit comfortably with modern day political correctness and equal opportunity. Women were to be admired, but not if they wore trousers, either in the physical or metaphorical sense. The female staff were only allowed to wear skirts, and although this was an issue that on several occasions came to light he wasn't openly challenged on the perspective. Even the female GP conformed, it was as if her competence as a woman was being judged rather than her competence as a doctor. Joan and Peter frequently had strong disagreements over actions taken, these would lead to heated debates but the pattern that emerged was often a passionate argument and then a negotiation of outcome. The issue would lead to closure at a more personal level, a drink at the pub or a meal out or some more natural activity, it was if the male female issue was very powerful here, but both of them recognised it and it worked for them. Is this so inherently wrong? Perhaps I use the same tactics too if in a situation there is a mutual attraction at a subconscious level. As the time continued I might have reacted in the same way, the pattern was set in his behaviour especially when he knew he had been on the attack! When it came to the final draft report I had used a diagram he didn't like, Peter got quite aerated because he took it as a criticism of his management style that I hadn't understood, in actual fact the GPs said that in fact I had understood too well and consequently the outburst. By this time I was able to stand my ground, afterwards came the phone calls, the birthday card and the cake, as if to say no hard feelings, but it was really his way of feeling better. We had several opportunities to talk at this level; he wouldn't let me use a tape recorder, so I tried to take copious notes soon after the event. The role of counsellor struck my mind on the latter occasions, but the bond had been created, which would end naturally as he left to work in the West Country."

Source: Reflective Journal 2000

This further highlights the different perceptions and agenda at the beginning of the project, I was an outsider with my needs and demand to be met, at this time I didn't own or understand the culture or the collaborative nature of the research. I talked about cycles of enquiry and reflection but I don't believe I made it meaningful or relevant to the group who would be partners in the journey.

The above text exemplifies some of the tension in action enquiry as a means of research and change management that I was aware of through the process of this developmental enquiry. My experience and sense of direction, influenced by my knowledge and the literature on reflective practice was the impetus for the developing focus in the practice. I dealt with this through dialogue and information with the key personnel, the most significant of whom was the nurse team coordinator. I was very careful that the direction of travel was fully

agreeable to the practice personnel, and as such my role was guide and mentor. Having said this I do believe my presence and influence could also be classed as 'new leadership for the nursing team'. Consequently this work will not be complete if my 'leadership' style is not referred to with some analysis in the later chapters of this thesis.

5.2.9 Developing reflective dialogue

The following text aims to give examples of how reflective dialogue emerged with the nurse team coordinator as a means of ensuring that leadership came from the 'right person' to the nursing team. This also identifies the personal mastery for the post holder who became able to articulate in writing and on tape the reasoning behind decisions and the reflective process.

Ann: Yeah yeah, the other thing is as well we're now looking at practice nursing hours again.

Sue: OK

Ann: sorry go on- how can I put it to jog my memory?

Sue: Group supervision, to look at issues when workload gets too heavy.

Ann: Yeah, and it would be nice to be able to do this. Because quite often what happens is that they'll talk about it on their own in little bits, and they'll moan and say oh were expected to do far too much, and they don't understand and the rest of it....it would be nice to discuss at our rapidly becoming redundant nurse meetings

Sue: So these redundant nurse meetings could actually be used in a more uhm, developmental way.

Ann: Is that verging on clinical supervision then?

Sue: Yes it could be.

Ann: It is isn't it?

Sue: I mean it depends on how you interpret clinical supervision. I mean it is about the clinical bit of doing your role, but actually it's a support mechanism too.

Ann: Yeah that's right.

Ann: To a certain extent that's what happens with the mental health liaison meeting. That's with Paul and the counsellors, and most of the nurses actually its really well attended, and we actually discuss clinical issues that we have. Its not a case conference and we don't actually mention names, its just how we felt about how we handled the situations.

Sue: That's really good.

Ann: To a certain extent within that group, I think that nearly every individuals come up with something that's almost like soul bearing about how we felt in that situation. How. Most of it feelings of inadequacy to be honest because nurses don't have to know much about mental health issues. Uhm so in a way that's possibly been a bit of learning situation to go on to something like this. They are all familiar with this sort of approach.

Source: Sue and Ann 1998

This dialogue also demonstrates the clarity that was emerging around my role in the practice; I was keen to model a 'critical friend' approach rather than an academic expert. This took a while to become clear in the practice, as traditional roles of expert and researcher were perceived in the context of this change management process.

Examples have also been captured of how thinking reflectively leads to action.

"Realise that I never reflect on the many interactions with other non-nursing staff. The interactions, which are the most influential I suppose, are between the Partners, which tend to be clinically based apart from day to day exchanges, and with Peter, Wendy and Mu. With Wendy it's often about staffing problems in reception, difficulties I have had with doctors or

personal stuff. I rarely feel the need to discuss innermost thoughts with people at work but every now and then Wendy and I have short but deep discussions about our personal lives. Its as though there's a common consent to go just that bit further, delve just a bit deeper and only sometimes, not on a regular basis. I do feel able to be open with her.... about most things.

Source: Ann June 98

This growing ability to be more reflective also enhanced decision-making in the complexity of the management role.

"Greeted by Wendy, in a stew, she had spoken to Jean, Health Visitor, on the stairs who 'told me their going to reorganise the appointment system. It is in my staff's contracts to do this, can you sort it out, they can't just come along and do this'. Classic communication failure but needed 'sorting' as Wendy appears to be really stressed out and can do without extra problems. Same easily resolved, Judith and Liz (receptionist) to meet to hand over all making of appointments to reception thereby releasing Judith from clerical duties. Wendy happier".

Source: Ann June 98

My desire for reflexivity to be part of all interaction for the nurse team coordinator was becoming a reality.

5.2.10 Challenging the practice to define what it meant by leadership

By the middle of 1998 I started to share my reflections with the practice team, within the context of a practice meeting. By this time I felt I was accepted as part of the practice, but this also was a challenge. Within the context of the relationships I was feeling that I was being seen as the 'leader' of the change process. To be true to the enquiry process it was important for me to ensure that I did not take on the role of 'leader', which would have probably seemed comfortable to the practice. Instead I asked the following questions of the group as we reflected on the first months of the project. The questions were as follows;

"The Key issue is leadership

- What does the practice mean by it?*
- How does it practice it?*
- How are decisions made?*
- Is self-management a reality/possibility/requirement?*
- What are the options?*
- What are the problems at the moment? This relates to the length of time decisions take...to be made.... to be implemented.... to be continuously evaluated.*
- What are the core tasks of the practice?*
- What are the added extras?*
- How is this dimension handled? What about the principles of a self-managed team what do patients see as core? Added extras? What are there expectations, essential and desirable?*
- Meeting structures; are they affective?*
- Are they necessary?*
- Are their alternatives?*
- What about audit? Continuing education? Patient involvement?"*

Source: Sue Journal and notes 98

The outcomes of the activity to answer the questions will form the basis of Cycle 3. Developing a shared understanding of leadership. This cannot be fully explored until Cycle 2, Group Forming and Norming challenges has been illuminated.

5.2.11 Cycle 1 Summary

Cycle 1 has explored some of the findings in relation to understanding the culture of the practice in respect of management and leadership practices. During this cycle new strategies were introduced to enable the participants to challenge their own and each other's thinking. This cycle has also uncovered some of the hidden tensions that would impact on the change process.

5.3 Cycle 2: Team Forming and Norming Challenges

5.3.1 Introduction

This cycle ran alongside the Cycle 1 'New leadership for the nursing team' and the illustrative examples that follow give some insight into the tensions and actions that developed as a result of the process of change within the practice. During this time, which related to predominantly the first year, 1998, I collected documentary evidence in the form of memos, reports and meeting minutes in addition to individual meetings with members of the various teams and with the teams themselves. In the Glynn Jones report in July 1997, it stated that 'the Practice was clear that the way forward was to appoint an experienced nurse to co-ordinate the nursing team.' The decision to call the post a 'coordinators post' was intentional, the team of nurses being reluctant to consider the term nurse manager or leader. In exploring this further within the practice it emerged that there were differences in understanding into both the terms and the roles of people who held the role of leader and manager. This early exploration was prior to the opportunity I have had to reflect on the two years of the project and to analyse the underlying dynamics that were not necessarily evident at the time.

"Yeah whether we want a self managed team (of nurses), if you want a self managed team of the nurses then its looking at the moment that its very much the leadership from Ann and them not necessarily taking responsibility, they should be taking responsibility for maintenance of their own individual roles but they don't. Then again, its early days. They're not taking personal responsibility for innovation and issues that affect the whole nursing team, let alone the whole practice.

Source: Transcribed tape from project evaluation meeting July 98

"They didn't have a voice (the nurses) but now they dump quite a lot on Ann "

Source: Transcribed tape from project evaluation meeting July 98

"Another thing that I am finding is a bit consistent in different types of reports and things that have been done in the practice, officially its all great and everybody has said yes we want to do it but when it comes down to within the nursing team, their individual responsibility, that is where I think more work needs to be done."

Source: Transcribed tape project evaluation meeting July 98

"I think you know because you are a sensitive person, but basically people have got their own agendas, and what gets lost is the practice agenda. Basically you know you have got to be disliked at times because that happens to managers. So they had their point of view in the Glynn Jones report and agreed the consensus to go forward and what's happened as you go? When you go to push the boat out, people say 'oh hang on a minute, the windows aren't in, and its how much time the manager gives to that, rather than saying to them, you have had your go, lets try it, this is a trial, lets see how it goes, if it doesn't work we will come back to that, but otherwise the boat never goes out."

Source: Peter speaking mainly to Ann, transcribed tape, Project evaluation meeting July 1998

As a nurse team coordinator the post holder was expected not to undermine professional autonomy by co-ordinating aspects of what could be considered to be a self-managed team.

This (my original report stated in 2000) did have its benefits especially in the early stages of the project where individuals were becoming accustomed to new roles and their individual place and value within the nursing team. The disadvantage initially was that the incoming post holder took a while to ascertain her level of authority for initiating change and the leadership role within the nursing team to drive change. This issue was recognised and resulted in collaborative dialogue between the practice manager and the lead GP for nursing. The outcome was more of a shared understanding, although not necessarily agreement! of the parameters of the role and objectives agreed.

The nurse team coordinator who was new to the practice recognised that significant team building activity had already been achieved. This had included the setting up of monthly primary healthcare team meetings for all practice personnel and all staff had participated in determining their compatibility and strengths by using the Belbin (1981) roles approach to team analysis.

However with all the good will the reality of integrated working had not been achieved mainly due to the way roles were defined and understood and communication structures that hindered rather than encouraged interdisciplinary working. The definition of what a team was and how teams were constructed in the practice had to be understood in the context of interdisciplinary working. Initial tasks undertaken by the post holder related to developing effective understanding of different roles within the nursing teams, sharing the realities and constraints of these roles, and in conjunction with managers from the Trust initiating efficient communication structures.

This was achieved in the first six months by:

- *Setting up a monthly meeting for the nursing team*
- *Reviewing the activities carried out by the practice nurses, including the availability of practice nurses to cover longer hours and key clinics which would lead to improved shared care with the doctors, a shift to greater care being delivered by nurses and increased availability of services to patients*
- *The development of the role of community (generic) staff nurse*
- *The development of the role of a B grade nursing auxiliary to carry out a phlebotomy service within the Practice*
- *A review of the role of the nursery nurse who supported the health visiting team*
- *A review of the system for documenting patient and client encounters*
- *Work load analysis for all nursing teams*
- *Good liaison with the designated manager for the Trust staff, who agreed to Individual performance Reviews (IPR's) being performed within the practice focusing on the objectives for the integrated nursing team. Appropriate feedback mechanisms to the designated manager were agreed*
- *Developing clarity relating to the strategic vision for the nursing team*
- *Developing an appropriate representation strategy to the doctors within the Practice*
- *Developing and strengthening an understanding of the benefits of reflective practice and clinical supervision*

- *Developing shared protocols for the care of certain groups of patients*
- *Focusing significantly on mental health care within the practice population*

Source: Allen (2000:11)

These achievements were not without their struggles and the following 'patchwork texts' identify the processes and challenges in the forming and norming of the nursing team.

5.3.2 The practice nurse review and related issues

This was the first change process that the newly appointed nurse team coordinator was involved in, and became an initial learning experience. The practice nurse review related to skill-mix and delivery of a timely service and led on from a meeting in March 1996 when it was established that some of the work done by practice nurses could be delegated to other healthcare workers. No actual action was taken to implement the changes at this point, and this issue is a demonstration of how the presence of the nurse team coordinator could effect change in the practice. An option appraisal was carried out with the preferred option being presented to the partners. This option was presented to the partners by the lead GP for nursing rather than the nurse team coordinator and was an example of the dynamics that evolved in the power relationships between the NTC, lead GP for nursing and the Practice Manager.

"Joan had presented the nurses' suggestion for shared care to the Partners meeting and they had identified lead GPs for each section. The Community Staff nurse pilot for May had been discussed, but when I eventually received the minutes the way in which it had been discussed made me feel momentarily angry and frustrated at the language used. Joan says it's 'just a turn of phrase'

Source: Ann April 1998

In accepting this option all the practice nurses were involved in a reconsideration of how the most effectively timed service could be offered to patients. This situation became a focus of potential conflict with avoidance strategies put in place to prevent disharmony, but which also hindered the required change.

Tensions in the relationship between the lead GP and the nurse team coordinator were evident during the practice nurse review.

"We need to move forward on this. Over the past few weeks, Beth, Angela and I have briefly discussed some options. Beth produced a rota based on these discussions to which I have made some suggested changes. I have given Beth, Angela, Jo and Jan a copy of these so we can discuss them over coffee tomorrow. Apparently, I've heard it on the grapevine there are strong anti-feelings. I would like to run tomorrow's session alone as I anticipate a lot of personal stuff being brought into it, which I want to put into perspective for some of the people concerned. Do you mind not being involved at this stage? I do feel that this is something I should handle."

Source: Informal memo 20th July 1998

"A long discussion about the change in practice nurse hours. Joan said the proposal would not be acceptable due to the fact that there is need for Family Planning on Mondays following any accident over the weekend. Therefore a new proposal to be written and submitted..."

Source: Multidisciplinary nurse meeting notes 29th July 1998

The nurse team coordinator then went on leave and during this period the lead GP for nursing and the practice manager implemented a decision! In a memo dated 3rd August 1998. This caused considerable concern to Ann (NTC) who felt that her leadership and management role was being undermined, and in turn this further illuminated power issues within the practice. Further examples emerged which challenged the autonomy of the nurse team coordinator in relation to the lead GP for nursing,

"Joan had already rung Angela to ask why Jan was working in Beth's room. I e mailed Joan to clarify, but I do feel she was more abrupt and interfering than was necessary"

Source: Ann May 1998

These examples had a potential disabling affect and yet through reflection were able to be recognised and dealt with.

"Have several items to discuss with Joan – trying to consciously involve her in nursing decisions by running ideas past her initially. I feel we are working together more closely, on a personal basis, as well I feel confident in my dealings with her. Recently this has been a recurring feeling, of being accepted as part of the general practice environment. It's a real confidence builder. I think much of my feelings of concern were self induced, I wanted to be as effective as possible as quickly as possible...I read somewhere that it is much easier to be self critical than to recognise ones qualities!"

Source: Ann May 1998

Meeting the many agendas was a tension the NTC had to handle and she did this well given the impression from the practice manager, and implied by the GPs, that things were not moving fast enough.

"Received partners comments on evaluation – initial feelings; 1. Disappointment – I don't seem to be as effective as they would wish. 2. Do they understand qualitative research? if not we are going to lose so much of the in depth, interpersonal stuff such as team building, personal challenges the girls have faced, conflict within the teams etc. 3. Senior partner very supportive -surprised- I have felt least supportive contact, least contact full stop with him. 4. Pushy personality transplant required-for me! I feel the comments to be constructive, but generally critical. I'll have to have a long walk with the dogs to sort out my feelings – my usual therapy is climbing a fell, sitting atop and talking things through with myself – difficult in the Midlands!"

Source: Ann May 1998

"Meeting with a stressed but friendly Peter who wanted to discuss how I felt about my relationship with Joan – not something I wanted to share at that time – but as he explained, as manager he was involved in all aspects of the practice team and he felt it was important to be aware of any tensions. Fair enough but I really felt it was a personal matter between Joan and myself. Needless to say I shared some of the situation with him, because I was simply fed up with it all. He put what he saw was a balanced view forward, I listened, for some reason felt totally peeved with the whole affair, didn't realise it had got to me so much and agreed to the personality transplant!!!"

Source: Ann June 1998

The relationship with the practice manager and his preferred style of written communication at times had a disempowering affect on the nurse team coordinator.

"Thank you once again for this most comprehensive list which I found most useful. I am quite clear that you are going on the right road, but if you feel you are getting into a hole then you must ask for help to get out of it"

Source: NTC Draft Objectives June 1998

Again management style in communication was an area for discussion that can mitigate against motivation and development in personal and organisational contexts.

5.3.3 The community (generic nurse) staff nurse

This initiative had also been discussed previously within the practice and had been a recommendation from the Glynn Jones report. The appointment was from within the current district nursing team, an E grade part time staff nurse, who had expressed a desire to develop this generic role. Training was recognised as a key component to the success of this role and several different models were attempted to ensure that community-nursing demands were met and that availability initially in the treatment room was at optimal times. Initially the days were split in half but this was found to interfere with the quality of supervision available after a morning in the treatment room. The post holder also commented that she felt split in two rather than providing a seamless professional service. It is important to recognise the stress attached with taking on new roles and the tensions relating to the UKCC Code of Professional Conduct. Professional identity was also an issue and it was interesting that in this situation as well as in others, identity was tied up with being a district nurse rather than a nurse. The illustrative examples that follow identify issues within the 'whole system' for the district nurses, who perceived they had lost a member of their staff to do a different role in the practice and at the same time had a new team leader who was settling into the role.

"Changes were introduced quickly with little regard for the feelings of the practice staff. Both of the district nurses had thought about leaving rather than confront the issues. Meetings to discuss changes were difficult but did allow an opportunity to 'clear the air'. The emerging roles in the community staff nurse role and phlebotomy roles were causing the feeling that holes were appearing in the quality of the district nursing being given and the remaining full time district nurse (not the new team leader) was feeling dumped on. Both the individuals in the newly developed roles expressed that they 'felt it was an expectation of the practice' and 'if we refuse we will be considered to be deviant'"

Source: Meeting with District Nurses April 1998

"Things have started to emerge that they are worried uhm, Penny is worried about what she was giving up and what Jan was giving up to do the other bits and it, it came out that there was quite a lot of, I'd be over the top to say resentment or anger, but certainly irritation from Sarah, that she was going to be lumbered with everything and that there might well be times when she feels she cant actually give the quality of care that she wants to, or she cant stay and talk to a family a bit longer like she could have done, because there will be all those other things to do."

Source: Transcribed interview May 1998

Analysing all the transcribed tapes and meeting notes, it would appear that the issues were mainly about

"the team being interrupted and that they were used to working with each other and therefore that made life easier. New people coming in disrupted all that".

This is an example of the shift that was required by all members of the nursing team as they adjusted to taking on the more generic role of community nurse rather than the disciplinary labels that have become a hierarchy within nursing. As the community staff nurse became more skilled and competent in the role so her confidence and job satisfaction increased. The other dimension of the community staff nurse role has been to work across the boundary into health visiting practice by taking the weekly baby immunisation clinic. The community staff nurse is supported in this role by the nursery nurse, who has significant past experience in neonatal and childcare. A health visitor is always present in the building ready to be called if necessary but is able to carry out other tasks relevant to her professional role during this time. This arrangement is seen to be entirely acceptable to parents who attend with their children. The following examples demonstrate how the role has improved the service offered to patients and clients:

"A woman gave birth to a son by caesarean section and subsequently developed a wound infection. The community staff nurse was involved with daily dressings at home and then, when the baby was brought to the surgery for his first immunisation the community staff nurse was able to check the mothers dressing and complete the immunisation in one consultation."

Source: Allen (2000:13)

The community staff nurse who works in the practice had identified several patients who no longer need a home visit and now attend surgery for wound dressings etc. or required a home visit as the journey to the surgery is becoming too arduous.

"Mrs. D is an elderly lady who had to book a taxi twice a week to attend the practice nurse session. This added to her increasing frailty making the journey something of an ordeal. The community staff nurse was able to offer a home visit thereby providing continuity of care and a more appropriate option for this lady. Although this example may seem rather simple, the community staff nurse recognised her empowerment to work across the traditional boundaries of the Practice and Community Trust, thus supporting more effective seamless patient care."

Source: Allen (2000:13)

The community staff nurse has also been seen to bring added value to the practice based nursing service, due to her specialist expertise she had developed as a district nurse. For example the practice nurses occasionally see patients who have identified continence problems.

"Mrs. K was such a patient, 51 years old and acutely embarrassed she was able to receive prompt treatment and advice from the community staff nurse due to immediate referral from the practice nurse."

Source: Allen (2000:13)

Not only were services becoming more user friendly for patients but nurses were becoming more able to make decisions, which improved their own working environment and were proactive in respect of patient care.

5.3.4 Introducing Phlebotomy into the role of the B grade Nursing auxiliary

Attached to the practice was an experienced B grade-nursing auxiliary who was part of the district nursing team. Due to changes in skill mix and expectations, concern was around about the potential of the current job role to remain satisfying to the post holder; this was acknowledged at several levels within the organisation. Initially the post holder was reluctant to take on this new role. This was expressed as mainly related to feelings of inadequacy and the development of competency in a skilled task, although interview data gave some deeper concerns.

"I found it very very stressful and had to have some time 'off sick' I had to think about where I could go to be out with patients because that's what I wanted to do and that's why I changed jobs (from an outpatients department at the local general hospital) But then I think I rationalised it by saying that this is a happy practice, its probably the same everywhere and I will just have to make the most of it as my job is no longer there"

Source: Penny, transcribed tape May 1998

However the practice had not just been focussed on task in defining this new role for Penny.

"Ann: I tried to reinforce it with Penny now it'll be interesting to see whether she's taking that on board as well, that we mustn't let it become such an overwhelming pressure, Because she does take things very much to her core really doesn't she? Yeah yeah, because it becomes totally out of proportion to what the thing is in the first place. And really the original thought was to uhm as we've said before to sort of widen her role, because we realise that her district-nursing role was being eroded. And the practice do value Penny, because she is a very popular person with the partnership and they want to keep her in the practice"

Sue: Has anyone actually told her that?

Ann: Well I feel, I felt sure I had done.

Sue: Right OK.

Ann: but this is prior to your conversation with her and I'm not sure whether

Sue: Whether she heard it?

Ann: Yeah. Because I did actually, I said she was very much valued by the practice, by the partners and this was an idea of theirs to actually, but she's not heard it. She hasn't.

Source: Transcribed interview May 1998

Special training was set up which was eventually accessed through reconfiguring workloads, and again as competence developed so did job satisfaction. The patients appreciate a timed service and the practice nurses were now released to carry out more appropriate tasks to their job description. Initially concern was voiced that this person being untrained would not recognise hidden signals in people who may have other issues that may be dealt with through the opportunistic event of having blood taking. It would appear that this fear is unfounded. The practice nurses are always available in an adjacent room and several examples have been highlighted where the insight of the post holder has been invaluable

"During a phlebotomy session in the surgery the auxiliary nurse noticed that the teenage mother who had come to have a blood test did not seem to be responding to her 9-month-old baby. The child wasn't held properly with his head 'lolling' and unsupported. His whimpering seemingly unnoticed by the mother. The auxiliary nurse made general conversation about the baby, admiring him and noted the mother's attitude. After the session the auxiliary nurse spoke to the practice nurse and together they sought out a health visitor, whom it transpired had

concerns about the mother, having completed the first Edinburgh Postnatal depression scale. The health visitor visited the mother and further help and support was instigated."

Source: Allen 2000:13

The post holder has been involved in the mental health developmental training within the Practice and the meetings and exploration of reflective practice. The post holder had developed an efficient, economic and effective service as indicated by the figures discussed later. Through the confidence gained in this experience the post holder commenced on the way to achieving the outcomes for NVQ Level 3 in Care.

5.3.5 Communication

As the year progressed patterns of communication became more accepted and recognised. Different groups within the practice were feeling the benefits of the appointment of the nurse team coordinator. This was especially significant for the reception team. The reception team reported that they were able to contact one person for all queries relating to nursing, this enabled them to be more confident in their role because they knew that patient referrals were being made appropriately. The nurse team coordinator also spent time in the reception area, especially at the end of the day, to develop a sense of knowing of the complexity of the reception role. This physical presence enabled relationships to develop to the extent that reception staff felt they could ask what to them felt like trivial questions but in fact had a significant influence on their understanding of how things worked.

"Good to see the growth of the third team, makes my job much easier. Things are actioned quickly and efficiently, this is a happy practice, very few complaints, about 2 in the last year; all nurses are more approachable, better relationships with health visitors. They are able to discuss individuals in the families so as a reception team things can get picked up"

Source: Interview with medical secretary September 1998

But as often happens in the happiest organisations undercurrents do exist:

5.3.5.1 Coffee Time

The Practice had always met together at 'coffee time' each day. This was seen by many to be a valuable time for discussing patient care and protocol issues. It was also an opportunity for mutual development and support. During the course of the year some tensions arose around the purposes of coffee time, and this had led to some communication difficulties especially with the health visitors, who had been reduced in numbers by a reduction in NHS Trust funding. Action was implemented by the nurse team coordinator to restore the communication channels.

"Rod: I have less contact with the health visitors, they're helpful, they're good, I find the way of communicating with them irritating, with the district nurses they communicate by a book or rather I communicate with them by a book, and sometimes by ambushing me at coffee. The health visitors are adept at ambushing at coffee, I find that an issue, I feel we are

communicating on their terms, like them I work hard and I need a bit of space as well. I feel that it is being invaded"

Sue: Have you done anything about that?

Rod: Not directly, I have sort of made jokes and things, never bothered me too much to make a fuss about it, but probably would after events that have happened this week, were to continue, I haven't thought how I would go about that. I would probably say something straight to them. I think this is contemporary at the moment and for the partners I believe. Coffee time has developed for the time for the nurses to catch the doctors...I don't think that is unreasonable its just that if its 2 or 3 people or if there are other things going on such as if it's a duty day which is one of the most stressful days of the week for me.... people don't have to make appointments to see me but they could recognise that"

Source: Transcribed interview tape July 1998

"Increased use of message books, HV's joining the practice at coffee time, by reorganising one member of staff's hours to maximise use of time, and using coffee time as an opportunity to raise awareness of the contributing factors to poor communication by openly discussing contributing factors on all sides...This together with the developments of the temporary and bank contracted health visitors, should facilitate clearer channels of communication."

Source: Memo August 1998

Yet further enquiry in dialogue between Ann and myself revealed different understandings and meanings of coffee time!

" Sue: And I think it's because uhm going to coffee you don't go with a purpose, the purpose is very abstract isn't it?

Ann: Yeah it is, yeah but you do in many ways because that's a very valuable time.

Sue: That's right, but the whole issue is actually recognising, and I'm talking around it by talking it through, which is also quite good, its recognising this whole business of work ethic, that actually things like coffee time are a valuable part of work.

Ann: Yeah, yeah.

Sue: and it actually is valuable

Ann: yeah yeah, because that's interesting because the health visitors see it as a chance to call the doctors, whereas I sort of talk to Rod about holidays and things.

Sue: Right.

Ann: Uhm, the district nurses seem to be somewhere in between.

Sue: Well and I wonder, because I was thinking about this the day I came to see the district nurses, because I went up there, you weren't around, even though I had been up there to coffee before but, I feel really surprised at my own reactions, because I sort of waited in the health visitor waiting bit and sort of hung around or pretended to go and do something else, because I felt awkward about just going in.

Ann: Yeah Yeah.

Sue: Now I wonder with them whether, and perhaps its something we need to discuss when we get into the clinical supervision idea, is whether they feel if they go to coffee and just have coffee and they don't talk about anything that is really relevant, or they don't go in with a purpose whether they're seen to be either not busy or wasting time?

Ann: Which is a real traditional way of thinking isn't it? It's going on a ward and grabbing a bedpan or whatever.

Sue: So?

Ann: Yeah that's very true that, yeah yeah yeah. Because this was one of the issues that came up, when we had a problem with communication with the health visitors The GPs had seen it. And they felt they (The health visitors) were just using coffee as a time to ask them things. The only time we ever saw a health visitor was when more or less we were told about a child protection issue or something like that. There was no interaction whatsoever apart from things like crisis management. And that was part of Bella's problem, that feeling not able to manage the caseload. And there was criticism came on top of all that and Joan and Paul were quite vocal about it.

Sue: Right.

Ann: And then all the rest started joining, yes yes we are having problems you know. And naturally the health visitors were defensive. We can't just come in to have a nice little chit chat

at coffee and all this sort of thing. And that's, you've hit the nail on the head, that's how they see it.

Sue: But I think the coffee issue is actually quite an important thing for the practice.

Ann: Yeah yeah no I do see it as valuable because again its one of the few times that everybody, its so hierarchical, I think it always will be.

Sue: But you also probably feel more comfortable with it because your type of position transcends everybody.

Sally: Yeah and perhaps being employed by them as well.

Sue: But you've got the confidence to go up to coffee, and I know it all sounds quite silly really doesn't it.

Ann: No I don't think its silly, it sounds childish but that's how we are in reality, its sort of, it is. And because it is so deep and ingrained in us.

Sue: And it, that's really what this is about, it's unpacking the stuff that is ready to be unpacked. And, to be honest I think actually that if we all talked about it at one of these meetings then people might see coffee in a different light and feel quite confident to go.

Source: Transcribed interview. Summer 1998

It was important that in the spirit of action enquiry these tensions were surfaced and discussed, this happened at a management meeting that followed the Multidisciplinary Nurse Team meeting.

"Health visitors and district nurses expressed concerns about speaking with doctors at coffee time and a discussion followed."

Source: Multidisciplinary Nurse Meeting notes October 1998

Suggestions, which were then adopted by the practice, were as follows

- *Increased use of Win Pop facility on PC*
- *Continuing use of message book for all staff*
- *Nurses to assertively maintain doctors attention at coffee time (Drs. Suggestion)*
- *Higher profile of all nurses at coffee time – not only when needing to discuss patients, would increase communication on all matters.*
- *Seek out the doctor, either in their rooms or in reception. This is a two way process and doctors often seek out a particular nurse to discuss matters.*

Source: recorded in multidisciplinary nurse meeting notes following practice management meeting.

Identifying concerns which caused frustrations in communication was an important aspect of this enquiry and when surfaced led to increased understanding and practical ways to improve understanding.

5.3.5.2 Titles of meetings

Titles of meetings etc. acknowledged the differences for the first year of the project. By November 1998 it was seen as timely to change the title of the fortnightly nurses meeting from 'Multidisciplinary nurses meeting' to 'Integrated nursing team meeting'.

"All present agreed they consider themselves as an integrated team so title of meeting changed"

Source: Integrated Nurse Team meeting. November 1998.

As well as the title for the meeting changing dialogue also led to structural change in the meeting time together.

"Ann: and this morning I've just been presented with the practice nurse ideas of how they'd like to work with the community staff nurse. And uhm I know there could be difficulties there.

Sue: Right.

Ann: sorry go on – how can I put it to jog my memory? Uhm.

Sue: Group supervision to, to look at issues when workload gets too heavy.

Ann: Yeah.

Sue: Because quite often what happens is that they'll talk about it on their own in little bits, and they'll moan and say oh we're expected to do far too much and they don't understand all the rest of it.

Ann: Yeah and it would be nice to be able to discuss, at these rapidly becoming redundant nurse meeting.... yes it would be good for these redundant nurse meetings to be. Could be used in a more developmental well. Is that verging on clinical supervision then? "

Source: Transcribed interview July 1998

The meeting changed in other ways as well, in that they became informative, one of the health visitors suggested having 'hot topics' to discuss on the agenda, with one member of the team taking responsibility for finding appropriate evidence from literature (Integrated nursing team notes March 1999) and the introduction of the mental health supervision group into the nursing team meeting (January 1999). Ground rules were set, and the team meeting started to become interdisciplinary, with the mental health critical dialogue occurring over the lunchtime and followed by the integrated nursing team meeting. This was an important move forward in the teams taking responsibility and providing focus by collaboratively agreeing how the mental health part of the meeting should be focussed;

- *Case discussion*
- *Informal staff support- personal issues which individuals felt needed to be discussed.*
- *Particular issues relating to work – time management etc.*

Source: Minutes of mental health supervision group January 1999

Communication using dialogue was making a difference both within the context and the content of communication structures whether in a one-to one or meeting context. These shifts were also being noticed to increase the learning that could come out of effective communication patterns and structures.

5.3.6 Mapping current developmental position

The nursing team at this point in its development was starting to challenge itself in a critically evaluative way and decided to take a half day out to map the present position in the key tasks set out for the integrated nursing team. For each of the areas the team came to a judgment of a score out of 10 as to how it was achieving.

Mental Health 7-8

The continued development of the mental health supervision group is considered an example of good practice. The group is well structured, boundaries are clearly defined and development issues are discussed. Participants have commented on their increased confidence in their own ability, and the need to move on from the 'defeat depression' agenda. Outcomes for depression for elderly surveillance are to be incorporated. The group is keen to be a pilot for a link Community Psychiatric nurse from the Mental Health Trust with the practice, meaning it can provide care for the more seriously ill with mental health problems.

Peer Support and Supervision 7-8

To consider further improvement by extending support group for mental health into other areas of care provision. Develop proper clinical supervision opportunities for nurse team coordinator, practice nurses and district nurses. Well established for health visitors.

Source: Steering group report March 1999

I took the opportunity within the one to one sessions with the NTC to reflect on the issues of mental health and peer support and supervision more deeply, and the following identifies the exploration;

Ann: mental health encompasses everything, you almost get steeped in it

Sue: Which is great

Ann: The primary healthcare team part of it, this includes nursing, So uhm yeah, we are 7-8, actually to many other practices in comparison

Sue: Right, do you think it's the same against your own goals and standards?

Ann: Yeah, be 7-8 because we are all using common tools of assessment, and we have had core and joint training

Sue: So have you set, even though they are probably not explicit achievement targets for mental health?

Ann: yes its to have a team approach mainly

Sue: So if its about 7-8 what's the 2-3 that's missing?

Ann: You can always be better, and I think its confidence in our own capabilities, we're all using the same tools. We're speaking from the same hymn sheet and we are going to have a link CPN.

Sue: Will that person be invited to the meetings?

Ann: She always goes

Sue: Yeah, but I mean will it be the same person?

Ann: Yes, and actually she does, she comes to the supervision meetings, and she gets the minutes of the integrated team meetings"

Source: Taped interview January 1999

And to return to mapping!

Education and Training 7-8

To map competencies to skill delivery. Use of time spent on study days etc. does it really make a difference in practice?

Explore ways in which sharing of educational outcomes can occur within the practice.

Education required for some individuals for chronic disease management, e.g. hormone replacement therapy, Children with Asthma, for the health visitors, Epilepsy, Hypertension and drug control, hypothyroidism.

Look at integration of clinical governance.

Health Promotion 7-8

Look to develop opportunities for adolescents. Identify if there is a gap for children with marginally chronic disease. Develop further ideas within elderly surveillance. Seek external funding for a key project.

Chronic disease Management 4-5

One of the problems here is recording accurately the data for patient consultation, in trying to run searches for evidence for the move from medical to nurse care it became increasingly apparent that individuals were using the computer system in different ways. Protocols would need to be updated to reflect a shared approach. Guidelines would also need developing which are based on evidence and incorporate standards for audit. Developing a service for housebound diabetics is to be considered.

Elderly Surveillance 3-4

Very little evidence to support significant achievement in this area, thought about considering counting the patients seen with chronic conditions, and sending out general health related questionnaires with invitations for flu vaccines. Search annually patients who have not been

seen by any personnel over the last year (including district nursing) and target this group over the next calendar year.

Audit 2

The nursing team need to sort out intentions and produce a plan, define measurement methods and tools to include patient satisfaction questionnaires.

Administration 2 as applied to the nursing role.

Actions for improvement;

Identify how much time is spent on administration

- *One person to order all vaccines for the practice nurses and health visitors*
- *Streamline communication to the Community Trust through the nurse team coordinator*
- *To discuss the structure of the day for the district nurses and the health visitors*
- *To discuss ways in which duplication in and between the teams could be reduced.*

Source: Steering group report March 1999

This activity was fun and collaborative but effectively focussed on mapping key objectives with the reality of developments.

5.3.7 Questionnaire

In September 1998 a questionnaire was distributed to all members of the nursing team. Appendix 2. The responses are discussed in Section 5.4.4

The purpose of this questionnaire was to get a sense of the perception of the changes that had taken place that related to teamwork in the nursing team. This was partly to get an overview of what the successes had been and what were the future challenges. The findings would feed into the steering group meetings that at one level influenced the cycles of reflection as they directed the collaborative enquiry with the nursing team. The total number of questionnaires distributed was 12 and those returned numbered 10 giving a response rate of 84%.

5.3.7.1 Individual nurse responses.

I also took the opportunity to reinforce the developments in 'reflective practice' by asking each member of the nursing team to reflect on and free write how, or if, having a lead nurse had made an individual difference for them. This served two purposes, the first an overall perception of the perceived differences that having team leadership had made and the second an insight into the fact that if this writing was an example of reflection we still had some way to go to demonstrate differences in thinking and reflection at deeper levels. The following examples identify the leadership skills of mediation and coaching;

"(Ann) acted as a mediator between Jo and the rest of the team, has helped to establish a better working relationship.

Has helped Jo in the role of team leader and helped her to get better with the rest of the team."

Source: Nurse 1998

Communication had been perceived as a positive improvement

"Has improved communication between the different nursing teams, by having regular nurse meetings and usually informing us of any changes which affect us and the surgery, I feel we are more integrated"

Source: Nurse1998

and insight into early learning was evident

"I felt initially that communication between myself and the practice nurses and the district nursing team was not handled very well. Decisions were not discussed with or communicated to those most affected"

Source: Nurse 1998

Reflections from other members of the team demonstrated differing levels of reflection, but also highlighted some of the tensions that existed but were not necessarily verbalised.

Three accounts are as follows;

"The nurse team coordinator role is an important part of an integrated nursing team, pulling together different nursing spheres and skills to communicate and share knowledge ideas and roles is much needed. A voice from nursing staff from all spheres, to general practitioners and management to help more ideas, difficulties, and changes in the right direction, aids and mediates during difficult and stressful times. Always open to suggestions and opinions even if not always in agreement with them, keeps focussed on what is required. I do not think an integrated team could be pulled together without a coordinator to facilitate the changes needed in order for the team to work"

Source: Nurse 1998

"Ann has been with us for nearly a year now and how quickly it has passed! I think its probably been difficult starting in a role where no one really knows what to expect and hope from this role? I think at LT we have always had an integrated team in many respects, the nurses have always communicated well together and shared information and we've also had nurse meetings, which included all the various nurse disciplines. From my personal point of view it has been very pleasurable to work with Ann, her door is always open and she is always encouraging and helpful. Ann has fitted into the treatment room side of work easily and it has lifted some of the pressure off Beth and I knowing that Ann is available to 'step in' at short notice. Ann's very easy to work with and we often have discussions about patients and Ann's views are open and non judgmental. I always feel I can approach her with a problem. I do feel that Ann has a difficult job in that she is in the middle between nurses and doctors, and this must by its very nature present many problems. The nurses naturally want their own views and ideas represented and presented but this is not always possible, as Ann also has to represent the GPs whose views may be in direct contrast to the nurses. Ann has been helpful to the girls in reception, passing on their wishes etc. and helping out and this in turn is beneficial to us as it makes our jobs easier and theirs"

Source: Nurse 1998

"My personal role has not been affected by the introduction of the nurse team coordinator role, although I have noticed that the nurse meetings have been more regular and more items are covered at the meetings. The nursing team as a whole has continued to work towards integration and I feel Ann has spearheaded this manoeuvre. It is reassuring to know there is someone approachable to call on should there be any problems within my working practice or outside, and also to know that Ann can work in the treatment room should the need arise for holidays and sickness. I feel that communication between the doctors meetings and nurse feedback could be improved. This is my only criticism, when I thought a nurse voice at the doctors meetings would enable more direct feedback to the nurses about relevant surgery matters and also items which were raised by nurses and therefore needing answers. On the whole Ann has come to the surgery, become a friend and promoted team work"

Source: Nurse 1998

Using this method did allow some unspoken thoughts to be surfaced. I encouraged the nurses to share the comments when they felt ready and in a meeting that was appropriate.

5.3.7.2 Leadership questionnaire

Following discussion at one of the nurse team meetings I decided to suggest the idea of a leadership questionnaire for developing self-awareness for all members of the nursing team. I used a standard tool³ (appendix 3) and the doctors and practice manager asked if they could be included in this activity. This process raised some interesting findings. Most of the nursing staff with the exception of one nurse, who was the source of the last quote, demonstrated more concern for people than concern for task. The nurse team coordinator scored relatively highly on both axis but with a slightly higher concern for people than for task. The practice manager was higher on the concern for task rather than concern for people, with the majority of the GPs coming high on both the concern for task and people. This process was formative and for interest and no claim is made to research rigour for this data. However it does raise some interesting questions for further study and the issues in interprofessional education.

5.3.8 Clarifying the definition of an Integrated Nursing team

This analysis of data, supported by observations and documentary evidence was discussed at a steering group meeting and led to the Practice challenging and reaffirming its understanding of an integrated nursing team after considering the following definitions;

A collaborative, flexible approach maximising the skills and expertise of community nurses to focus on the health needs of the practice population

A community nursing team which utilises specialist and general skills in a manner best suited to the needs of the practice population Source: Sheffield Community NHS Trust

Confident, competent nurses, working as full members of Primary Health Care Teams, providing a flexible high quality service with a minimum of hierarchical restrictions Source: (West Berkshire)

Bringing together the different skills, knowledge and expertise of a team of nurses so that priority needs can be met and a comprehensive service provided within a community.

A team of practice based nurses from different disciplines, working together in a primary healthcare setting, pooling their skills, knowledge and ability in order to provide the most effective care for the patients within a practice and community it covers. Source: CPHVA

Health Visitors, District Nurses, Practice Nurses and others, working together with clear aims and objectives with an understanding of each other's role to provide high quality care for patients – Gwent NHS Trust

Source: Multidisciplinary Nurse meeting June 1998

The local definition was arrived at following a meeting with the nursing team, and a presentation and discussion as the practice away day in the summer of 1998.

³ Pfeiffer J.W. and Jones (eds) A handbook of structured experiences for Human Relations Training. Vol 1 revised, University Associates incorporated. San Diego CA 1974 page 12.

"A team of practice based nurses from different disciplines working flexibly together, supporting colleagues, maximising their skills and focusing on the health needs of the population."

The way forward for the second year of the project was agreed as an outcome of the discussions which led to a greater understanding and ability to articulate the function of the integrated nursing team;

- *To actively seek areas for further collaboration within the integrated team*
- *Agree as a practice on effective audit questions to measure shift to shared care*
- *Continue to evaluate the changing roles within the nursing team and their effect on the Practice.*
- *Continue to move towards becoming a learning organisation.*

Source: Allen (2000:19)

This was a generative phase in the project that enabled a fresh sense of energy to develop the focus for the team and a sense of firmer identity to move forward in both process and outcome for the second year of the project.

5.3.9 Team Processes

The first year of the project saw the nursing team pass through the well-recognised process of group development as outlined by Tuckman (1965), Forming, Norming, Storming and Performing, and as referred to in the previous discussion on group effectiveness. These phases have been visible to the team and related to the initial stages of understanding each other's roles, recognising what was common and what was specialist and deciding ways in which everyday working practice could be improved.

This led to a normative phase where equity between groups was discussed as an issue and quality of care became a shared responsibility. This phase was potentially influenced through outside intervention in respect of reduction of firstly health visiting hours, which coincided with the normative stage of the group. During the potential storming phase the personality and skills of the nurse team coordinator were a positive calming influence.

The second year of the project has seen the integrated team at the 'performing stage' with the learning from the previous stages now a tacit understanding between the team. Changes of role within the team have occurred, but the movement of staff in or out of the team has been minimal.

The confidence with which the nurses now function in the Practice has been tracked through observation of interactions within and between professional groups. This was commented on by many, and observed by the evaluator at the Primary Health Care Team meeting held in September 1999, which centred on the contraceptive service offered by the

Practice. Whilst the meeting itself was very constructive in its outcome the dialogue and banter between the individuals present, doctors, nurses and reception staff, demonstrated an equity in respect and openness which was hard to imagine being present at the beginning of the project. Body language was open, questions were asked for clarification that may previously have been seen as trivial and the patient focus was paramount rather than differing professional roles. A comment from a doctor on the final questionnaire provides support to this observation with another example relating to coffee time.

"Bon homie at coffee time with friendly banter from nurses i.e. more equalisation of psychological size, therefore improved communication."

Source: Allen (2000:20)

This example of team working brings together an issue that had been evident from the beginning of the project. This was the perceived safety in which participants felt they could articulate and share questions, thoughts and comments within the primary health care team. Comments had been identified relating to the risks attached to venturing comments when the atmosphere could be openly or tacitly judgmental. This was applicable across the grades within the nursing team in relation to interactions with both the practice manager and doctors in the early stages of the project.

In the late spring/early summer of 1999 the individual sessions with the nurse team coordinator were starting to focus more fully on the post holder's career aspirations for the future, given that the pilot appointment following the two years was potentially open to re-negotiation. The post holder came to a informed decision that a management role was not as satisfying as direct patient care and successfully applied for an alternative post in the Community Trust.

Parallel to this the Practice submitted an application and was successful in being awarded 'Beacon status'. Part of the stimulus for the application was that with the team working efficiently more time was needed to achieve the potential as evidence through innovative developments and a wider provision of services to patients. The submission for Beacon status entitled "Integrated Nursing Team" recognised that:

"While the project is not complete, it is apparent that it will be difficult to demonstrate the achievement of all the objectives and that the needs of the practice and the service require further developments building on the existing project."

Funding was also necessary to allow replacement of the nurse team coordinator beyond November 1999 to allow the project to progress.

Funding issues were resolved and the Practice took the opportunity to reappraise the role, its purpose and direction and determine the way forward for a succession appointment. This was influenced by the experience of the previous eighteen months and the issues relating to leadership as referred to earlier. The Practice recognised that a cohesive, willing team had been developed which now needed to move forward to demonstrate real growth and innovation in quality patient care.

A final questionnaire was sent to the healthcare professionals in the Practice in October 1999. (Appendix 4). The questionnaire was intended to highlight trends towards principles of a learning organisation. A response rate of 88.2% was achieved, 33% of the respondents were doctors. Focus groups asking similar types of questions were held with reception and administration teams. The returned questionnaires revealed some rich rationale, comments and examples as data. Overall the respondents from the nursing groups gave higher scores for improvement than the doctors. Within the responses the scores from the doctors gave a wider range. The doctors, who have been closer to the project, being more aware of the changes that have occurred may influence this. This gives an interesting insight as to the perceived advantages for any change to those on the edge of developments and is an area worthy of further discussion.

Both the administrative and reception teams were fully supportive and appreciative of the role of the nurse team coordinator, especially in relation to being a channel for communication to the doctors. The personality of the post holder was seen as a significant variable in creating a positive working environment in the Practice.

Overall the results of the questionnaire (Figure 1) indicates that when the totals in each category (maximum 150) are identified, improvement is ranked in the following order:

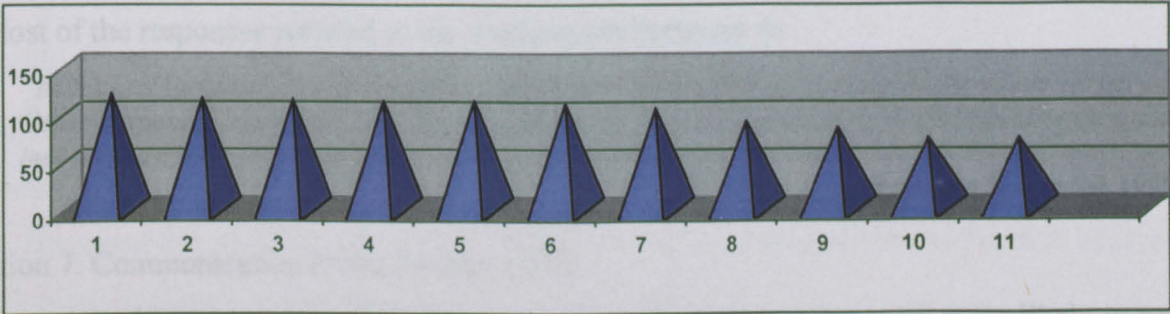


Figure 1 Ranking of perceived improvement in organisational effectiveness

Question 1. Understanding the role of other team members. (121)

Responders identified that regular meetings and discussions with others with the purpose of understanding other people's roles in the practice had been successful, as had the opportunity for regular formal and informal meetings and the mental health case meetings had been found to be very helpful.

Source: Questionnaire November 1999

Question 2. Understanding the role of other practice members. (116)

"All staff have given a talk on their roles in the primary healthcare team meeting." "Think this is improving as we have much more two way discussion on what we do for patients"

Source: Dr's response to Questionnaire November 1999

Question 3. Perceived value of other's contribution. (115)

Several responders felt valued in their role (4) with positive comment about being asked for opinion and being listened to. 1 respondent suggested that resistance to other ideas and hierarchy still exists; yet this is of a decreasing influence.

Source: Questionnaire November 1999

Question 4. Nursing team co-operation. (113)

Responses focussed on discussing cases openly with each other, good support with sense of humour, feeling safe giving opinion and helping each other under pressure.

Source: Questionnaire November 1999

However one of the Doctors responded,

"I feel the appearance is greater than the reality. I am not sure we have got the organisational and interpersonal framework right"

Source: Questionnaire November 1999

Question 5. Understanding of individual team objectives (113)

Whilst recognising the "whims of government" respondents felt able to contribute to developing a focus for long term goals, and to set and review objectives regularly" However the doctors felt that "doctors need to have joint objectives in addition to our individual ones; and "tensions between personal doctoring and team care, nursing versus medical care"

Source: Questionnaire November 1999

Question 6. Improvement in practice teamwork (110)

Most of the responses referred to the working environment as

"being less turbulent, more cohesive, and a more open relationship across the whole surgery." Other responses suggested that the "organisation is more focussed with clearer structure and less concern over professional roles-more concern over patient needs."

Source: Questionnaire November 1999

Question 7. Communication in the Practice (105)

Two main themes emerged from these responses. First that nurses were more likely to tackle doctors on issues, and secondly, of the

"impression of us all recognising care agenda, working for patients rather than our own agendas."

Source: Questionnaire November 1999

Question 8. Understanding of reflective practice (91)

Understanding of the process had increased and was being practised at an individual level, some suggested

"Deeper sharing within the team" and "ideas and attitudes present but the process only embedded in mental health"

Source: Questionnaire November 1999

Question 9. Effect on patients (84)

Although this was an area where respondents considered change had not been so significant as in other areas, the responses demonstrated the potential for sustainable and developing change. For example

"Team members have been able to 'step in' and cover in areas where at one time we would have been short staffed. This has meant the patients have not had to suffer any inconvenience"

"More communication between ante/post natal patients and practice nurses and health visitors. Professionals therefore more informed which enhances patient care."

"Patients are given similar rather than conflicting advice and treatment by nurses"

"Decreasing patient load on partnership"

Source: Questionnaire November 1999

Question 10. Perceived feedback on individual performance. (73)

The comments overall recognised that encouragement was a feature of the management style of the nursing team. However it appeared that this was an area for development and that staff saw that in the context of a 'learning organisation' this required more than a yearly appraisal.

Source: Questionnaire November 1999

Question 11. Understanding of primary health care team objectives (73)

This question came about as the project had developed further from developing an integrated nursing team, to integrating nursing. The questionnaire recognised the challenge still existed:

"Some aspects are outside our control, however we need to develop a dynamic approach to the development of our Practice Development Plan (PDP), linking needs of population, needs of staff and needs of research"

Source: Questionnaire November 1999

These findings support the literature (Ovretteit 1996: West and Poulton1997), which identify the factors that lead to successful team functioning and suggest that a solid foundation for effective team working had been established.

The areas that show less significant development correspond with the Practice awareness of initiatives planned within the Beacon site proposal.

The finding that may be overlooked within the survey relates to the level of perceived feedback on individual performance. A further analysis of the questionnaires indicated that the doctors scored lower in this category than nurses.

The results of this questionnaire were discussed with the Steering Group and at the Primary Health Care Team; this resulted in the practice setting the direction by responding to

"What are the challenges for the immediate future"

- *To make the most of the new post of Practice Development Nurse*
- *Review Doctor: Nurse integration in relation to patient services*
- *Review team roles in nursing*
- *Explore new ways of involving nursing in practice development*
- *Educate the general public in Health Promotion*
- *Support and advice the younger population in the community*
- *To maintain a happy nursing team*
- *Clear shared objectives for practice based healthcare*
- *Keep the momentum going*
- *Consistent use of computer technology by all teams*
- *Integration of link Community Psychiatric Nurse into Primary Health Care Team*
- *Management of total nursing team (attached and unattached staff) by practice*
- *Telephone consultations*

Source: Primary Health Care Team meeting January 2000

This would be translated in to the next stage with the support of 'Beacon status' and ideally provide the patient focussed services that all the practice were aiming for.

5.3.10 Summary

This cycle has identified the key issues that emerged as the nursing team in the context of the primary healthcare team developed an identity to work in a way that enhances patient care through developing better communication channels. Cycle 3 will explore some of the dimensions of leadership that helped and hindered this process.

5.4 Cycle 3: Developing a Shared understanding of Leadership.

5.4.1 Introduction

By July 1998 it became evident to me that clarification and articulation was needed around what was understood as management and leadership in the practice. The previous cycle will have demonstrated the tensions, which were emerging between the NTC, the lead GP and the practice manager as to their individual interpretations of management and leadership. It was my assumption that in the nature of this collaborative enquiry this aspect would be vital to the overall success and ownership of the changes that were being implemented.

"Key issue is Leadership;

What do the practice mean by it? How does it practise it? How are decisions made? Is self-management a reality/possibility/requirement? What are the options? What are the problems at the moment? – Length of time decisions take to be made/to be implemented/to be continuously evaluated. What are the core tasks of the practice, what are the added extras?"

Source: Reflective Journal July 1998.

These were the questions I posed for us all to explore as part of the collaborative enquiry, and in meetings people started to argue for their own perspective to be considered as the right one! Following discussion it was agreed to explore these concepts in a variety of ways to include questionnaires, individual interviews, focus groups and discussion groups. I agreed to do a presentation on the 'Learning Organisation' and reflective practice, as this was for me an important dimension for the successful management of change in this context.

"The presentation put reflective practice into the context of the healthcare centre, integrated nursing and the new NHS 'White Paper' It was a broad introduction to reflective practice which enables us to look at what we say we 'do' and what we actually do in reality, being aware of any deficit between the two.

It opened with an OHP presentation of the Learning Organisation, the five disciplines selected from 'The Fifth Discipline' by Peter Senge. Sue offered an explanation of each discipline constantly referring back to practice linking the theory to our every day lives. (Copies of the overheads are attached to these minutes)

Sue followed this with an historical account of reflective practice dating back to the 19th Century and up to current nursing practice using Pat Benner's work 'From Novice to Expert' as an illustration of contemporary use and reflective practice.

We identified that reflection takes place informally and that individuals choose where and when to do so. Traditionally nurses have 'unpacked the baggage' surrounding a situation with each other in an informal way, perhaps not realising the importance of the process.

Sue explained that Benner's work illustrated how, as novices and students, we learn in segments and it takes experience to bring the segments together to form the whole picture, until the process becomes intuitive

Source: Multidisciplinary nurse meeting notes June 1998.

All the members of the nursing team were present at this meeting and two GPs and this became a turning point in the development of the change management process. Consequently several strands will be explored in this cycle. Individual understandings of management and

leadership: developing a shared understanding of the way forward and a clear sense of direction for the remaining year of the project.

5.4.2 Leadership profile.

To raise awareness of leadership competencies and the balance between people and task and in addition to the questionnaire explored in the last cycle (September 1998) all members of the nursing team were asked to complete a leadership profile (Appendix 3). The total number of questionnaires distributed was 12 and those returned numbered 10 giving a response rate of 84%.

The leadership profile demonstrated that all staff had potential to develop both on the concern for people and the concern for task axis. The nurse team coordinator scored higher on concern for people than concern for task. This exercise acted as an individual learning point for development individually and within the team. In addition to the questionnaire given to the nursing team, the GPs would all be interviewed individually and focus groups with the reception team would ask similar questions. All this information would then be collated and lead to the discussion on developing the direction for the future.

The above exercise along with other data demonstrated that nurses needed help with developing leadership skills, rather than assuming it is present in experienced staff.

5.4.3 Skill development

During the weekly reflective sessions the nurse team coordinator was able to clearly articulate both the management and leadership skills required in the post by the second year.

"Meeting with district nurses re elderly surveillance- felt I needed to represent the bigger practice picture, used feedback from Paul as a start. Sarah looked tense at some points so I was conscious of continually reassuring and trying to turn negatives into positives but in doing so retaining the original message. Many negative points but two positive points (on revamped questionnaire) so whilst acknowledging the negative and taking on the constructive criticism the partners made I seized on these two points and we immediately incorporated them into the questionnaire."

Source: Ann July 1998

These skills were not necessarily clear at the beginning of the project, and neither did the post holder consider that she personally had all the skills. Considerable time was spent exploring the dimensions of leadership that facilitate change and the assumption that within nursing leadership skills are 'caught' rather than taught. The career pathway of senior nurses finding themselves in leadership positions has often been from promotion from staff nurse to sister/ward manager, and then into senior positions requiring skill in change management, but for which little formal preparation has been given. This supports the recognition of needing

to invest in the development of leadership programmes to realise the nursing strategy as set out in 'Making a Difference' (Department of Health, 99) and also is supportive of a team approach to the management and delivery of care, where individual's skills can be maximised to the advantage of the team. This is illustrated by the following reflections from Ann following a meeting with two managers from the Community Trust

“And at the end of the meeting, which, it was an hour, we then went up for coffee, and uh Cath spoke to the partners and she spoke to the nurses afterwards as well. And I could, well it really highlighted why Cath had been chosen for her job. She sees things in a very much wider and clearer way and she's articulate in, that sort of global sense. Whereas Trish, comparing the two Trish came across as excellent at what she does but very much on an operational level. Now whether that was a conscious effort on her part, maybe lower her sights if you like. But she kept coming up with comments about 'I think its going to be really difficult for me because I've got to...and Cath supported her...but there was just little, just little sort of conflicts, where, uhm as I say Cath would, she'd be very sort of , she'd appear very PC, in fact you could see, I felt she was schooling herself to be patient with what Trish was saying. Because Trish did an awful lot of the talking”

Source: Transcribed interview August 1998

The information in the questionnaire and the responses from the team leaders and doctors was fed back into the Practice via the steering group.

5.4.4 Questionnaire responses (to Appendix 1)

This questionnaire was open ended and the following comments are the responder's own. This provided a documented overview and understanding within the practice and linked back into the discussions around 'mental models' as a discipline within a learning organisation (Senge 1970)

Question 1

What do you consider is the primary purpose of the nurse team coordinator role?

Response	n
	=
Co-ordinate and integrate all nursing disciplines	9
Represent the nursing team	6
Organise cover to meet needs of practice population	3
Improve communication	2
Organise training	2
Monitor and support team leaders	2
Listen to team members	2

Appreciate different job functions	1
Co-ordinate projects	1
Co-ordinate policy	1
Co-ordinate Health and Safety issues	1
Assist with audit	1
Provide information	1

This seemed to be consistent and clear across the respondents

Question 2

Do you think this is being fulfilled?

Response	n =
Yes	6
Sometimes	4

No respondents considered this was not being fulfilled, on exploring what was meant by ‘sometimes’ this was as a slower response to *‘making things happen’* as was desired by some participants.

Question 3

What do you think are the differences between leadership and management?

Response	n =
Left question blank	4
Leadership is the art of persuading people to want to do what the leader wants them to do	1
Management is organising people and what they do	
Leadership is one who can guide, lead and direct	1
Management tends to maintain the status quo	1
Leadership tends to facilitate creativity and development	
Management is by appointment or remit, leadership is achieved by quality	1

management	
Leadership is taking what we have and moving forward, management is controlling what we have and not necessarily progressing	1
Leadership must be allowing the nurses a certain amount of freedom but be able to co-ordinate and express ideas etc.	1

This was an interesting response and reinforced my view that this was not clearly understood within the practice.

Question 4

What of the above qualities are needed to perform the role of nurse team coordinator?

Response	n =
Understanding of all roles	3
Communication skills	3
Provide inspiration	2
Appropriate attitudes	1
Approachability	1
Alliance	1
Strong personality	1
Tact	1
Diplomacy	1
The ability to lead without alienating	1
Developmental	1
Manage resources	1
Able to identify needs of practice population, staff group and individuals	1
Utilise skill mix effectively	1
Patience	1
Vision	1

Reflecting on these responses with the primary healthcare team led to a more commonly understood awareness of what the role was for, and helped both the post holder and the practice staff clarify identity.

Question 5

What do you mean by an integrated nursing team?

Response	n =
Inter-role support, each separate group assists others. Everyone working together to benefit the patients.	1
All nurses working together – sharing skills to benefit the patient to give holistic care.	1
Good communication between teams, some job share but only to a certain extent. A team that shares responsibility, knowledge and support	1
Being able to step into another nurse's shoes.	1
Different nursing teams working together	1
Identifying individual skills in a group and using these skills appropriately in delivering patient/client care. Recognising overlap in roles and working together to fulfil need.	1
Utilisation of nursing skills in most appropriate way. Excellent communication pathways with an understanding of the roles of each team member.	1
An integrated team is where everyone is pulling in the same direction. Individual roles are understood by everyone.	1
Good communication and relationships between various nurse disciplines.	1
Simple and easy communication, ability to recognise and acknowledge training needs	1

supportive, clear roles and identity.	
---------------------------------------	--

In Cycle 2 the end point questionnaire was referred to as at October 1999. The responses a year earlier as identified above were important as part of the action learning and action research process, in identifying, reflecting and taking action on the direction of travel for the second year of the project.

Question 6

What do you think are the main strengths of the nursing team at Leicester Terrace?

Response	n =
Good communication	6
Willingness and ability to work as a team	3
Mix of skills	3
Support each other	3
Knowledge of each others roles	3
Nurse meetings	1
Flexibility	1
Training opportunities	1

Question 7

What do you think are the key developmental tasks for the team at Leicester Terrace?

Response	n =
No response	2
Gain further insight into others roles	2
To develop further integration	1
To recognise what cannot be integrated	1
Develop practice profile	1
Share newly acquired skills	1
Team leaders need to be more responsible and accountable	1
All need to take responsibility for developing own skills	1

Question 8

How would you describe communication within the team at Leicester Terrace?

Response	n =
Excellent	2
Good	2
Better than most surgeries but could be improved	2
Hierarchical	2
Communication between nurses and reception staff very good	2
Nurses feel apprehensive about approaching doctors for professional advice	1
Good in parts	1

Again the opportunity to share these findings from the end of year 1 (1998) had an impact on the developments in year two of the project, and communication change and development was more evident at the end of year 2.

5.4.5 Interviews with administrative staff

Taped interviews were held with the team leaders for the administrative and reception staff. Transcript analysis from these tapes indicates good overall communication and support to reception staff. Issues relating to the appropriate use of information, especially in respect of computer data available from the Vision system were emerging. The use of information for audit and planning of care was also an area that needed further clarification as to a) the way data is collected, b) the way reports are written and c) the purpose and interpretation of reports were an issue.

5.4.6 Individual interviews with GPs

Semi-structured interviews were held individually with all the GPs, who were asked a series of questions as at Appendix 5. Overall their answers reflected similar perceptions and concerns. The majority of respondents were keen to support the integration of the nursing team but to develop this further into an integrated primary care team. In fact it was obvious from three of the respondents that this was how they saw the purpose of the project. From this there was a perception that the aims of the project were not very clear or the milestones in

getting there. The majority saw this as their failure to be really clear about what they wanted in the first place. However others considered that this was a strength because it allowed the project to evolve utilising the skills and motivations of the present team.

Leadership skills were overall seen to be more important than management skills for the nurse team coordinator, the view was expressed that within the Practice there was strong management and the nurses were very skilled and able to manage themselves well. A person with vision, drive and enthusiasm was needed to work with the creative ideas that the practice team was very good at articulating and bring them to fruition, which was seen as a present weakness. The doctors felt that they could have been clearer about objectively defining leadership skills in the process of appointing the nurse team coordinator.

Overall the doctors recognised some shift towards the nurse team working together with sharing of roles, the issue to do with the delegation and sharing of some tasks with the doctors was less clear, some supporting the concept more than others.

All the doctors felt that the measurement of effectiveness and outcome of nursing activity could be more robustly audited, however this was recognised as an integrated initiative.

This analysis of data, supported by observations and documentary evidence was discussed at a Steering Group meeting and led to the Practice reaffirming its understanding of an integrated nursing team in the following definition;

A team of practice based nurses from different disciplines working flexibly together, supporting colleagues, maximising their skills and focusing on the health needs of the population.

Source: Allen (2000:19)

This set the scene for the development of year 2 of the Project. The developments are referred to in Cycle 4 but must be seen in the context of Cycle 2. This debate on Leadership was crucial to getting to a point at the end of the first year where clear direction could be deliberately facilitated in the reflective learning process.

5.5 Cycle 4: Developments

5.5.1 Introduction

This cycle will discuss the service developments that occurred during this period of time and links with some of the issues discussed in cycle 2. Cycle 2 related to the 'people' issues, which were important to enable these developments to be achieved. Within the context of group development this cycle relates to the 'performing' aspect of the primary care team and in the previous cycles elements of the 'storming' process have been identified. This is exemplified by a key issue that emerged half way through the project as a consequence of using an action learning methodology. The Glynn Jones report acted as the blueprint for this project and as such made a list of recommendations (Appendix 1). The emphasis was on the tasks and purposes of the primary healthcare team and what apparently in the view of the Practice was ripe for attention.

Less clarity was given to the process of team working in respect of the primary healthcare team. This may have confused the understanding for some of the purpose of the project and it was clear from the ongoing dialogue with the nurse team coordinator and interviews with significant others, that there was not a shared meaning and understanding of the purpose of the project. This can be best summarised as integrated nursing *or* integrating nursing. Where the first concentrates on the integration of purpose and function of the nursing team and the second implies the integration of nursing into a patient focused primary healthcare service and includes the delegation and sharing of medical care.

Once this duality became apparent it was discussed with the Practice as a whole and it was recognised that actually the intentions were both. However an integrated nursing team was essential to the aim of developing a patient focused primary health care team.

This was recognised in the submission for Beacon site status

"the Practice recognises there is a need to develop the work to provide holistic healthcare in a primary care setting and achieves the broader objectives of the project"

This cycle will conclude with a discussion of the potential reasons why some of the intended service developments were not achieved.

Within the following descriptions the grading structure for nurses in force at the time will be referred to. Grade ABC relate to unqualified nursing grades. D, E, F and G relate to qualified nursing grades, the higher the grade the more advanced skill, experience and leadership is expected.

Cycle 1 referred to some of the issues that arose as the role for the B grade Nursing auxiliary in the practice was redefined. This included the introduction of this post holder taking on the phlebotomy service for the practice. Figure 2 demonstrates the number of blood tests taken within an agreed period of time. This was dependent on the post holder undergoing appropriate training and supervision and her previous duties being covered by predominantly the district nurses in the practice. The introduction of this role also had to overcome traditional views as to the qualifications of this group of support staff.

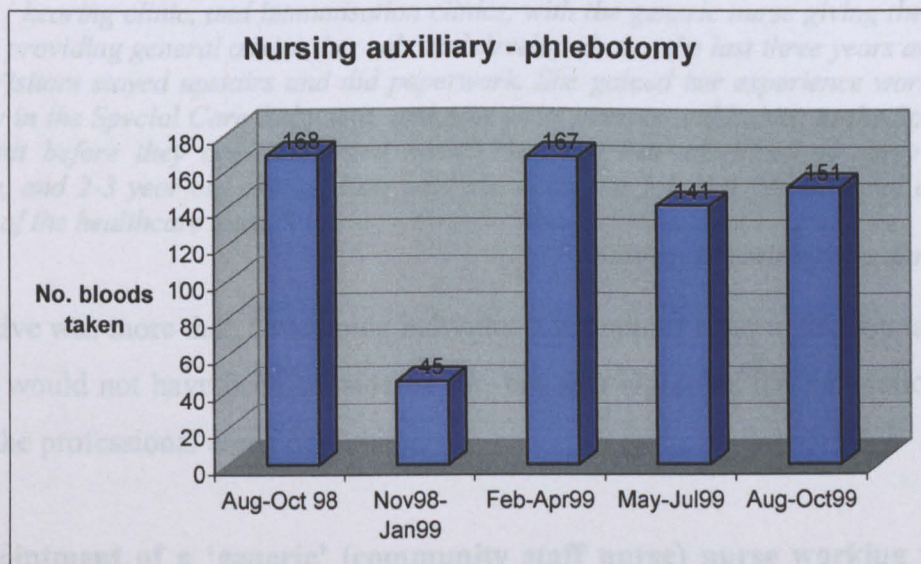


Figure 2 Number of blood tests taken

Readers will notice a dip in the level of service offered in the period November 1998 to January 1999 and this is explained in the district nursing caseload for this period.

Within the Practice at the time a significant number of patients required terminal/palliative care, this resulted in an increased number of home visits to deliver a high standard of patient care, and as such was a resourcing issue. Managing this dimension was discussed at a Nurse Team meeting and shared with the lead GP, and the decision was taken to support the district nursing team by releasing some time that the nursing auxiliary was spending on the phlebotomy service. This demonstrated that newly introduced systems of working were flexible and dynamic rather than rigid and restraining. As the new ways of working became embedded in the practice the role for the nursing auxiliary further extended to include,

- Registration information recording,

- Blood Pressure Checks
- Stock replenishing.

This directly released the time of the G grade (senior practice nurse) to enable more appropriate specific tasks and development activities to be undertaken. For example 44 hours of time was released from June-October 1998, this made a substantial economic saving which funded more development in the practice such as researching the potential to offer a Hormonal Replacement Therapy (HRT) monitoring system by the nurses in the practice.

A nursery nurse also was employed in the practice to support the health visitors. The health visitors seemed very aware of their professional role and at times were challenged to 'let go' of everyday tasks. However tensions came when the funding for health visitors were cut by the Community Trust and the number of child protection cases increased.

"Kate seemed very satisfied with her role, she told me she covered all clinics, including the 'drop in ' hearing clinic, and immunisation clinics, with the generic nurse giving the injections but Kate providing general advice, her role had developed over the last three years and now the Health Visitors stayed upstairs and did paperwork. She gained her experience working as an auxiliary in the Special Care Baby unit, and now visits parents and babies in the Special Care Baby Unit before they are discharged home. Her role has developed to carry out Baby Massage, and 2-3 year old checks. Kate said she loved her job and felt an equal and valued member of the healthcare team."

Source: Interview notes January 1999

This initiative was more than developing individuals in support roles to take on tasks that they previously would not have been considered for, but also identifies the integration of support staff in to the professional arena of nursing.

5.5.3 Appointment of a 'generic' (community staff nurse) nurse working within clear guidelines

The information collected on which the Glynn Jones recommendations were made demonstrated that over 70% of the Practice professionals agreed that there was a role for a generic nurse. The use of the term generic is perhaps unfortunate due to the connotations that have been linked to these kinds of developments within the nursing press. This did not seem to affect the perception of the perceived advantages of developing a community staff nurse role within the Practice.

The E grade nurse worked within the district nursing team for five sessions weekly, (each session is 3hours) with the practice nurse for two sessions each Wednesday, and with the nursery nurse doing baby immunisations on Thursday mornings. Thus releasing 9 hours of F/G grade time weekly.

The Community staff nurse undertakes the following procedures.

- Blood pressure readings
- Pill checks
- Blood tests
- Dietary advice
- Assist at sigmoidoscopy
- Registration appointments
- Dressings
- Removal of sutures and clips
- Ear syringing
- Baby immunisations
- Electro cardiograms
- Swabs
- Injections
- Health checks

Patient evaluation and a random audit of selected patients by the nurse team coordinator revealed no quality of care issues.

In a final interview with the post holder in October 1999, the community staff nurse expressed considerable satisfaction with her developing role. She was undertaking cytology training and was becoming increasingly involved in the practice patient focused contraception service.

Another advantage came to light for patients. The post holder would see patients or their immediate family as she worked as district nurse, the patients would then appear at the surgery to see the practice nurses. These dual visits could now be prevented as an appropriate member of the primary healthcare team could give appropriate care on one occasion.

The success of this initiative in terms of effectiveness, economy and efficiency should not be underestimated and is a direct measure of success of an integrated approach to nursing care.

5.5.4 Shared Care

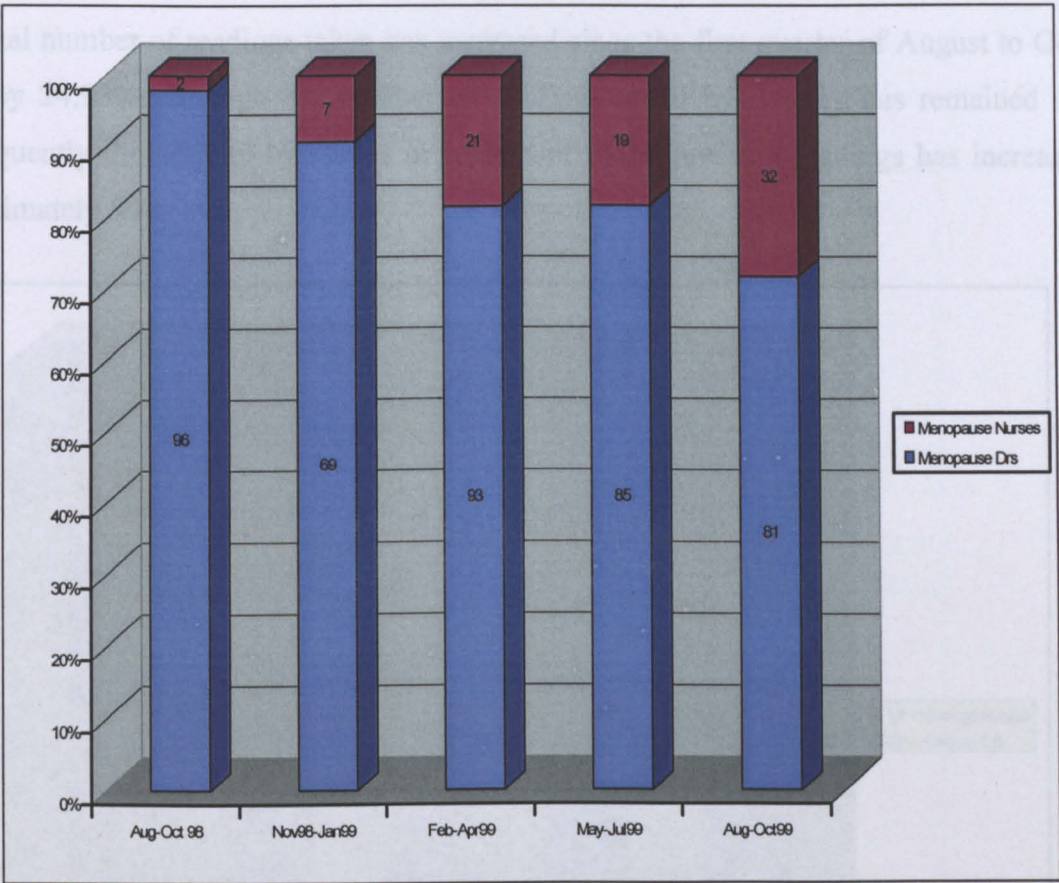
The Glynn Jones report recommended that the Practice considered the movement of some areas of care totally to nursing staff. Following discussion areas in which the sharing of care was appropriate was determined. Joint protocols were agreed, set up and audited. Comparisons of care delivery by doctors and nurses have been retrieved from the practice computer system in the following areas.

- Menopause
- Blood Pressure Readings
- Asthma
- Depression
- General Contraception
- Emergency Contraception

5.5.4.1. Menopause

Following an audit of Menopause shared care from 1st August 1998 until 31st October 1998, the statistics demonstrated that patients with a diagnosis of menopause symptoms or receiving

Figure 3 Shift of care of patients from doctors to nurses - Menopause



hormone replacement therapy were seen on 96 occasions by doctors and on 2 occasions by nurses. This situation was reviewed with the outcome standard being that practice nurses should see 50% of patients. One of the practice nurses developed her interest, knowledge and skills in the area of menopause care, hormone replacement therapy, and breast screening, and the practice nurses are now able to offer a comprehensive service to women in the appropriate age group. The practice nurses work to a protocol developed collaboratively in the Practice. The shift to this additional service being offered by the practice nurses commenced in February 1999 and Figure 3 demonstrates the relationship between nurse and doctor consultations.

5.5.4.2. Blood Pressure recordings

Working to national standards and local protocols the care of patients with hypertension is managed between the doctors and practice nurses. Figure 4 relates to the number of blood pressures taken.

The total number of readings taken has increased since the first quarter of August to October 1998 by 24.93% although the number of readings taken by doctors has remained stable. Consequently the activity by nurses in respect of blood pressure readings has increased by approximately 50%

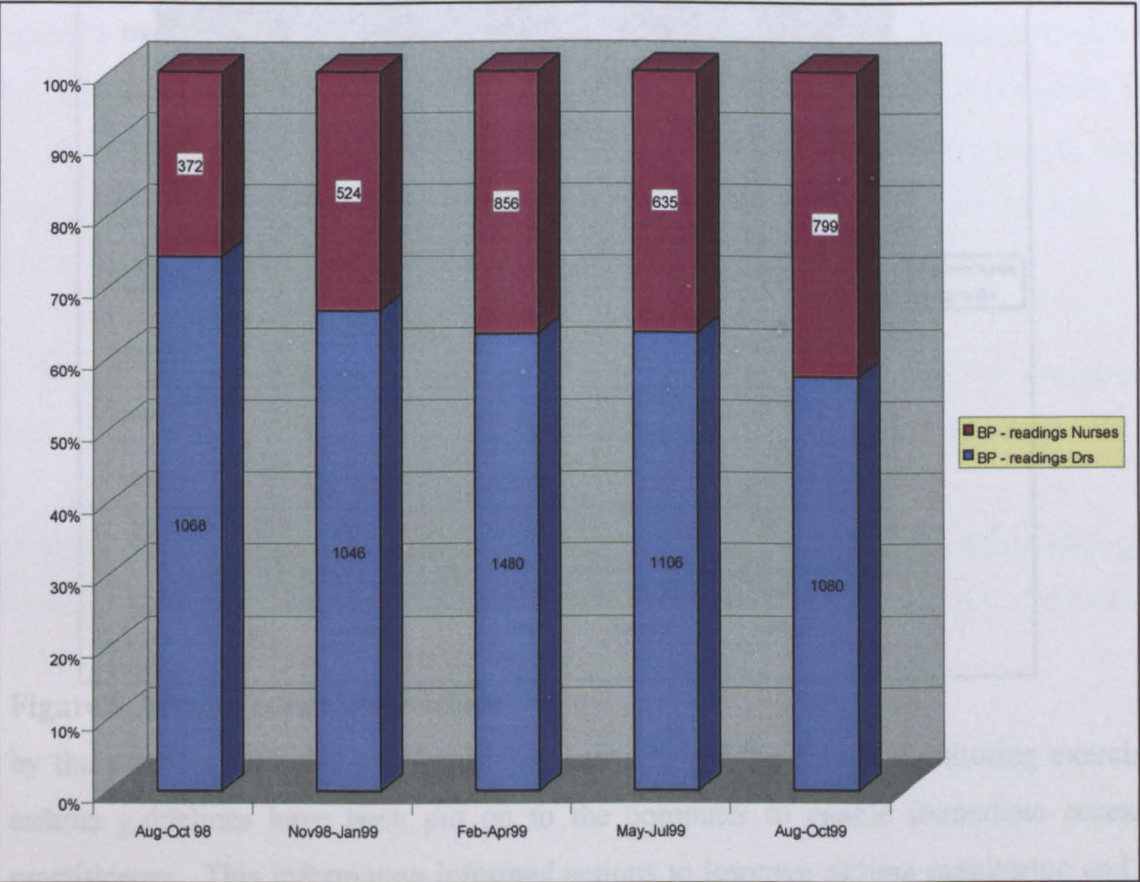


Figure 4 Blood Pressure recordings

5.5.4.3 Asthma Care

A protocol relating to the shared care of patients with asthma has been in existence since 1996. Care is audited relating to the implementation of the protocol on an annual basis. The audit for the period August 1st until October 31st 1998 (Figure 5) demonstrated that the consultations were more or less shared between doctors and nurses. However it emerged that only 50% of patients were having their asthma reviewed annually. A standard had been set

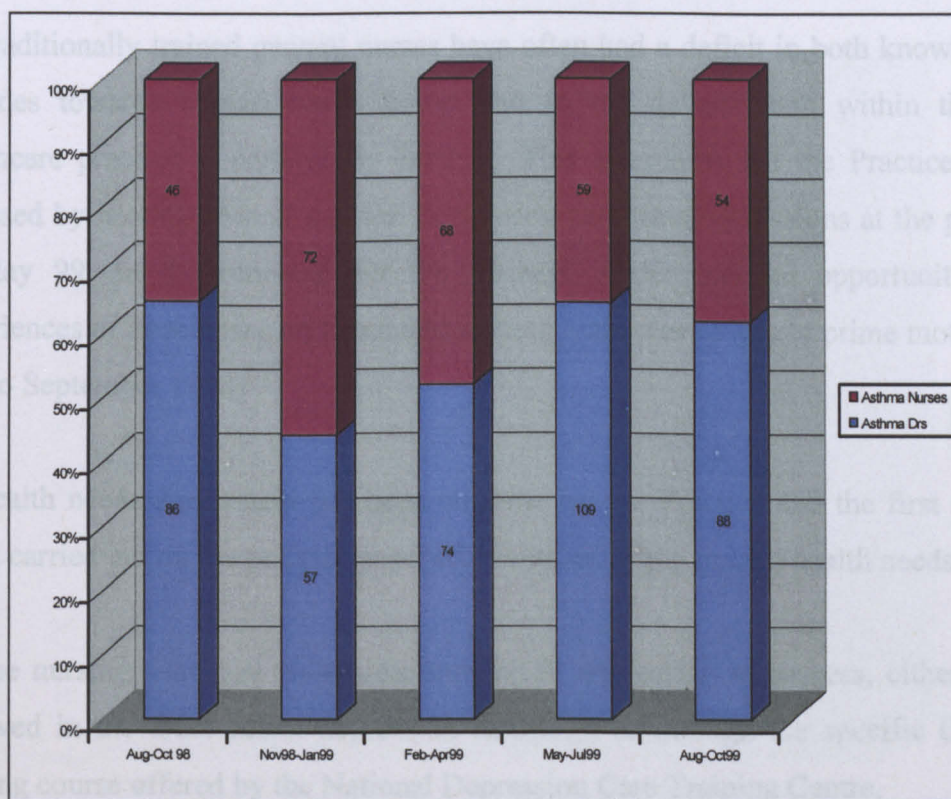


Figure 5 Asthma care consultations

by the protocol with the practice nurses carrying out the annual monitoring exercise. The asthma guidelines have been put on to the computer to enable immediate access by all practitioners. This information informed actions to improve asthma monitoring and resulted in a further audit cycle of other elements of the protocol in June 1999.

5.5.4.4. Mental Health Awareness and Depression

The Practice has had a historical interest in being responsive to patients with mental health problems and had benefited from a counselling service that is attached to the Practice. Patients are asked questions relating to mental health when registering at the Practice. Information is readily available for patients and the practice notice boards and displays often focus around mental health issues.

The Practice had been involved in depression care training since 1996 as part of the 'Defeat Depression Campaign'. This training was evaluated with the use of two questionnaires; the depression attitude questionnaire and a specially designed questionnaire to evaluate actual and potential use of depression care resources. These questionnaires were repeated in October 1999. Direct tracking of change in individuals was not possible, as comparative data was only available for two current staff. However, the results of the recent survey revealed a generally high level of commitment to and knowledge of depression care.

Traditionally trained general nurses have often had a deficit in both knowledge skills and attitudes towards mental health issues and so the development within the team at the healthcare practice is particularly exciting. This awareness led the Practice to be outward focussed by hosting several national depression care training sessions at the practice the first in May 99. In the rationale for the national conference the opportunity to share the experiences of developing an integrated nursing team was seen as a prime motivator. (Source: Memo September 1998)

Health needs assessment has been an issue for the Practice and the first assessments are being carried out on the practice population with enduring mental health needs.

The nursing team has undergone training in depression awareness, either through being involved in the local defeat depression campaign or through the specific Depression Care training course offered by the National Depression Care Training Centre.

This has resulted in the needs of patients being assessed and acknowledged from a mental health perspective and is across all aspects of the nursing team role. Examples exist of how the nursing auxiliary has been able to identify needs from her interactions taking peoples blood samples and ensuring appropriate referral, to the health visitors regular post natal assessment that uses the Edinburgh detection scales.

All nursing staff use the same assessment tools (Hospital Anxiety Depression Scale, Edinburgh scales, yellow depression cards) and the depth of understanding is developed through the monthly mental health supervision meetings.

These meetings are multidisciplinary, and use case discussion and critical incident analysis as a focus for discussion. The community psychiatric nurse, lead GP and counsellor act as a resource to develop a knowledge perspective.

This meeting is also intended to offer personal staff support in coping with challenging issues and as such is seen to incorporate good practice as outlined in recent government reports. This meeting is well attended, enables sharing across and within professional boundaries and helps to develop critical thinking in relation to clinical practice.

This model of supervisory support, based on shared protocols and understanding has added to the development of integration at the Practice.

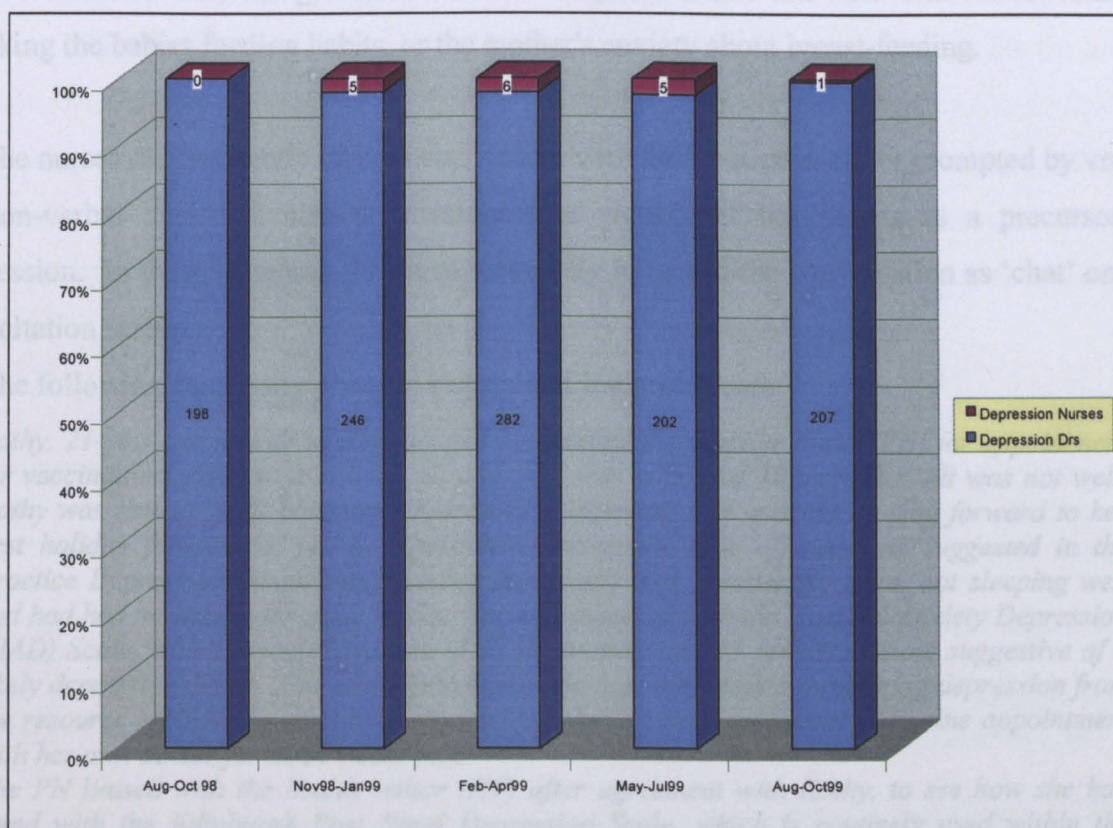


Figure 6 Consultations with patients presenting with Depression

The data derived from the computer records relates to the coding system 'Read codes' and consultation on depression shows no significant shift from doctor to nurse consultations. (Figure 6) When this data became available in the autumn of 1999 the reasons for the lack of apparent shift were widely discussed, especially as the Practice consider that mental health awareness and earlier detection of depression has significantly increased overall in the Practice in the last two years. A depression attitude questionnaire was administered in the Practice in late 1999 and most respondents noted an increase in patients with depression within the Practice since the 1994 Defeat Depression Campaign. This questionnaire also provided evidence of an effective primary care service for depression, results demonstrating a team who had access to guidelines and resources, a good level of knowledge and who felt comfortable and supported in meeting the needs of depressed patients.

The discussion centred on ways in which individual practitioners were aware of the holistic approach to health and how the learning that had come about through formal staff development and the in-house supervision sessions was now internalised into their individual practice. The nurses also recognised a reluctance to enter 'depression' as a code onto the computer system and gave reasons relating to arrogance in making a diagnosis when this was the doctor's domain, and that follow-up of patients whom they were concerned about was often under the guise of another consultation. For example a health visitor who had concerns about the mental well being of a new mother may make an extra visit with the rationale of checking the babies feeding habits, or the mother's anxiety about breast-feeding.

The nurses did frequently discuss such issues with their patients; either prompted by verbal or non-verbal cues and also an awareness of significant life events as a precursor to depression. In these instances the nurse was likely to record the conversation as 'chat' on the consultation screen.

The following case study gives an example of integrated care:

Kathy, 21-year-old mother of Kieran aged 2, attended the practice nurse (PN) for appointment for vaccinations prior to a holiday abroad, and was allocated 10 minutes. All was not well, Kathy was listless, paid boisterous Kieran little attention and was not looking forward to her first holiday for several years. Questioning using the type of questions suggested in the Practice Depression Guidelines revealed that Kathy was persistently tired, not sleeping well and had had no energy for some weeks. She was assessed with the Hospital Anxiety Depression (HAD) Scale, which revealed a score of 15 for anxiety and 12 for depression, suggestive of a likely depressive illness. She was offered an audio tape and leaflets explaining depression from the resource shelf in the treatment room which she accepted and made a routine appointment with her own doctor for three weeks time.

The PN liaised with the health visitor (HV) after agreement with Kathy, to see how she had fared with the Edinburgh Post Natal Depression Scale, which is routinely used within the practice. The two nurses gathered background information for the doctor prior to Kathy's appointment.

A fortnight later, Kathy saw the PN again. Kathy had chosen to return earlier than her planned GP appointment to say that she felt a little bit better, but wanted further discussion on some of the issues which had been raised. She returned once again to the PN before her GP consultation. Her HAD score had reduced to 10 for anxiety and 9 for depression. She had listened to the tape with her partner and they had made small changes to the daily pattern. Her mood has lifted and she was now planning for the New Year.

At her GP appointment she commented on further improvement in her mood and marital relationship that had been problematic with previous loss of libido and frequent arguments. She was beginning to regain her libido and mood changes were such that, although her symptoms suggested that she had suffered a major depressive illness, she now seemed to be recovering from this. A further appointment was suggested for review after her holiday. She was not prescribed antidepressant medication.

Source: Allen (2000:43)

5.5.4.5 Contraceptive services

This provides an example of how a service was required to change to maximise the income for the practice. This followed an audit (financial on contraception), which helped to focus the advantages in financial as well as patient well being terms in the development of a new

service. The decisions on the way forward were taken collaboratively, with the aim of *"Maximising the income from contraceptive claims"* (Practice Meeting notes July 1999)

A nurse-led family planning service commenced in September 1998. Protocols were developed and agreed and advertising literature was developed. The initiative was discussed at joint meetings and doctors, health visitors and midwives distributed leaflets. Notice boards were attractively used to their full potential within the Practice to advertise the service. Care was given to schedule the clinics at appropriate times - lunchtime and two evening sessions weekly. Initially the practice nurse who'd completed a family planning course ran the clinic. A health visitor who also was appropriately qualified later joined in supporting the service. Attendance and perceptions were monitored for the first seven weeks. Initially attendance was erratic, the maximum attendees at any one clinic within the first seven weeks being 6.

"Evaluation of this new service included using three open-ended questions in one to one interviews with 10 of the clients

- What attracted you to this service?*
- What do you think about the advertising?*
- How often in the last six months have you been to the Practice?*

On the whole they found the times suitable, one exception was a lady who had to borrow her husband's car to come, which necessitated a whole catalogue of actions. However she did say that she could belong to another practice but the inconvenience was worth it to be registered at Leicester Terrace.

All the women had accessed the clinic by attempting to make appointments to see the Doctor. Four were newly registered.

Not all had noticed the poster display. One lady said that reading the posters had alerted her to seek a different form of contraception that she did not previously know about."

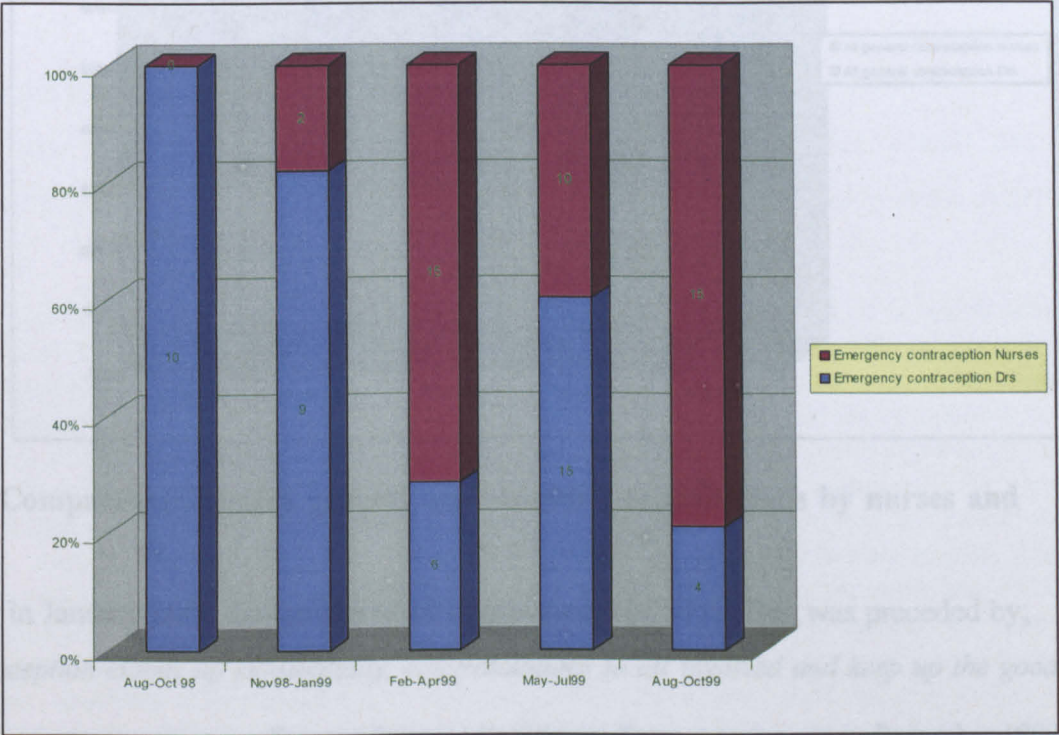
Source: Sue October 1998

The practice nurse was happy with the range of issues she had to deal with and gives the impression that the experience is professionally satisfying. A post consultation questionnaire was given to the above ten women, with all responses being more than satisfactory.

This initiative has become standard practice. In July 1999 the integrated nursing team agreed core objectives for further development for the next year. It was agreed to involve all the Practice in standardising the care of people requesting a contraceptive service. Subsequently a very effective Primary Health Care Team meeting was held in which a pathway of care was developed using standardised literature and documentation processes. During the two year period data has been collected on the comparison between doctor and nurse consultations. (Figure 7 and 8) Within both areas relating to contraception some shift is demonstrated from doctors to nurses, although it is interesting to note seasonal variations which could be explained in a number of ways.

The data for emergency contraception shows an increase in nurse consultations which is probably due to a combination of factors relating to timing of service and expertise of the practice nurse.

This initiative describes the development of a shared care area through to integrated nurse



team working and integrating the service in a client-focused way throughout the Practice.
Figure 7 Comparison between emergency contraception consultations by nurses and doctors.

5.5.51. The vaccination

In 1998 the primary healthcare team worked on an integrated approach to the flu vaccination agenda. 919 over 75's were identified as the practice population who would require vaccination, along with other individuals who met other vaccination criteria. This led to a successful and sustained service in terms of vaccination and effective use of opportune events for giving the vaccine.

At the end of December 98 the regional health care team reviewed the process and put in place actions for the 1999 flu vaccination campaign. This included:

- Having a targeted letter for vaccine 100 for mid September and 100 for early October 1999
- Early start to the flu vaccine campaign for high risk groups for the season
- Advice staff to write to all residents requiring a flu vaccine as to when they are used
- Mail also to go out to the general public as well as to the residents if necessary can contact with district nurse team
- Practice nurse and health care team to work together to vaccinate nursing residential homes. This health care team is also to be used

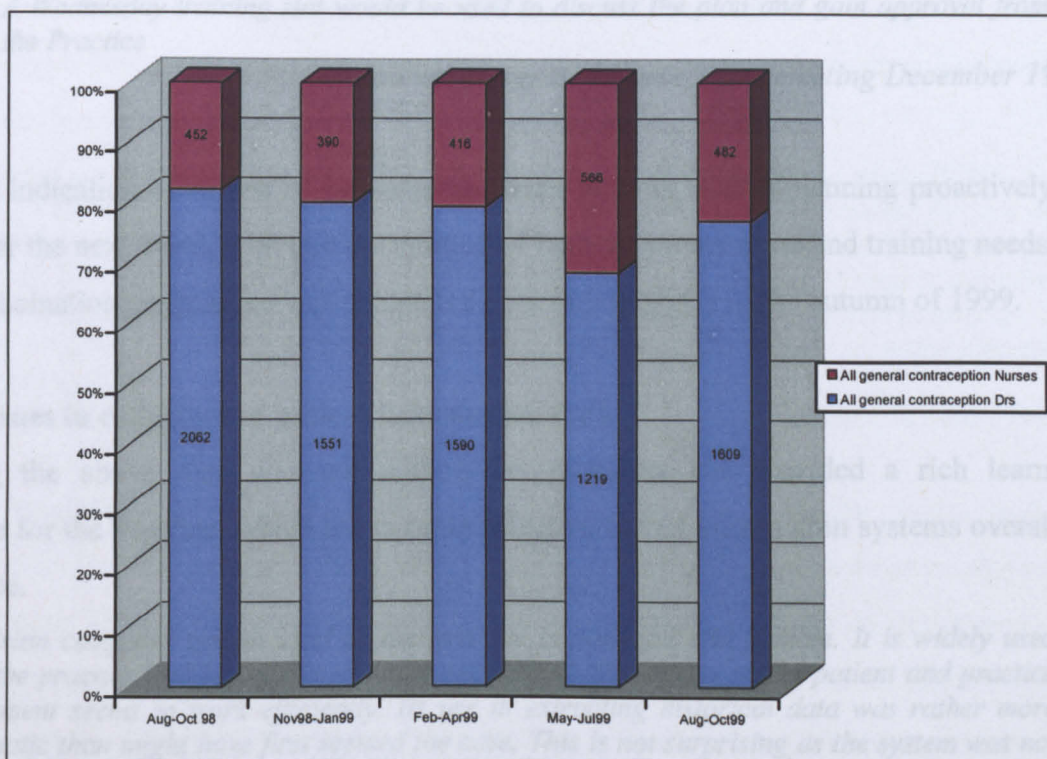


Figure 8 Comparison between general contraception consultations by nurses and doctors

A re-audit in January 2000 demonstrated an improvement of 54%. This was preceded by;

"Contraception claims up substantially, congratulations to all involved and keep up the good work!"

Source: Primary Healthcare Team meeting notes. December 1999

5.5.5 Other developments in integrated working

5.5.5.1. Flu vaccinations

In 1998 the primary healthcare team started an integrated approach to the flu vaccination agenda. 919 over 75's were identified in the practice population who would require vaccination, along with other individuals who met other government criteria. This led to a successful and managed venture in terms of team working and effective use of opportune events for giving the vaccine.

At the end of December 98 the integrated nursing team meeting reviewed the process and put in place actions for the 1999 flu vaccination campaign. This included:

- *Placing a staggered order for vaccine, 600 for mid September and 700 for early October 1999*
- *Early issue of lists, for doctors to peruse and sign, with master list in reception*
- *Admin staff to write to all residential/nursing homes to ensure up to date lists are used*
- *Mail shot any new 'at risk' patients using a tear off slip so that visits if necessary can coincide with district nurse visits*
- *Practice nurse and health visitor would work together to vaccinate nursing/residential homes. The health visitor to liaise with the homes*

- *A Wednesday training slot would be used to discuss the plan and gain approval from the Practice*

Source: Integrated Nurse Team meeting December 1998

This is an indication of review of implemented team process, action planning proactively in advance for the next event, with due recognition of both communication and training needs.

The flu vaccination programme was completed very satisfactorily in the autumn of 1999.

5.5.5.2. Issues in collection of patient information data

Collecting the above data was not without its problems but provided a rich learning experience for the Practice, which led to more effective use of information systems overall in the Practice.

"The vision computer system used by the practice is powerful and flexible. It is widely used across the practice and has replaced paper records. Its day-to-day use in patient and practice management seems to work efficiently. Its use in extracting historical data was rather more problematic than might have first seemed the case. This is not surprising as the system was not set up originally to capture this data either in the system architecture nor (more importantly) in the way the system is used. One correlate of the system's flexibility is its complexity. We were fortunate in being able to set the search strategies with the help of the consultant retained by the practice, even so there were aspects of the system that produced erroneous results. One example of this was a misunderstanding concerning the logic structure of the searches, which then had to be defined from first principles. A comprehensive manual for the system would have been helpful. Some of the searches take a very long time (sometimes over one and a half hours). Overnight searching is not practical as this time is used for system back up, acquisition of external data etc. and so these searches need to be fitted into the normal daily routine operations. The final search results were arrived at after a lengthy and iterative process of definition of data to be collected, system familiarisation, preliminary searches, error identification, redefinition of searches and validation of results that involved staff from across the practice.

In setting up and running the searches it became increasingly apparent that individuals were using the computer system in different ways. The Read Codes (on which the system is based) used were wide ranging, although the searches were structured to take account of much of this diversity. The most important confounding factor in this data collection exercise has been the fact that the appropriate code is not entered each time a patient is seen. Often the code may only be entered when the initial diagnosis is made, or when there is an alteration in the management. As this exercise is concerned with the number of patient-doctor and patient-nurse interactions, this could considerably skew the results.

Source: Report to steering group March 1999

Through the collaborative processes the following issues were discussed and addressed.;

- Specific searches were time consuming and blocked the networked computer system
- Nurses more consistent than doctors in entering data, however the doctor's data was more complicated with regard to codes
- Need to agree which Read codes to use as different codes could be used which then distorted data.
- Consistent entry of Read code on every patient encounter, to reflect true picture
- Review of appointment screen to identify inactive clinicians

Hidden within this was the purpose of patient records in respect of an integrated PHCT. The following extract from a memo from the GP with the lead for Information Technology identifies the importance of collaboratively developing systems.

"I am interested in the use of the computer record, as a shared record for the whole PCHT. To this end I would like your views on firstly whether you think it would be practical for you to enter information on at least the most significant of your patient encounters and secondly whether you would find this helpful for your own working purposes. This might require a degree of extra help in using the system initially, but I do not think this will be too difficult to arrange. I would be grateful if I could have your individual views in the next few days or so, either directly to me or through Ann if you prefer."

Source: Memo October 1998

This seemed fairly straightforward but failed to recognise the competing system used for recording visits and appointment activity for the staff attached to the practice but employed by the Community Trust. The nurse team had already tried with the help of the relevant IT departments to align the two mechanisms but this seemed impossible to do. In fact the nurses had little faith in the system rolled out nationally and used for collecting data by the Community Trust.

"Silly system, nurses reckon it's a waste of time because it generates meaningless statistics."

Source: Ann February 1998

The training of all staff in the protocols for recording information took place weekly. Internal audit practices developed around these new understandings and overall the computer system became more easily accessible to provide staff with information relating to effective patient care. This set the scene for the clinical governance agenda within the Practice.

5.5.5.3. Trial telephone Triage study

Working on the assumption that a senior nurse could take a proportion of calls and direct patients to the appropriate Primary Health Care Team member, or resolve queries by phone, a trial system was set up for eight weeks in the autumn of 1998. If this demonstrated a net gain in efficiency this would translate into more effective healthcare delivery for the practice population.

The nurse team coordinator made herself available in reception for 8 hours over an 8-week period. Patients phoning in were given the option of discussing their query with the nurse or of being processed in the usual way. After a low number of calls reaching the nurse during the first four sessions the process was modified so that callers were automatically passed for triage subject to the nurse being ready to take the next call, although this was limited by the capacity of the technology to cope with the process.

"Saw Ann in reception doing triage- now Ann is taking all calls for emergency appointments. Has deflected 3 this morning, especially important as they have only two doctors on duty rather

than the usual three. Problems with the phone system cannot stack calls, patients struggle to get through anyway (Ann's words) and this only takes more time because all the phones become engaged."

Source: Reflective Journal October 1998.

In addition to the eight hours spent in reception further calls were passed for triage on an *ad hoc* basis over the eight-week period.

Results;

- *Total calls referred for triage; 34*
- *Total calls where patients accepted triage; 33*
- *Total under 16 years; 6 (18%)*
- *Total adult females; 26 (78%)*
- *Total adult males; 1 (3%)*
- *Telephone advice; 9 (31%)*
- *Referred to GP; 13(45%) All deemed appropriate referrals*
- *Referred to other members of the primary healthcare team; 7 (24%) 1 inappropriate.*

Source; Triage survey December 1998

The nurse team coordinator demonstrated considerable ability in referring calls appropriately. The initiative was not developed further at the time due to inadequate evidence that this was an effective way of utilising H grade nursing time. The likelihood is that triage systems in general will be explored further in the years ahead.

5.5.5.4 Epilepsy management

This was an area for attention that was signalled in the original Glynn Jones report and also in the Practice Development Plans as a priority. However there appeared to be a lack of motivation within the nursing team to take on this nurse-led service, even though in September 1998 the dialogue with the nurse team coordinator seemed positive.

"Epilepsy screening, we have reviewed training and this seems fairly extensive, although probably uncoordinated. The practice also belongs to the local epilepsy awareness set up that is very good, and most of the meetings are hosted by the practice. Mel is very good at enthusing people about epilepsy; Angela comes up with lots of barriers. The intention is not to run a clinic as this would label people and it was thought that people would not come. However the intention was not to allow repeat prescriptions after a certain time without a visit to the practice nurse. We talked around the problems of making people fit an 'illness model' when they were actually healthy with a well controlled condition, and whether intervention actually made any difference and was cost effective."

Source: Ann September 1998

However it was an objective not being met in the Practice Development Plan and a year later in September 1999 the nurse team co-coordinator requested that the specialist nurse employed by the community Trust attended a meeting to help the practice team to determine a way forward. This meeting happened and was enhanced by a nurse advisor from a pharmaceutical company that provided support and lunch. The outcome from the meeting developed a shared understanding and approach to epilepsy management including the hospital service. The nursing team appeared very sensitive to the needs of this patient group

and accepted that sensitivity issues may have hindered taking action in this way, especially when it emerged that there was a perception that

“Patients in this group resented being identified as having a problem and having to come to the surgery”

Source: meeting notes September 1999

Discussion led to the agreement that a lifestyle questionnaire would be sent to all patients, with an appointment for a review with a practice nurse. The drug company were funding evening clinics for further investigations and consultant review for six months and it was agreed that any referrals would be made along this pathway. If patients did not attend they would be sent a reminder with a follow up telephone call. The opportunity for repeat prescriptions being attached to attendance at the surgery was considered but this was seen to be a ‘risk’ to patients not taking prescribed medication.

This area for development was recognised by the practice both in the context of the Glynn Jones report, the Practice Development Plan and also the primary healthcare team meetings, and yet little progress was made, despite the policy directives relating to these groups of patients.

There appeared to be a relationship between intrinsic motivation and leadership to achieve change and outcome. Within the practice ‘champions’ who had a passion for certain aspects of care was obvious and identified, for example this was most evident in the area of Mental Health awareness.

5.6 Discussion of Cycles

5.6.1 Introduction

This discussion will identify the conclusions to the project at the end of the action enquiry period of two years, these are the conclusions owned collaboratively with the practice and identified in the final report. This will be built on with my reflections in chapter 6. Some developments were identified that will continue to be implemented in the practice and it is hoped that the ways of working will encourage ongoing dialogue and collaborative decision making for the future. Chapter 6 will relate to a discussion on the process of implementing the enquiry from my perspective as a researcher and illuminates both the influence I potentially had on the developments in the practice but also the learning for me that was part of my professional journey.

The cycles of enquiry have illuminated the changes that took place in the practice as they moved toward the goals they had set themselves and this chapter will explore the issues that emerged in two key areas. The first relating to the effectiveness of the project in developing an integrated nursing team. The second in relation to the overall objectives that the Practice set themselves, i.e. that the outcomes would be achieved if the following occurred.

5.6.2 Development of integrated nursing team

The nursing team at Leicester Terrace emerged over the two years achieving the expectation that the Practice would have three functional teams. These three teams work independently of each other but each show the characteristics of independent teams, which have the leaders as a 'linking pin' (Likert in Mullins 1990:371). This appears to be a successful model for communication at the Healthcare Practice.

Within the literature on integrated nursing teams two main models have been proposed, the self-managed team and the team with a named leader/co-coordinator. The team at the Practice is of the latter model, and within the context of the Practice this has been a successful way of implementing and maintaining a team, as evidenced by the positive responses to the questionnaire explored in Cycle 2.

Over the period of the two years discussion has taken place into the way in which all-individual teams and their members could contribute to strategy development within the Practice. An example of the shift has been in the creation of the Practice Development Plan for the year 2000, where ideas have been generated from the teams, refined at the primary

healthcare team meetings, with the final version being produced by the partners and practice manager. For the nursing team this has been a valuable development as they are fully conversant with the primary care agenda. The administrative and reception teams have valued the way in which through the team leaders their contribution to the Practice Development Plan has been received. At present this development is the result of one iterative cycle from the three teams, with each team discussing ideas for the team leader to bring to the three way practice meeting. The way each team leader communicated with their team and gained a view for the future was largely collaborative, although care needed to be taken in some teams that the leader was not just assuming what was the view of the many. The most significant value of this approach was the greater understanding of the importance of the '*troops on the ground*' to the overall key direction of the practice and the ownership of a '*shared vision of the future*' (Senge 1990: 9)

From my evaluation of the development and functioning of the nursing team in conjunction with the team, we suggest that using West's (1994) Team type ratings the nursing team is between an A (fully functioning) and a B (Cosy team) type. This acknowledges the warmth, support and cohesion amongst the team members, and the high regard with which the team is held. The team would benefit from giving more attention to the way in which it reflects on, and modifies its objectives, processes, and tasks. This was significantly seen to increase in the later stages of the project, and would match with the earlier discussion on the team entering the performing stage of group development. Consequently continued consideration needs to be given to the development needs of the team to ensure that the team remains competent to react to a continually changing external environment. Given the dimension of interpersonal effectiveness and task effectiveness given within this model of effective teams (West, 1994), I do not believe the outcome would have been as successful if the model chosen at the Practice had been that of a self-managed team. This assumption is based on the knowledge of the individuals, who make up the teams at the healthcare centre and the predominant belief that management and leadership is invested in roles that have status and reward. This may be a bigger issue for a health service as it develops more autonomous ways of working and requires personal leadership and team leadership. In this context I make a distinction between organising the workload, when resources are seen to be adequate and developing services when resources appear to be limited and need to be negotiated between key stakeholders who have the power to make arbitrary decisions. The nature of the tasks to be achieved within a service which has seen the unit of resource reduced, and the consequent professional challenges to individual roles, as has been demonstrated by the earlier discussion on the reduction of health visiting hours, requires

strong leadership to motivate teams to work in new ways to overcome the predominant 'mental model' (Senge 1990).

5.6.3. Overall practice objectives, to be achieved by end of two year project period

5.6. 3.1 Nurse Team Coordinator appointed

This was achieved in November 1997. Initially the nurse coordinator post had agreed funding from the Health Authority. Given the perceived success of the post and the award of 'Beacon status' the post has become part of the permanent establishment and funded successfully for a further four years.

The pre-planning phase before the appointment of the nurse team coordinator in 1998, including the discussions as to the appropriate leadership model and the commissioning of the Glynn Jones Report, gave a clear direction for the developments that were achieved over the two years. This clear intention was enhanced by the emergent model that has been used to implement change based on critical reflection and further action cycles, rather than a rigid implementation plan of the recommendations from the Glynn Jones report. Issues that emerged in respect of the job description and the person specification for the nurse team coordinator role were incorporated into the selection process for the Practice Development Nurse who was appointed in the autumn of 1999.

5.6.3.2 Integration of nursing

Integration of nursing was being achieved at the healthcare practice.

"All commented how the integration of the nursing team has a) improved interdisciplinary communication b) increased awareness of colleague's situations and c) demonstrated higher level of support"

Source: Integrated nursing team minutes March 1999

The infrastructure for team learning, developing shared visions and being able to reflectively evaluate care was becoming embedded. The team had identified for themselves on-going objectives for realising the potential of further integrated approaches to care. Communication structures were in place and the roles of community staff nurse, phlebotomist and nursery nurse were deemed to be effective, economic and efficient. The other functional teams value the nursing team as working to provide good patient care. The role of the nurse team coordinator was especially valued by the administrative and reception staff who can give substantial examples as to how improved communication has improved both their job effectiveness and satisfaction.

5.6.3.3. Staff working more appropriately

At the beginning of the project there was an assumption that across the primary healthcare team staff at times were working inappropriately and not making full use of the specific expertise invested in each of them within the time available. This has been a key issue within the project and the results of shifting patterns of care were only just beginning to emerge, as the project came to an end. As the shifts in care become more apparent, and supported by appropriate infrastructures and audit, discussion will take place on more effective ways to provide patient care. This may be for example increasing the consultation time available to explore mental health issues with patients.

As an outcome measure this has been reflected in the additional time available to F and G grade health visitors by the development of the roles of the nursing auxiliary, nursery nurse and E grade staff nurse. Extra services have been taken on such as family planning and menopause clinics, shifts are being seen in nurse rather than doctor consultations, or hours have been cut by the Community Trust as occurred within the Borough Health Visiting review.

5.6.3.4 Patients getting better care

A subjective judgement on patients receiving better care is difficult to justify. Patients have been asked for their opinions in respect of the care that they receive at the Practice. This has been in respect of the new contraceptive service as referred to earlier, and also patients attending practice nurse appointments. Patients' comment that they feel valued and respected by the reception staff.

Selection, preparation and supervision of reception staff, including the impression they give to visitors is something that has been a management objective at the Practice, expressly articulated by the practice manager.

Direct observation of aspects of caring has been noticed. Two examples spring to mind.

"When observing in reception I was impressed with the way that staff 'valued' a patient who I was told seems to attend 'every other day for one thing or another' or counselling. This relationship was interesting and it obviously met a social role for the patient who had brought the Practice an herb display – this was lovely and sweet smelling. One of the receptionists commented that they would have to look after it very carefully as the last two plants this patient had brought in had died"

Source: Allen (2000:48)

"An elderly gentleman had died the previous night in the General Hospital. A request from the coroner to the GP for a death certificate was dealt with promptly and courteously. Systems for

removal of appropriate data from the Vision computing system were put in place and the family sent a tasteful bereavement card from the Practice."

Source: Allen (2000:48)

Patients getting better care could be measured by the number of complaints received in the Practice.

Complaints received	no
April 1996 – March 1997	18
April 1997 – March 1998	5
April 1998 – March 1999 * (1 nursing)	5 *

The nursing complaint that was fully investigated related to administration of cytology results.

Part of the outcomes of the project were to ensure that as part of the Practice Development Plan processes, patient health needs would be more clearly identified in the practice population leading to the ability for more specific measurement or patient satisfaction to be available.

5.6.3.5. Nurses working more to Grade

Clarification of roles and the development of new roles in the two years of the project gave the opportunity to ensure that roles reflected the full range of activity expected with each post. For the G grade practice nurse role this required giving consideration to the managerial and leadership aspects of the grade. This was achieved by reframing the roles of other staff to release time for the G Grade to action these aspects of the role. This has included

- Lead responsibility for audit of practice nurse activity.
- Development and review of practice nurse protocols.
- Supervision of BA (Hons) Community nurse students.
- Accreditation as a specialist nurse practitioner, by submitting a portfolio to a local University.
- Ongoing professional development to achieve Community Practice Teachers Certificate and BSc (Hons) Nursing Studies.

By further development of the nursery nurse role the health visitors were given space to concentrate on "at risk" families of which the area has a higher than average percentage.

5.6.3.6. Offering more services to patients

This was partially achieved and the Practice remained enthusiastic to develop new initiatives in line with the national and government agenda.

Clinics have been reviewed, with the realisation that specific clinics for identified diseases were not well attended by patients. Therefore protocols were revised in respect of all patients registered with chronic conditions. This was through a period of discussion and negotiation which included staff development sessions to ensure the needs of patients in certain chronic disease groups were fully understood, and careful consideration was given to the kind of service that would be most patient friendly and therefore more likely to be successful for patients.

The health visitors ran a variety of initiatives, including using the Open University pack on Positive Parenting with young families. For this initiative they went to a local mums and toddlers group rather than expecting parents to come to a different 'clinic' at the practice.

The integration of the nursing team has in some respects reduced the duplication of care between professionals. Also the reflective components of supervision and good communication at coffee time have enabled links between cause and effect to be made in relation to some patient complex problems. This has resulted in patients seen in family groupings and links have been made between different members of the family and how health problems may be linked, examples were evidenced of one family member attending with problems with depression, against chronic disease in the family and difficulties with children failing to thrive. This led to more joined up care within the practice and the opportunity especially for the health visitors to be mindful of all the family regardless of the age group. This had the makings of an early intervention service for positive health status.

The Practice has worked in conjunction with the General Hospital to provide a local anti-coagulant monitoring service for patients. On occasions to prevent inconvenience to patients practice based staff have taken blood samples. This required flexibility within the practice and the competence of staff to make this a reality.

The reception staff made considerable efforts to provide a welcoming informative environment. Good quality literature was available and poster displays regularly updated in patient friendly terms. The reception team were able to contribute more widely to such an

initiative, as they became more understanding of the priorities of the practice and consequently the patient education and involvement issues that resulted.

5.6.3.7 Needs of patients being met by Primary Healthcare team

At the completion of the project, apart from the implicit assumptions that a change of ways of working would meet the needs of patients it is difficult to argue that this was fully achieved as the needs of the practice population were not uniquely defined. The Practice was aware of its practice population and its requirements in relation to ill health and strives to meet those needs. Where the Practice was aware of unmet need, it worked hard to develop strategies to ensure its services were available, appropriate and effective. For example, as part of the integrated approach to meeting mental health care needs, team roles have been clearly defined for the management of depression. (Appendix 6)

The health agenda nationally is reflected in social, emotional, economic and cultural dimensions and along with other aspects of the health service the Practice was aware of its developmental need in this direction.

The student population has health needs met by a negotiated service between the Practice and the neighbouring independent tutorial college, similarly students with disabilities who enter the area as temporary residents have their health needs identified and met. Sometimes these needs can be complex and liaison and communication with expert services present funding issues that can take time to resolve.

80% of elderly residents have contact with a healthcare profession during each calendar year. A sophisticated multidisciplinary strategy has been developed to identify the unmet health needs of the over 75's. This was an interesting development in the process of the enquiry and identified issues around motivation, leadership and passion for the care of certain professional groups. For some projects such as flu vaccinations to residential homes the system became quick and efficient by practice nurses, health visitors and district nurses working together in pairs to complete the vaccinations in one day. (Integrated nursing team meeting December 1998).

This would not have been considered the previous winter and the flu campaign was considerably more successful in 1998.

During 1998 it was recognised that the caseload of district nursing patients requiring terminal and palliative care had risen. This was a direct result of responding to patient choice relating to preferred place of death. Figures cited were that 80% of the local population were enabled to die at home compared to 58% of patients nationally.

The process of this decision can be tracked through the enquiry at the healthcare practice and demonstrate how decisions were made in the interest of patient care in line with meeting the strategic objectives of the practice. The issues were discussed at a Primary Health Care team meeting following a presentation by the local Macmillan nurse and the District Nursing Sister who was being seconded to the Diploma in Palliative care course at Oxford. This is an example of patients' needs or desires being met by a primary healthcare team who take responsibility for both the training and quality needs seriously, and yet resulted in a downturn in the number of patients seen within the newly developed phlebotomy service. This is an important observation which links to the advantages of developing a whole systems approach (Senge 1990) especially in a healthcare environment that is target driven, with targets not always in relationship to each other.

The Practice supported the notion of attached staff, to provide physiotherapy, chiropody, counselling and acupuncture services. Previously the Practice was able to support patient awareness and support sessions on eating disorders, and considered that complementary therapies were indeed complementary to a conventional health service. This was valued by therapists that I interviewed and provided opportunity for development and dialogue between conventional and complementary therapists to improve opportunities for influencing the health status of the population.

The Practice employed a 'carers coordinator' to help meet the needs of this group. Sadly the post holder died suddenly whilst on holiday last year, and this was a significant loss, both on a personal level as a member of the healthcare practice, but also to the carers who really benefited from this support. Within the course of the enquiry this care for carers exemplified the desire of the practice to really demonstrate care for the practice population, and was an activity carried out, with commitment before the government drive to include Service Users and Carers significantly in the management of health care at a local level.

5.6.4. The way forward.

The Practice considered that it had achieved what it set out to do ... create an integrated nursing team. The first Nurse Team co-coordinator had resigned but was still working within the practice as the District Nursing Sister, and employed by the Community Trust.

The practice took on the notion of collaborative enquiry as it reviewed the previous job description and person specification. A paper written by the Senior Partner and originally discussed at a practice meeting and then sent to all staff for consultation facilitated this. An extract from the paper indicates the success of the developments by the use of language that embraces the principles of a learning organisation;

"Future Role of the Nursing Team Coordinator: Some of the strengths of the developments to date are an increasingly inclusive atmosphere within the practice, positive team building and an emphasis on individual development as well as the development of roles across disciplines. These however are insufficient without a generally shared vision and the ability to implement plans that follow from these. Whilst the Nursing Team Coordinator has been pivotal in achieving the positive outcomes, the post now probably needs to be refocused into implementation whilst not losing current benefits. Another feature, which we would not wish to lose, is an approximately 50/50 split between clinical and managerial work. These considerations suggest that the key areas of the new post should include:

- *Clinical work*
- *Developing with partnership, management and nursing team a shared vision of the future*
- *Implementation with management of plans derived from vision*
- *Leadership role in education and development of learning organisation*
- *Leadership role in quality improvement and assurance*
- *Maintaining enthusiasm for innovative solutions to staffing and patient care*
- *Familiarity with academic aspects of nursing and primary care.*

Source: Draft paper on Integrated nursing July 1999

Previously the partners would have taken this decision. Following this process it was decided from two final suggestions to appoint a Practice Development Nurse to continue to co-ordinate the team and to continue the development of nursing within the Practice. The other suggested post title being Head of Nursing Development. The emphasis was intended to be on development rather than management. The job description and person specification was re written in the light of the learning that occurred in Cycle 1 of the enquiry. The Practice was clear on the initiatives it wished to concentrate on and would no doubt achieve these intentions through the opportunities that would be offered to them as a 'Beacon' status practice. The Practice believed that their best option for achieving success was to give further attention to exploring and implementing the five disciplines of a 'Learning Organisation' (Senge 1990)

5.6.5. Team learning

The overall opinion was that the three now established teams worked well and have moved towards a spirit of sharing issues, reflecting upon the issues involved and determining new ways of acting. They agreed that this could be built on, especially across the teams in the model that has evolved in the mental health supervision meetings. This would enable the confidence to grow across disciplines and further breakdown the traditional barriers that potentially exist between different grades of staff. Given the evidence that individuals learn best when they receive accurate feedback from others, the Practice was aware that some groups considered that feedback on performance both individually and in teams could be improved. The practice committed to action in this respect.

5.6.6. Developing-shared visions

Early on in the enquiry it was acknowledged that the first step towards a fully integrated primary healthcare team was the development of integrated functional teams within the Practice. Now this had been achieved the practice agreed it was timely to review the overall direction and objectives of the Practice in a way that allowed individual teams to develop their own vision whilst contributing to the shared understanding of the total Practice. The intended approach to future development of a dynamic practice development plan would facilitate this.

5.6.7. Mental models

Whilst it was acknowledged that communication worked well in the Practice, there was evidence that individuals' perceptions of purposes and intentions for the future did differ. Continuing and further developing opportunity for dialogue and informed debate would strengthen the capacity to be a dynamic organisation within a changing healthcare environment.

5.6.8. Personal mastery

Ongoing staff development is addressed in several ways, using formal and informal means. Examples have been given in this report as to how personal mastery has developed for the nursing team. With the introduction of Personal Learning and Development plans for healthcare workers the Practice will pay attention into how the specific needs of individuals can be met within the Practice to enable the present high levels of self esteem to be maintained. The nursing team in particular need to exploit the advantages of critical incident analysis and coaching models of staff development, which the present team had the internal capacity to support.

5.6.9. Systems thinking

The model of teamwork that evolved at the Practice worked well within the current structure, and with a patient centred focus. As the Practice debates more the desires and opportunities for developing patient care pathways the interrelationship of all different aspects of care provision both within and outside the Practice will need consideration.

It was recognised that this may give the Practice concern and frustrations, as the system is the larger provision of primary secondary and tertiary care that is available in the local Health Community. At the time of the completion of the enquiry the Practice was well represented on the local decision making forums and by continuing to support new developments and initiatives intended to add to the body of knowledge and promulgation of good primary health care practice.

Chapter 6 and 7 will explore the rationale behind these statements in more depth and reflect on the process as a means for sustainable growth and development within the primary healthcare sector.

5.7. Chapter five summary

Chapter 5 has attempted to tell the highlights of the narrative at the healthcare practice as they moved towards creating integrated approaches to working. As identified in both the title of this thesis and the initial chapters the intention was to create an integrated nursing team. What has emerged from the enquiry was that the nursing team could not function in an integrated way without being integrated into the other activities of all the other teams and groups which functioned within the practice and the immediate external healthcare environment. Some of these issues will be explored in the next chapters.

Chapter 6. Discussion of Findings

6.1 Introduction

This chapter will identify the key patterns that emerged through this enquiry and will attempt to draw the threads together that have been identified within each cycle of enquiry. The guiding focus will be towards the ongoing development of 'personal mastery' for both myself and co enquirers in the journey.

As is the nature of action research as new challenges and issues arose I and co enquirers referred to the literature for help in clarifying the way forward. Therefore some of the discussion will relate to the literature from the literature chapter but new literature will be introduced to support, verify or give clarity for further direction for the healthcare practice.

Some of these issues that have emerged will have been discussed with the healthcare practice but others have emerged through the process of the classification of data and the writing up of this thesis. As my relationship with the practice is ongoing the finalised work will be discussed with them as I gain their support for submission of this thesis as a representative account of the activity from late 1997 until the end of 1999.

Before I even started on the action enquiry with the healthcare practice I started a personal reflective journal. It was through this medium of writing and reflection that issues became clear which led to potential for action. Importantly for me through this process I can track my growth and development, as I was a co enquirer in the process, as such this created significant new personal knowledge.

I had been socialised as a 'nurse' and through my reflections I am aware that I identified most clearly with the nurses, but also had some understanding from the perspective of the medics in the team, and was able to interact with them in a way that overcame initial socialisation. This had been influenced by a parallel stream of activity that I had been involved in which related to developing multidisciplinary teams for acute hospital staff by outdoor education. Through my involvement with this, some of which occurred simultaneously to this enquiry I believe my confidence grew in my dealings with the medical profession.

6.2 The Outdoor Experience

In 1995 I was asked to facilitate a series of weekends for an educational development company called the Outdoor Experience. The environment was mainly in the hills and valleys of Mid Wales, with a variety of groups from different healthcare backgrounds. Most of the groups came for a period of 4 days with the intention of team building. Many teams were interdisciplinary and from acute hospital settings. The groups would usually include Consultants, Doctors, Nurses, Allied Health Professionals and support staff.

Being involved in these activities informed both my personal development and understanding of how multidisciplinary healthcare teams operate. My facilitation was firmly grounded in a reflective methodology centred on the notion of internally examining an issue of concern, triggered by an experience, which clarifies meaning and leads to action. (Boyd and Fales, 1983)

This clarification of meaning in terms of self was helpful to me as well as the participants and this learning impacted on the way that I managed the enquiry at the healthcare practice, and within my job role. The following extracts from my Journal will highlight those that were significant for me;

Later on back at the apartment and after 2 bottles of wine B was talking and said what he admired in me was that I listened and then succinctly was able to summarise the broad picture and draw out meaningful relationships, he said that this was in his opinion what reflective practice was all about, giving others the space to think things through and then help them make the links. He said although he felt very inadequate at doing it he was trying to operate his staff meetings in a way that gave people thinking time and then as a group to try and make sense of what was really happening.

Source: Reflective Journal September 1998

Other incidents helped me understand different personalities in the healthcare practice.

K was a senior sister with experience of outdoor type activities. She had come on one of the series of programmes organised by a large NHS Trust. She had 'starred' as a key member of a television documentary that had been filmed in the directorate in which all these individuals worked. Indeed the television crew accompanied this course with the intention of filming the key players on an outdoor teambuilding event. I believe therefore that openness to thinking and acting in new ways was compromised by the need to 'act'.

When asked to select photographs from a collection of 250 that were laid out on small coffee tables, she said she couldn't see the point, and that she didn't want to pick any of them. It was interesting to watch the body language of the rest of her group, with those that knew her apparently ignoring her. Throughout the weekend I noticed she was happiest in a dominant leadership role that tended to be directive in style. Interestingly by the Monday her peers were able to challenge her away from an autocratic style to one that involved them more.

Source: Reflective Journal January 1999

Working with the Outdoor Experience ran parallel with the enquiry at the Healthcare Practice and I was aware from the early days that I had a role in developing the knowledge base in the practice, one example of this was in respect of conveying the perspective of reflective practice and the concept of a Learning Organisation. At the time of these activities most of the teams that came had questions and issues around improving the quality of care in the NHS. This was focussed around the government policy document a First-Class Service (Department of Health, 1998) that expected teams to move away from a blame culture to a learning culture to learn from what went wrong. This required a shift in thinking for managers away from using punitive disciplinary methods towards a learning culture, for as Ackoff states (1998:35)

"the organization must be capable of rapid learning and adaptation. All learning derives from experience, our own and others. Mistakes are the ultimate source of learning which occurs when they are identified, diagnosed and corrected"

This was not the norm for the NHS at that time in its history as complaints and mistakes were seen in a negative way that required punishment. This led to the perception of a blame culture and hindered good communication and potential for learning when things went wrong. Consequently it seemed appropriate that linking the quality of care and challenging this blame culture, which were part of the same system could be achieved through a process of reflection, as a means of learning collaboratively. Therefore I introduced some of the techniques identified by Senge et al 1994, along with using Learning Histories (Roth and Kleiner, 1995,) and mind maps (Buzan, 1993) to record the results in a way in which teams could take back the learning and hopefully the action to put into their work place. It was during this process that the idea of Communities of Practice started to develop in my thinking (Wenger, 1998) along with the realization that a straightforward way to convey my thinking to participants was through Senge's (1990) five disciplines of a learning organisation. What I wanted to convey was that in this context a learning organisation was more than an organisation committed to teaching and training and still today I find organisations that assume this understanding.

The following observation focussed my attention on preparing effective materials to support the development of change in the practice.

"On occasions it has occurred to me how compliant people are when they come to a learning situation, how they expect to be led and directed and how willingly they comply with the tasks expected of them. As I have gone through the years I have recognised how important it is to plan good quality learning experiences to challenge this early compliance with deeper learning as the course or learning event proceeds. This cannot be taken for granted as in my job role experience I have seen how students get disillusioned if their expectations are not realised. Part of the art of 'teaching' is to fulfil individual expectations that they will learn from whatever is

offered. This is not just about what is taught but encompasses the whole learning experience. Maximising the learning is the intention of the team that makes up the Outdoor Experience."

Source: Reflective Journal March 1999

This means that learning must be a challenge and learners need to have opportunities as we all do to see things in different ways and through new eyes, followed by the opportunity to make sense of such opportunities. Garvin (1993) suggests that only by asking questions can real change occur, and the concept of 'enquiry practitioners' (Argyris and Schon, 1996) enables the development of a spirit of curiosity that serves as a catalyst for learning (Preskill and Torres, in Easterby Smith, 2002:96)

6.2.1 Developing confidence

One of the themes that will be developed in this chapter is the development of confidence with other professionals especially doctors, this was a challenge for the nursing staff in the healthcare practice, and I needed to develop this confidence as well. The literature links personal mastery with self-image (Senge et al) 1994. Earlier writers suggest that personal power is significantly affected by self-image (Adler 1930; McClelland 1975; 1976; Hersey and Blanchard 1993,). In later times emotional intelligence is explored by several writers (Goleman et al, 2002; Cherniss and Goleman, 2001) who identify self-awareness as a key cluster of competencies for effective performance, both for individuals and for leaders. Self-confidence is seen as having a positive impact on performance (Goleman et al, 2002a:33) and a high degree of self-confidence distinguishes the best from the average performers (Boyatzis 1992)

"Day with 24 doctors from Oxford and Marlborough. I realised that I have now become more comfortable with doctors, not intimidated by their presence and able to relate to them on a human level. This was quite a realisation. I also had to role-play as part of the scenario a confident but incompetent role. In this role I was able to be assertive and realise that I can be very firm if necessary in my approach. This was quite a breakthrough I also felt I facilitated the feedback session quite naturally, linked with this I no longer felt a need to justify my position or my credentials Neither apologising nor making my role sound grander than it is The evaluations referred to 'the valuable and well facilitated feedback'

Source: Reflective Journal June 2000

Making the assumption that it is nurses who have to develop confidence with doctors may just reinforce the traditional hierarchies. Using alternative environments such as the outdoors provides an environment outside of the normal socialised structures and has the potential to challenge perceptions of doctors to the others in the healthcare team, as the following extract exemplifies:

"a key learning point which was openly acknowledged in one of the debriefs was how the perception of other staff towards an HCA had changed as he was the most knowledgeable and competent in the outdoors. A doctor made the comment to a Health care assistant from the same department; 'I hadn't noticed you before'"

I went on in my journal to relate this to power and leadership, and confirmed my own perspective that had developed through a variety of experiences, linked to the enquiry with the healthcare teams.

“Personal power and credibility is important in any situation in which you are leading others, whether it is in a shared team approach to delivering a course based in the outdoors or whether it is working with a general practice identifying and developing new ways of working. Within the context of action research this dynamic cannot be ignored and in the exploration within cycle 1 the importance of setting up a scenario where I had personal credibility is given some attention.

Within this is the dilemma of what it means to be a good leader and the literature on leadership and also the outcomes of this study will relate to those skills that represent personal power and yet the leader becomes servant. What are the qualities required to be a servant, in the form that facilitates others learning!”

Source: Reflective Journal June 2000

On returning to the literature in respect of power and organisations it was interesting to note that the majority of texts published in the last ten years, which develop a more transformational approach to leadership and organisational development do not expand on power as a significant issue in the text. Covey (1992:101) identifies ‘*principled centred power*’ as a key issue in principle centred leadership, and it was the clarification he identified that deepens the understanding for me of an effective and credible power relationship.

“Real leadership power comes from an honourable character, from the exercise of certain power tools and principles”

Source: Covey (1992:110)

And he goes on to recognise the tensions in leadership choices that have to be made to enable the purpose of leaders and leadership to be realized.

“Whenever a problem or opportunity arises that requires the involvement of other people, the leader must make a choice. The essential leadership choice is to decide on a power base-coercion, utility or legitimacy. The choice will be limited by the character of the leader (who she really is and what she has become by past choices) and by her interactive skills, capacity and history. It is relatively easy, when push comes to shove and the pressures are on, to lean on position, status, credentials or affiliations or size to force someone else to follow. And in the absence of well developed interactive skills, or the capacity to remain true to deeply held values under pressure or a history of integrity and trust with others, it is almost impossible not to resort to force when a leader is in the middle of a crisis”

Source: Covey (1992: 105)

Kakabadse and Kakabadse (1999:11) suggest that

“the balance each leader determines between transactional and transformational, and whether ones self view is driven by the belief of innate ‘greatness, or the insights that wisdom provides, makes each leader unique”

And that consequently “*power and politics are viewed as higher order transactional leadership skills*” (Kakabadse and Kakabadse, 1999:10)

So for me the issue of the use of power and confidence went hand in hand, and later on in this chapter, I will challenge my self-view and ask the question. *'Do I practice what I preach?'*

This opportunity to develop my confidence in an alternative setting but with senior staff from the medical profession was an asset for me. This was especially relevant to my role as a researcher in a situation in which the subjects, or co participants in the enquiry were likely to be more powerful than myself (Easterby Smith, 2002:59) and as I get to the end of the enquiry I notice how the development of confidence links to effective leadership and especially for the nurse team coordinator both had to happen simultaneously, she had not had the advantage of developing this competence in the same way that I had.

Developing confidence and being able to recognise the issues working across boundaries was also enhanced for me by working in the local NHS community trust.

6.3 The Community Trust

As well as the Outdoor Experience I also had the opportunity to work for the Community Trust which was the organisation for which the 'attached staff' in the practice worked, these were the Health Visitors, District Nurses, Community Psychiatric Nurse (CPN) Community Midwife and Podiatrist.

One of the factors that were largely dismissed as having much impact on the process of change through the action enquiry was the local NHS Community Trust, as little opposition had been raised to the developments in the practice. Consequently they were seen, as having little significance although conversations and observations during the process of the enquiry indicated that the potential of the power they could yield was significant. It is only as I reflect now on the data that this issue, so easily not to be considered, is actually important within the discussion on the findings of this enquiry and can illuminate issues from several perspectives; namely

- The perception, from another organisation's perspective, of what change means and how they have influenced the change, whether knowingly or unknowingly.
- How organisational factors in other organisations within a system can have an impact on change in the present but also influence change for the future.
- How key people, who are given the opportunity to work, act and live across these boundaries can influence the process of creating living systems.

The Community Trust was the organisation in which I was offered a half time secondment, completed in the latter part of the enquiry in the healthcare practice. Consequently the role of

Acting Director of Nursing in the Trust gave me the opportunity to explore and come to understand the complexity of roles and dynamics that I had previously seen played out in the healthcare practice. I started to understand individual players agendas and the reasons behind developments that had been supported or vice versa. As the Community Trust went into merger in the latter part of 2000 and the early part of 2001 the Northampton Primary Care Group started to develop its plans for the consultation paper prior to it applying for independent Primary Care Trust status from April 2002. Being involved in this development identified the complexity of keeping many stakeholders happy, when a pilot project carried out in one of the healthcare practices (Leicester Terrace) had been deemed successful for the participants. In turn this gave the voice of confidence and power from the practice and was a powerful dynamic in creating the way forward for the new organisation the Primary Care Trust (PCT))

6.3.1 Peer support across boundaries

The Nurse Team Coordinator had regular meetings with the Community Nurse Manager, as she had the management responsibility for the nursing staff employed by the Trust and attached to the Practice. They were not in line management relationship to each other but were peers in the process. As peers they also found that they had other things in common and struck up a friendship which was a mutual support role in the work environment but also had social connections, for example on several occasions they went on holiday together. This relationship professionally was supportive to both parties and acted as an informal means of mentorship. The manager from the Trust was going through a period of uncertainty as the management structure was being re-configured. Consequently the manager had a holding interest in the integrated team as it developed but in spite of her being the designated line manager to the district nurses and health visitors she was quite happy to give authority over to the nurse team coordinator, not least because her future was uncertain and this led to her feeling apathetic about the future.

6.3.2 An autocratic leadership style

I later found out that the Nurse Director that had been appointed six months into the start of the action enquiry (whose footsteps I followed) wished to modernise community nursing in Northamptonshire. She implemented a system that she had been familiar with and had worked in a deprived area of Inner London. The assumption was made that autocratically implying that the service in Northamptonshire needed modernising and that less staff were needed would ensure change. This was interpreted by the locally based staff that overspends in other

parts of the Trust were being managed by reducing the number of health visitors and managers in the community nursing part of the Trust.

Senge (1990) explores the difference between commitment, enrolment and compliance suggesting that there are different positions on a continuum and whilst it is more pleasant and reassuring to have considerable commitment it is not necessary for everyone to be fully signed up to change. Within the context of the Community Trust whilst some individuals were signed up and committed to the changes being driven through, some were ‘*grudgingly compliant*’ meaning

“they do not accept that there are benefits of what is proposed and do not go along with it. They do enough of what is asked of them not to jeopardise position. They voice opposition and hopes for failure.”

Source: Senge (1990:219)

This led to a sub culture which as Lok and Crawford (1999:365) suggest can affect the relationships and is key to the relationship between commitment and organisational culture, sub culture, leadership style and job satisfaction in organisational change and development.

In addition, this unhappiness was added to by the approach that became a characteristic of the Trust over the next two years, this was to select a group of people in a project management approach to sort out dysfunctional areas (as perceived by the Nurse Director) in the Trust.

One such project was to implement integrated nursing teams in the North West of the County, this approach was very different to the approach we had taken as action enquiry. I visited the project lead with the responsibility to ‘modernise nursing’:

“ Right integrated nursing teams, I suppose if I go into the history of how I became involved. This organisation about three years ago set up, or there was established in the organisation what was called SORT, which was a Service Operation Review Team. Which was a group of people from a variety of backgrounds who were seconded into the SORT team to do a bit of work. And I was seconded into SORT alongside a dentist, the continence advisor and somebody from learning disability. And one of the things we were to do was review community nursing”

Source: Interview transcript with project lead March 1999

I collected this information along with the interviews and observations that were happening at the practice, in concordance with methods suggested for action research by writers such as Zuber-Skerritt, (1996)

I didn’t realize at the time what is so obvious with hindsight and the knowledge of what was to follow, how setting up an independent group with an acronym implying that areas of

practice needed *sorting*, with a group who had little real knowledge of how the micro organisation within the organisation worked, was a potential recipe for failure. This was a pattern to be repeated in the future. For completeness the modernising community project that was instigated by the Nurse Director and managed along a systematic approach to project management was not completed within the time scales set. However, modernising the service meant that the reduction in health visiting posts happened anyway and the attempt to implement a Community Trust wide means of health profiling failed, due to flaws in the methodology. Consequently front line staff lost confidence in either the process or intentions of the community trust initiated study.

This was important learning as effective organisational development, which aims to change individual and collective thought paradigms, as is the thinking behind learning organisations (Easterby Smith, 2001) is required to be collaborative, and this requires creativity. Mc Fadzean et al (1999) undertook a study to encourage creative thinking in organisations and found that participants who were uncomfortable (psychologically) were less effective in creative type sessions and some participants refused to participate at all. The reasons for this are complex and some will have been identified in this study.

6.3.3 Introducing more collaborative decision making

When I took over as Acting Nurse Director of the Trust one of the tasks handed over to me was to complete and publish the modernising community nursing study. I called together the community nurse managers and asked them what they wanted to do about a final report. The goalposts had changed, the managers wanted to influence the way in which care was managed as the two Trusts merged together. The Trust in the north of the county had a very different management configuration which was very hierarchical, they wanted to have their say for the southern part of the county and to influence the configuration of community nursing for the new Primary Care Trust.

This was further complicated by the fact that a Primary Care Trust in the north east of Northamptonshire had commissioned a study to review community nursing in the county. I was able to get the community managers and the Director of Community Care to write a report that demonstrated the positive aspects of the project with signposts to be part of the debate for the future. I was also able to ensure they were represented in the discussions that would be held by those conducting the review countywide in Spring 2001. I personally felt reassured that the methodology for conducting the review would include all stakeholders in the future services (a fellow PhD student was conducting the enquiry). Easterby Smith (2002)

explores the politics of corporate stakeholders in management research, and I was aware of some of the dilemmas in relationships not just between the Community Trust and the Practice but also more significantly between the then Area Health Authority and the Practice, which held both the financial and accountability power over the Practice. Easterby Smith (2002) identifies the concern that this can contaminate the project. This potentially was less likely to happen using a participatory action research methodology. However another form of contamination may

“ Come from people within the organisation deliberately feeding information into the project, which is likely to support their political agendas ”

Source Easterby Smith (2001:67)

This was a concern I recognised and tried to challenge myself throughout the course of the enquiry through the form of a reflective journal.

Was the fellow PhD student a stakeholder in my enquiry? We had formed a group of initially ten PhD students pursuing action enquiry approaches and the group itself became an action enquiry. I found the process very frustrating at times and tended to identify with other students from a similar background and view of the world. As I reflect on this I don't believe that in this situation the work within the countywide community service was contaminated, but in hindsight this could have potentially reinforced my preferred ways of doing things, and would this actually have been a problem?

6.3.4 Concerns expressed from a different perspective

On meeting the manager that I had first encountered in the early days at the Practice and later at the Community Trust in October 2001 she told me quite spontaneously that they had had no feedback from the proposals outlined in the report that had been submitted. Her body language and facial expression were sad, it struck me that valuing people and their contributions are key to maintaining a motivated and effective workforce. I felt angry that my colleagues who had followed on from me in the Trust had not taken account of this simple but important factor.

“Leadership consists of guiding, encouraging and facilitating the pursuit by others of ends using means, either both of which they have either selected or the selection of which they approve”

Source Ackoff (1998:24)

This had not happened and the result was evident in the persona of the individual. As Goleman et al reinforce (2002a: 53) *Particular leadership styles affect an organisation and its emotional climate*. As I explored this further I started to consider whether individuals in leadership positions realized that they had such a significant effect on people in their

organisations, and across organisational boundaries. Indeed it seemed that making structural change would make things happen, with the assumption that the human way things were made to happen, wasn't really even considered. The review of Community Nursing in the Trust certainly influenced the enquiry in the healthcare practice as I pondered in my writing on the following conversation in March 1999.

"...One of the things we were to do was to review community nursing. We did a literature review and then I suppose eventually we thought it was all a bit too hard! But one of the things that had come up when doing that literature review was the whole concept of integrated nursing. And there was particularly written about the need for a primary care nurse and she was talking much more about generic nurses within primary care. So we discussed this with the Director who suggested that what we should do is write a strategy for primary care. So a piece of work started on developing a primary care strategy, and people said they saw the way ahead as integrated nursing teams."

Source: Manager Community Trust March 1999

Writing 'strategies' is a current hallmark of the NHS and other organisations, and is certainly a helpful management tool to benchmark progress. Murray (in Dopson and Mark, 2003) explored options of scenario planning and strategic conversations, thus linking vision with strategy. In the above example from the community trust whether the process of writing the strategy was grounded in evidence and represented a shared and therefore owned vision for the future (Senge 1990) was debateable.

6.3.5 Teamwork assumptions

As well as being seconded to the Role of Nurse Director for the Trust I continued in my day job. Some students who had recently enrolled on a BSc Top up degree which I had the course leadership for also influenced me. One of the students held a senior position as Head of Professional Development in a Community Trust in another county. Her role had been to implement integrated nursing teams across the county. She had come across a lot of opposition to this move, however I made assumptions that the difficulties had been encountered as change had not been managed well, the teams were self-managed and the staff had had no choice. I do not remember considering whether the concept was flawed. I was too thrilled with what I was encountering with the Outdoor Experience in the outdoor environment to consider that teams of people working harmoniously together could be anything but a good thing? Or as Peters and Marshall (1991:13) suggest

"That empowerment may depend upon a recognition of 'community – in –process', that 'in –process means a historical projection, which working through the differences of gender, race and class in collective self reflection, can also provisionally re-establish an unforced unity of community – a unity which is not a transcendental synthesis of sociality and individuality, but one which openly and critically appraises difference and heterogeneity- as a basis for collective self consciousness and community action."

Firmly accepting that this process would be generative for organisations to move forward, I still continued to challenge myself on the purpose of self managed teams, especially the role

they had in developing new services and reflecting within the whole system in which they operated. So a fundamental question around the necessity of leadership for developing and delivering a vision remained.

6.3.6 Influencing the wider healthcare system

As the developments at the Healthcare Practice have shown the new ways of working that developed did enable teams of people to function in more efficient ways, whether or not the real outcome was an integrated nursing team is debateable but good teamwork in practice rather than in the theoretical domain of the literature, did lead to added benefit in many ways.

These benefits filtered in to the local health discussion and debate around the future configuration of primary care services in many different ways. This included the network of the Primary Care Group Board, as one of the GPs at the practice was a Board member with lead responsibility for clinical governance, also the local network of GP trainers as one of the GP's was involved in this activity. Because the practice was successful in becoming a Beacon Trust this meant a series of presentations on the developments to a wider audience and the publication of the initiative in the NHS Beacon Handbook.

Consideration was taken of the project in developing the plans for the consultation document for the proposed Primary Care Trust. The outcome was a proposal for the Borough of Northampton to be divided into four neighbourhood teams. The teams would have all disciplines including social work. The flaw for me in the proposal was not the concept but the sheer size of the teams, which would make them unmanageable. Consequently within the four major administrative areas local neighbourhoods would have the flexibility to create multidisciplinary teams that reflect local need. This outcome reflects another link with some of the key influences that have developed the model locally and returns to the interview recorded earlier in March 1999;

"What I would see as an integrated nursing team is a group of people who share a common objective and have common goals, have commonality among them so probably looking at a practice population, but if it's a very small practice it might look, I expect that the teams are too small to actually function...might be, say you looked at. ...health centre which has got four practices, surgeries now but they are all very small practices, one or two GPs, one health visitor, maybe a third of a district nurse, things like that. It may be in that situation your integrated nursing team might actually service all those practices. Because although the GPs don't get on with each other because that's why they're separate practices, personalities on the whole preclude them from working together, doesn't mean the nurses don't get on with each other. And their client base is probably the same and they serve the same geographical area. So if you go back to Cumberlidge and think about localities, those nurses probably fit a Cumberlidge model, although they are GP attached. So I would say that in big practices it's probably within a practice. Smaller practices might be wider and I would say core members of it are people who are ideally based in the surgery. So you're talking about practice nurse, district nurse, health visitor. My theory is that the research suggests that the development of

those effective relationships that work doesn't happen. So although you may have said 'oh there are the midwife and the CPN and all those other people, they are not part of the core team'. Its almost as though you could, its like an onion, you've got the core team and then its where your boundaries go. So, I would still see clinical specialists, so ~I would see practice nurse's, health visitors, district nurses, but I would see them as like three overlapping rings and depending on their skills and interests those rings will overlap more or less. But they all have a commonality in being a nurse, so there's a core. That's the generic nurse. And at perhaps Grade D, if we keep that they might work across all three specialities."

Source: Transcribed interview with Community Nurse Manager March 1999.

Linking structure with process was being considered from a cause and effect perspective but also from the interrelationships between the different professionals within especially the nursing workforce. This identified the predominant concern about making things happen but without necessarily considering the 'how' of interpersonal dynamics to create motivated and creative staff teams.

6.3.7 Concerns about generic practitioners

The concern that generic health professionals will start to emerge has been voiced on many fronts, and the use of the word generic nurse in primary care is no exception, indeed the move towards a generic primary health care practitioner has also been mooted. Again this respondent clearly articulated what became two years later the prominent view in the development of the local healthcare service.

"I don't ever see those clinical specialities going really because I think they are quite different, they do bring their own skills. And I think that's perhaps where some GPs might find that difficult because they will say 'well we're all general practitioners, were all the same'. But in fact they're not because one specialises in obstetrics and one mental health and if you talk to them about it they recognise what you mean. But for some reason some of them find that difficult with their nurses to say their nurses have special skills and interests..."

Source: Transcribed interview with Community Nurse Manager March 1999

So locally within the context of developing new organisations to meet the healthcare agenda at the beginning of the 21st Century, issues around how well teams can best work together to deliver effective patient care has been influenced by the developments in both the local Community Trust and the Healthcare Practice which has been a pilot for new ways of working.

So why did this leave me with a dilemma?

6.3.8. A personal challenge

The consultation document for the potential new Primary Care Trust had the words around effective teams. A change manager was appointed to help with the transition from two single Community Trusts to one merged Mental Health, Learning Disability and Community Trust, and to facilitate the next stage in the development, which was further reorganisation from April 2002 when the Community Healthcare Trust would maintain Mental Health and Learning Disability Services and the Community Nursing Service would be integrated into the new Primary Care Trusts across the county. I believe this process of change management is about getting hearts and minds signed up to the concepts, and my concern was that the way of collaborative change management was not clearly understood in the mind of the change manager or the other key players in the Trust.

Eventually following poor feedback on the process, the change manager came to see me and asked me to lead the consultation workshops of which there were 10. I made the decision not to be involved. My reasons were;

I was now back in my full time role in education and reflecting on the secondment into the Community Trust I recognised that things had been left undone in my absence. This was not deliberate, and was more about the way I interpersonally interact in situations. Consequently giving an excess of time to a developing organisation would take me away from my core purpose and put the organisation at risk that I worked for. This in itself had been an interesting revelation; I had assumed that I would not really be missed for half time out of the organisation for six months, especially as my role is very often of the 'jack of all trades' variety. However in the time I was away issues which normally would have been nipped in the bud grew out of proportion and one member of staff said to me that it felt as if;

"I had abandoned my children to look after the kids down the road"

Source: Academic member of staff April 2000

Although this could be interpreted as reinforcing a paternalistic approach this was not what was meant but the message got home. Katz (1955) explores the importance of human skills in communication and enabling managerial effectiveness through the delivery of technical and conceptual skills is not sufficient without the important human element. This provided an opportunity for the executive team in my work environment (the three of us) to talk freely and learn from the

"The issues that had been exposed in my absence of our personal and joint management styles"

Source: Reflective Journal February 2001

"The journey through some turbulent times has been important, Mark has learned and I have learned, we have gone through the emotions of anger, blame, defensiveness but followed

through by reflection both individually and collectively which has brought us to a new understanding.”

Source: Reflective Journal February 2001

Secondly the new organisation (PCT) had to own and facilitate its own development, this lay at the core of how I valued the change process, by agreeing to facilitate the workshops I felt I would be disempowering them as both individuals and organisations, especially as I had no long term intentions of being part of the management group.

I did attend one of the workshops when I was struck by the lack of embedded knowing by the participants that had been called upon to facilitate the small group discussions. My sense making of the unease I felt was confirmed when the manager who I have referred to earlier in this chapter and who is now a student on a programme I ran, said that she wanted to take the experience of facilitating the workshop as a focus for an essay, as she felt very upset by and unprepared for the whole process.

Previously I may have felt guilty that I didn't agree to help in this situation especially as one of the GPs who attended the session where I was present alluded to the fact that I should have been asked to facilitate the workshop, as I would have got the required outcomes. But this would have gone totally against the way in which I have come to work and recognise that full involvement of participants is the most effective way towards sustainable change.

The leads into the following section which identifies the key issues that have emerged from this process of enquiry, as they are discussed within the text. In Chapter 7 these findings are linked to suggested ways forward for future research and development within the primary care sector.

6.4 Developing confidence 2

It is not surprising that the majority of extracts from my data, that I have selected for this part of the chapter to demonstrate increased confidence in participants, are dated sometime into the study, and in other aspects of this chapter quotes will demonstrate that the development of identify, self esteem and confidence were critical to this enquiry. For some of the new roles, learning and adapting had to take place, smoothly on the surface but not without personal challenge and anxious reflection. One of the roles was that of the generic community staff nurse, and a change of behaviour signalled developing confidence and well-being.

“Noticed behaviour change in Jan...in fact spoke to her about it, remarkable, a softer approach. Laughing more readily, joked about herself at yesterdays training meeting (subject:

assertiveness) Jan laughingly pointed out that her personality sometimes comes across as aggressive not assertive if she really cares about something. Just this one thing has lifted my day, credit due to all the district nurses, they are really trying to make it work."

Source: Ann May 98

"Sunday morning, and listening to tapes, a sentence struck me that I said – collaboration and negotiation are all very well if you can cope with it. ...Confidence and self-esteem are emerging as key topics in the enquiry both personally for me as the researcher but significantly for the team. This leads me to thinking about a question that is at the heart of this enquiry for me, the practice knows what it wants to achieve but how are 'learning organisations' created in the context of healthcarehow can developing confidence and self esteem generate creativity and generativity."

Source: Reflective Journal 1999

Being confident seemed an issue that was perceived to be linked to credibility by individuals in the nursing team. Whilst relating to me the narrative of a meeting between the partners and practice manager with a local senior Trust nurse representative to discuss the reduction in health visiting hours, the following comment was made.

"LD became flustered under pressurised questioning and somehow for the practice she lost credibility"

Source: Reflective Journal March 1999

Confidence also seemed to be related to how individuals came across in dress, manner and a certain amount of presence. I know for myself that confidence can be linked to how I feel others perceive me, but as I noted in my reflective journal

"I need to be careful that I do not put onto to other people the assumption that they see themselves in the same way that I see myself"

Source: Reflective Journal March 1999.

This goes not just for how I look, but how I think and feel as well. In my reflections I noted that misunderstanding could result from the use of language at an individual and organisational level. This was particularly so across professional boundaries and a factor I noted needed exploring in depth with a group of nurses and social workers who shared a course in clinical management which I taught. This seemed to be something that I paid attention to at a meeting in Norway later in the year.

"Several interesting examples of how people interpret different words to have different meanings, and how things are perceived differently in different cultures. I have sensed an undercurrent/tension about presents, size and cost, this is important especially to the Scandinavians but not to the English. Also difference in the way words such as meeting and conference are understood."

Source: Reflective Journal April 1999

Holman and Thorpe (2003) explore the issues of management and language and support action enquiry processes whereby managers become practical scientists, reflective practitioners and practical authors. It seemed to me that this was the process being created

within this enquiry, and yet this potential could not move forward for some, especially the nurses, until confidence had developed.

Confidence in team meetings was an area where personal perception was potentially anxiety provoking at the beginning of the project and hindered the development of collaborative ideas. However this was probably part of the process that had to be worked through.

"Interesting that during the discussions I tried to involve the nursing team, did not get very deep responses. Ann went quite red and embarrassed when put on the spot"

Source: Reflective Journal June 1998

Another issue emerged as the practice came to grips with the process of action enquiry, initially being quite sceptical of the process but later some sound converts emerged. During this phase with a group of the nursing team we discussed coping with uncertainty or more effectively voiced as 'tolerating ambiguity'

"But it is more than tolerating ambiguity, we can do that! – It's about coping with the tension of not being seen to agree with the other (more powerful) person. This then reinforces the power for them and is a negative aspect"

Source: Nurse meeting July 1999

This was an important moment in the process of dialogue and the group were challenged to recognise when this happened within the practice meetings, and to overcome the reticence of challenging others opinions. This was a useful reference point for the discipline of sharing mental models (Senge 1990)

"Very good meeting (steering group), a lot of camaraderie, noticed how the meeting has changed from the beginning. Recognised how comfortable they all were with my presence, wanting me to be involved in the new appointment and continuing supervision"

Source: Reflective Journal October 1999

This could give the impression that within the practice everybody was being accepted as equals, certainly from my perspective this was a value I believe in and sub consciously wanted to instil. This value for me means that all people are equal but they may well do different jobs, for which different levels of training and responsibility are required and this is reflected in salary. Naively I thought this was being achieved until following a dialogue I wrote the following in my journal.

"Met with Paul, who talked about the receptionists being subservient to the Doctors and Nurses, we explored what subservient meant, we talked about issues to do with equity as people rather than equality, recognising pay and responsibility differentials. I came away thinking that he did actually see them as lesser mortals. I tried to explore issues of power differentiations that hindered interpersonal communications, and how that had shifted between doctors and nurses, and how that needed to include all staff if it was to be a really cohesive practice. Paul talked about how the personal development plan (PDP) had been developed that year with everybody including the reception and admin staff all involved. He gave me the impression that it involved everybody but actually following my discussion with the receptionists it emerged that it was only the team leaders who were invited to the meeting, where they felt intimidated by the

language and the doctors and (on the tape) talked about even how Dr. G who is normally quite nice shouted at her and reduced her to tears!)".

Source: Reflective Journal and tape transcription December 1999

This example got to the core of the different philosophical views of leadership. Paul came from an authoritarian 'leaders are born' camp, possibly influenced by his time in the army. Through dialogue and discussion, he did start to recognise that valuing people and treating them with respect, as they perceived it, may influence the speed of development and harmony in the practice. This issue was something returned to and discussed in the light of questionnaire responses that indicated that feedback to staff on performance could be improved. Kakabadse and Kakabadse (1999:315-316) discuss the '*paradox of feedback*' indicating that in order to find ways through such a paradox '*it is necessary to identify the degree of ownership people hold towards realizing their responsibilities*'. This was particularly important and required sensitivity in the early stages of the project when individuals with fragile self-confidence took negative feedback as criticism, which resulted in refutement, disagreement and challenge, rather than constructive reflection and support for future development.

Handling constructive feedback was a learning experience for the practice and coincided with the development of confidence. An area in which confidence was enabled to develop was through the 'Depression Care Training' initiative and the mental health supervision group,

"All acknowledged that as a result of the high profile of depression care, awareness, confidence and practice had changed"

Source: Multidisciplinary nurses meeting November 1998

This confidence led to challenge others practice, perceptions and assumptions. The same diagnostic tools were introduced that were to be used by all practitioners, and this led to the first objective evidence that learning was a key aspect of changing practice.

"Karen referred to the importance of integrated learning and the usefulness of meetings to capture shared learning. Issues surrounding this important statement will be discussed at the next meeting"

Source: Multidisciplinary nurses meeting November 1998

Following this, documentation alludes to training being important for all staff, and not divided in to teams.

In Cycle 2 of the enquiry attention was given to exploring the dynamics of coffee time. The tensions around nurses speaking with doctors was in essence an issue of confidence in the power relationship of doctors to nurses and the evidence I have used to support this was from 1998.

"Ann: This coffee issue is important for the practice, and I do see it as valuable, because its one of the few times that people.... but it is so hierarchical, I think it always will be Some of us don't seem to have the confidence to go up to coffee, I know it sounds really silly and childish, but that's how it is in reality, its sort of in us, it is so deep and ingrained in us"

Source: Interview May 1998

During the same interview the presence of the lead GP for nursing being present at the nurse meetings was discussed and the barrier that created to the nurses fully exploring and airing concerns and solutions;

"Sue: So you think quite a lot of stuff is ready to be unpacked by all the nursing teams together?

Ann: Yeah but its difficult to get them to speak if Joan is there.

Sue; Yes I noticed a difference when she was called out from the meeting

Ann: Yeah when she was called out it was like the flood gates opened. I think some of it comes from, it stems from the original request of the nurses not to have anybody non-nursing there, but they wanted to come as they thought otherwise our meetings would just be chitchat!"

Source: Interview May 1998

The easy response for me would have been to suggest in many of the meetings where I had opportunity, that the nurses could cope well without having any other presence at their meetings and this may well have helped to restore their confidence to speak out and grow together as a team. My concern was that by doing this the relationship with other members, who were perceived to be higher up the hierarchical tree, would not have the chance to develop, and for the nurses to develop the confidence that would be required for the Primary Healthcare team to work effectively in partnership together.

Along with many other examples of confidence developing, this communication channel between two professional groups was no longer considered a significant problem by the participants by the end of the enquiry.

6.5 What is being marginalised in the enquiry?

In September 1999 the work of Gerald Midgely (1992) made an impact on my thinking, especially in respect of his writing in "The Sacred and Profane in Critical Systems Thinking". Whether it was the terminology relating to the religious that attracted me I am not sure. He discusses the issues of boundary judgments that are made in respect of what is considered (valued, *sacred*) and what is excluded (not valued, *profane*) Midgely 1992: 5. I started to 'think about who and what is being marginalised in my research' (*Reflective Journal September 1999*)

In July 1999 along with the nurse team coordinator I had to give a presentation to the board of the Primary Care Group on the developments in the practice. This was a turning

point that led to highlighting questions to the practice at the end of the first year, as explored in Cycle1

"Felt the presentation went fairly well, although the expectations of some of the members of the group (predominantly the GPs) was that we would feedback on the project outcomes – this was not the purpose. What did I learn? That the subject was an integrated nursing team but what I was really advocating was participative working within primary care, which doesn't necessarily mean integrated nursing teams. The question was asked whether or not integrated teams were radical enough! Could now see where Paul was coming from on Tuesday. Felt a tension within the group, as the assumption was that healthcare professionals talk to each other. – What is evident is that they don't. Getting people to communicate is what my research is actually all about."

Source: Reflective Journal July 1999

On holiday in Spain in 1999 I reflected on this issue further, by asking two further questions, prompted by reading work by Edgar Schein (1974)

- *What I notice and what I do not notice?*
- *Who is talking but not being listened too? In the context of the healthcare practice, I identified one individual who I should take time to actively listen to, and possibly challenge the preconceived ways of seeing the world of the healthcare practice.*

Source: Reflective Journal September 1999

What I missed at this point was that to a certain extent the patients and their voice were marginalised from the enquiry. They were not full participants in the developments and yet the altruistic intention in the policy literature and the rhetoric of the practice was better services for patients, especially patients from marginalised groups such as those with mental health problems or the elderly. How did this marginalisation impact on the enquiry?

6.5.1 Elderly surveillance.

From this reflection I noticed that a lot of talking occurred around mechanisms for 'elderly surveillance' but very little actually happened. Was this because no-one really had a passion for this activity, was it because the district nurses who had put a lot of thought into the processes did not at this time have a significant voice in the practice? Does the following quote give some hint, in the context of why mental health awareness was successful and yet the team struggled to develop much action around elderly surveillance? Taken Midgley's view (1992) the elderly are seen as a undervalued group in society, but so are people with mental health problems, so this was not necessarily an appropriate causal link.

"You see we should be doing elderly surveillance. The geriatric depression score is incorporated into our elderly surveillance questionnaire. After the last elderly surveillance meeting I have been trying to think of something we can either use as big stick or carrot to make people want to do it. We've got to inspire them to want to do it, cos its very low on the list of priorities, perhaps we could do something with the depression questionnaire."

Source: Ann January 1999

This being low on priorities took on another dimension on the return of the District Nursing Sister from a period of sick leave. A lunchtime 'catch up' session was arranged and I was invited to attend. It became apparent in this meeting that the district nurses relied predominantly on the Community Trust manager to organise their work load, this upset the nurse team coordinator who felt that she had the agreement of the Trust to manage these individuals, the Trust had even agreed to Ann doing the Personal Development Reviews in line with the practice agenda. The following reflection notes on the meeting highlight such an issue;

"The main thing that emerged was about elderly surveillance and some really good ideas emerged. One was that they should take elderly surveillance to residential homes, invite the clients that were part of the practice to attend an informal information session. Ann discussed the problems that may arise with patients from other practices, but that would be overcome if communication was made explicit to start with. The conversation on elderly surveillance developed because it was perceived that Sarah and Penny, and Jan on the weeks that Jo was away actually gave out work to other practices when they only had one or two visits themselves, and didn't take the advantage of the time to do office work which needed to be done. Jo was obviously a bit miffed about that and there are obviously issues to do with the number of patients visited and how that is monitored with the caseload. Jo believes that they have plenty of time to do elderly surveillance if they wanted to!"

Source: Meeting notes May 1999

Could this be explored within the context of a systems approach at the practice?

"Who is at the centre of the system? Does it depend on the stakeholder? The rhetoric says that the patient is at the centre of the system, but not really, everything actually mitigates against putting the patient at the centre of the system. Paul thinks he as manager is centre of the system, GPs think they are the centre of the system, Ann thinks she is the centre of the system. Where does this cause tensions? Receptionists think they are the centre of the system,"

Source: Reflective Journal October 1999

This was part of the consideration of what leadership meant within the practice, explored in Cycle 3 and also redefining the role of the integrated nursing team and asking questions whether the practice really wanted to achieve integrated nursing, or whether the intention was to 'integrate nursing' as a more holistic activity into the life of the practice.

This led to a generative debate. With lots of flip charts, to produce boundary diagrams for each person and stakeholder. Questions were asked such as 'Where are the tensions, and can they actually be overcome?

From this open atmosphere it was identified that there was a need to explore the whole issue of conflict within groups. (Senge, 1990; 1994; Covey, 1992; Hobden-Clarke, 1997; Goleman et al, 2002; Easterby Smith, 2002). How is it lived and handled in collaborative enquiry, and how can people get to win-win situations. This was very productive for the practice, enabled

patients to be less marginalised and helped to develop confidence and trust between professional groups.

6.6 Leadership and learning and support

The potential to lose sight of the strategic direction by concentrating on everyday operational issues was a risk because of the way the post of nurse team coordinator was set up. The role was 50% clinical and 50% developmental. Evidence was available that throughout the course of the enquiry the post holder more than met the 50% clinical aspects of the role. During periods of staff shortage, due to leave and sickness this was significantly more. This became a focus for dialogue at the regular meetings between the post holder and myself.

“Because what I’m worried about is that you’re actually losing sight of what you’re trying to achieve with all the nitty gritty everyday stuff, of things like arguments over hours, which until its resolved, its taking ages and probably wont get a positive resolution anyway”

Source: Sue, May 1998

“Yeah, yeah, its hindering development and growth and there’s sort of walls going up!”

Source: Ann, May 1999

We explored this further and found that in developing an approach to shared care some of the barriers, and feeling so precious, were linked to concern that jobs may be cut by the local Trust if tasks could be invested in other people. This seemed particularly to relate to practice nurses and district nurses taking on health promotion activity that was traditionally seen as the role of the health visitor. This has been identified as a key issue in the development of new roles and interprofessional working in the health service (Freeman et al, 2000)

These tensions were discussed at what became a regular reflective session, branded as ‘peer supervision and training’ and in the conversation with Ann she identified that:

“Because what I’m worried about is, that we’re going to lose some of the things that are really important to the practice. What we need somewhere along the line is that all of them need ongoing education, lets say peer supervision and support and education”

Source: Ann, June 1999

Perceiving education and peer support as positive rather than a response to a skills or performance deficit was an early challenge in the enquiry and this was facilitated by the selected model of a learning organisation (Senge, 1990). Providing an opportunity to motivate individuals to do things differently and to try new ways of working again challenged both confidence and the status quo of the organisation. This was enabled by the leadership style of the nurse team co-ordinator but at times disabled by other key leaders within the practice.

This key task for the nurse team coordinator was hindered, as often the operational needs took precedence over the nurse team coordinator having both opportunities for her personal education and development, but also the support of others undertaking such activity. This emerged when we were reflecting and discussing the scoring given to elements of development as explored earlier in this thesis;

“Ann: Education and Training, I think that’s quite good actually here. Except that the health visitors would just pull them out of any future courses because they don’t feel they can make the commitment to study time. And that’s going to be a real problem.

Ann: the Trusts are very good actually the educational consortium is an excellent arrangement, for the attached nurses.

Sue: How about the areas such as IT and all those kind of borderline areas?

Ann: It’s there, but it’s the time to take it up, they’ve all been on the Cochrane database for instance.

Sue: Oh right

Ann: I’m the one who hasn’t because I got called to do an extra clinic, and I really regret it now because everybody said how useful it is.”

Source: Taped interview January 1999

This database provides the opportunity to search for the evidence for a wide range of treatments and interventions, for a leader in the modern health service evidence based practice implementation, whether clinical or organisational, is a key issue.

This is linked to an area where the nursing team considered they were weak, in scoring 3-4 for evaluation and audit. This was reflected on as part of the enquiry and led to more definitive action, in partnership with the medical team, and probably the improvement in evidence-based practice was one of the hidden successes of this project.

“Ann: We are getting better at it (audit) but uh 3-4 really,

Sue: How are you going to bring that up to a 7-8, which is the maximum score you have given to other areas?

Ann: Well getting our finger out and doing it more, we do it, we are, its almost like being, were probably 3-4 years old on a life cycle of audit you know. Were sort of in child mode as yet and Rod said about getting an, audit group up to learn more about it and the answer was yes, but we haven’t got any further in doing it”

Source: Taped interview February 1999

This conversation sparked action, the audit group was set up, with a schedule of audits that included topics across the disciplines, changing practice and supporting the development of an integrated service.

Within the context of the enquiry a lot of skill development and working in new ways was required by the staff. Education was not planned in a systematic way, but it did happen.

As I reflect on this now it was difficult to plan in advance specific education and training as the process of the enquiry itself led to change of different magnitude depending on the outcomes of collaborative enquiry. The practice was signed up to becoming a ‘learning

organisation,' and in the context accepted responsibility for education and training of staff. This was made explicit within the discussions, which led to the Practice Development Plan in 1999 and 2000.

And yet peer supervision meant more than monitoring and reflecting on performance as the following dialogue demonstrates.

"Sue: Now there are things that you're moving to doing more centrally

Ann: Mmm and by less qualified people

Sue: Yeah so what is common and generic could be done by anybody?

Ann: anyone who's qualified. Certain aspects of all these things can be done by an unqualified person

Sue: Right yes, mental health can't can it?

Ann: It can in terms of looking after each other's mental health.

Sue: Right

Ann: For instance Penny and Judith shine at peer support for all our mental health"

Source: Taped interview September 1998

Within the context of this organisation feedback on performance improved, education and training became recognised as an important vehicle for new development and the interpersonal nature of support at work was recognised. This mapped neatly on to the expectations in the NHS outlined in the 'Improving Working Lives' document (Department of Health, 2000) but in a inductive, generative model from within the healthcare practice.

'Sacred and Profane' (Midgely, 1992) or valued and devalued. These aspects also are exemplified in the following section relating to some of the power dynamics in the practice.

6.7 'Problems' and 'Disappointments'

The enquiry has also highlighted issues to do with language (Holman and Thorpe, 2003) and use of the word 'problem'. If something is a problem to me is it to other people? It was interesting to note the use of the word 'problem' in the practice. What may be a problem to one person is not to another and this leads to the challenge of how the direction is taken forward in a collaborative manner.

"a problem will often depend on the relative power of the people that the people who define the problem have over those who are defined"

Source: May (1993:36)

This consequently impacts on the issues of power within the practice and issues identified as problems by the partners or the manager were given attention to. This also was a hierarchical issue, as the nursing team did not have the same authority or positional power within the organisation to bring to the surface their problems. This was evidenced within the nursing team sectors, such as the issues within teams e.g. the district nursing sister and also in

the relationship between the nursing team and the partners, with the potential for the nursing team seemingly being seen as the problem rather than identifying problems. This was evidenced in the second cycle of enquiry with the discussion on coffee time. Therefore, was this an area where it influenced what was included and what was not included in the developments within the practice, and how did I potentially collude rather than challenge this because of my desire to feel that I was respected within the practice, did I learn things about manipulation, and negotiation here? Or did I collude with the potential for oppression within the practice? What about owning problems as a practice, did this make, as Gerald Midgely would suggest, people defensive? Looking at the strengths and weaknesses of the process of developments or activities, would this lead to more of a shared responsibility for issues, how could this move forward...all part of my journey to looking at introducing the theory around learning organisations.

The literature in chapter 3 explores different understandings and meaning of teamwork and also the issues of medical dominance. (Ovretreit, 1993,1996; West, 1995; Partington and Harris, 1999) This also relates to research carried out by Freeman et al (2000) which identified 3 different philosophies which emerged as understandings for effective multiprofessional teamwork, from six case studies of different multiprofessional healthcare teams. Only one of the teams was a Primary Healthcare Team. The three philosophies are described as Directive, Integrative and Elective. Freeman et al (2000) suggest that members of the medical profession (and some specialist nurses) frequently held the directive philosophy, based on an assumption of hierarchy where one person would take the lead by virtue of status and power. This was my perception in the early days of the project when the power of the practice manager and lead GP was more keenly felt as alluded to in Cycle 1 and 2. Secondly this philosophy created assumptions about levels of communication (Freeman et al, 2000:241) since the *"team leader would determine what, when, and how information was communicated and to who"*. In the early days of the enquiry we have evidence of this in respect of the 'Practice Nurse' review and the implementation of the community staff nurse role. Freeman et al also found that this philosophy determined the way in which professionals learned from each other, as learning is defined by status; those in power believe they can only learn from their peers.

Some evidence of this occurred with the meetings for audit only being open to the doctors at the beginning of the project, although some more integrative practice was evident with the mental health awareness sessions. However, not all the medical staff were engaged with these,

whilst not necessarily opposing the meetings their lack of involvement potentially led to a fragmented service for the care of patients with mental health problems.

At the end of the enquiry considerable evidence of an integrative philosophy was evident, demonstrated by the commitment of individuals to being team members and the practice of collaborative care and therapy, a recognition of different role understanding and the development of negotiated role boundaries. (Freeman et al, 2000) This had been achieved by the process of enquiry as documented in this thesis and from embracing a reflexive approach to learning as an organisation. (Senge, 1990, 1994; Goleman et al, 2002; Saint-Onge, and Wallace, 2003) However some elements of the practice were more aligned to the 'elective' philosophy. (Freeman et al, 2000) Freeman et al suggests this was the style preferred by professionals who preferred to work autonomously, being synonymous with insularity of practice and would liaise with others when they perceived they had a need. Several of the characters in the healthcare practice enquiry could be identified as fitting this description. Firstly, those who were mainly independent practitioners, i.e. counsellor, midwife etc. who were members of multiple teams and for whom full team involvement would have detracted from their overall peripatetic work practice, but also two of the GPs, one who continued to work in this elective way but became much less intimidating as the confidence of the nursing team developed and another GP who resisted the more integrative philosophy initially but by the end of the enquiry had become a fully involved and active team member.

The previously identified elements of effective team working (West and Poulton, 1997; Onyet et al, 1996 etc) such as shared vision, good communication, role understanding and role valuing, were exemplified in this study. This enquiry also shows that the development of confidence, redefining power relationships and critically reflexive learning opportunities have all been interconnected and interdependent in the journey of enquiry at the practice.

Medical dominance was seemingly addressed within this enquiry and yet within the wider healthcare community this is a significant issue yet to be effectively overcome, as is highlighted by the following comment.

*"Nurses got no ***** idea, all caught up in their own little world."*

Source: Junior doctor February 2000

And

"Nurses focus on themselves and are precious about their own professional groups, i.e. district nurse, health visitor etc. not community nurse even. They all want to be represented by their individual disciplines, its so frustrating. Doctors think about what the practice population needs"

Source: Project lead for Commissioning Pilot. October 1999

This latter comment was from a key individual in the local healthcare community who was setting up a pilot for what would become the Primary Care Trust in the Northwest of the County.

The question to be asked is whose attitude needs to change? Is it of the doctors to the nurses or the nurses to the doctors? I would suggest that this is not an either or situation but common understanding, respect and value have to be determined by giving significant attention to challenging stereotypes and developing a belief in interdisciplinary teamwork.

As part of the process in the practice we had moved towards a common understanding of community nursing, but this only served to alienate the practice initiative for other nurses who had not experienced the development of confidence, to behave in an interprofessional patient focussed way. This raises the issue of when change in perspective happens in a small part of a much larger community and how that larger community can in effect hinder rather than encourage future growth and creativity.

Driving to work that day, the following poster struck me “ *Never underestimate a minority!*” (The Countryside Alliance) This led to further reflection, which was ultimately recorded as

“Strikes me that although I am attempting to get barriers broken down between professional groups part of the initial struggle is breaking down barriers within professional groups, plenty of evidence of this both at the practice and in my work. Could relate it to Men are from Mars and Women are from Venus but perhaps can better be explored through the deep learning diagram in the Fifth Discipline field book ”

Source: Reflective Journal January 2000

The word problem was overtaken in my reflective journal of October 14th 1998 in respect of the use of the word ‘disappointment’ and how Hugh who had strong links with the practice used it. I decided I would challenge him and ask the following question;

“Does he use the term disappointment as a put down? Is he aware of this and what type of response does he usually illicit?” this decision was influenced by reflecting on a supervisory session where I wrote in my Journal “ the big lesson I am learning at the moment is that I need to be more forceful even if it upsets people and I need to learn to cope with this upset” I made an appointment to see this person and explored this and other issues, interestingly he seemed to really open up and I was aware that my ability to listen was being quite helpful and cathartic to him as he proceeded to tell me his life story. At the next meeting I attended that he was at and at which I presented the draft report of the first year activity he was really supportive and seemed to be much more aware of how his language and body image affected other people in the room. Presenting this draft report had been a challenge for me and I had discussed its format with Peter as I was worried how the nurse team coordinator may respond to it and if her self esteem took another hit how that would affect her performance in the second year of the project. I noted in my reflective journal that” Pleased with myself that I decided to write in the first person and around the action research methodology...had a bit of a battle to get agreement to distribute the draft prior to the meeting so all would be informed and challenge/develop the content’...following the meeting, which went well I asked myself if I regretted the format of the report, there were comments that it had too much prose, they wanted punchy headings and

achievements celebrated much more. Did it really bother me that this was implied criticism, is it part of my concern at being unpopular or critical? Interestingly enough during the meeting I was given the feedback that I am quite frank and constructively critical, which they felt really challenged their thinking to move forward"

Source: Reflective Journal November 1998

At the end of the first year of the enquiry, a "transformation perspective" occurred (Mezirow, 1990), when it became apparent that the practice did not just want the nursing teams integrated but integration of all services provided to the practice population. It was recognised that this would be a long-term aim, but was built on the mutual respect and confidence that had developed. Consequently, for the practice this was a positive thing that was a direct result of a year's hard work toward integration. However I was aware that the understanding of integrated nursing and integration was perceived differently in the local community. This was influenced by the literature being circulated, (Young, 1997) and interpreted from a negative perspective within the Trust at the time, where other attempts were being made to develop integrated teams from a different developmental base.

This demonstrated how far in relationship terms the practice had moved forward and beyond some of the power politics at work in the external environment.

6.8 People versus Tasks

Several issues have emerged in respect of developing new ways of working within the integrated nursing team and indeed within the whole healthcare team. The first can be explored under the heading of identity.

"Ann says it is difficult sometimes because she can change three roles and three uniforms in one morning!"

Source. Notes on transcribed tape May 1998

"If Jan can master that type of skill this is an element of my job. Its about having flexibility and the skill, this is a key to making an integrated team work. This feeling being part of being three different people and this lack of identity and isolation. Its about the whole team changing there perceptions and ways of working, so that you don't feel three different people wearing three different hats, that actually you are Ann and you are a community nurse. I am trying to get Jan to capture how this process occurs, because she is a district nurse, and to be honest deep down I am a district nurse, and it is difficult, really difficult. What is this animal that is a community nurse and where does she sit?

It's easier for me because I am identified separately and have identity and power, which is management. When you make the transition from clinical nursing into nursing management there is that slight...one of the interview questions that Peter asked was, how would you feel with the isolation of the post when you have to be unpopular. In a different way Jan will experience some of those feelings. Its about tribalism, it really struck home to me and the more I do this job the more I see how strong we are as nurses, but we are so safe within our own discipline that it works against us sometimes"

Source: Transcribed Tape. June 1998

Mullins 1989: 384 discusses the importance of 'role' and how the coherent patterns of activities and relationships are important for an organisation to achieve its goals and objectives. Team roles have been researched in respect of team functioning but the aspect of role being considered here relates to the identity of the individual in the role. Within a changing organisation this can have an unsettling affect and individuals seek to clarify their purpose, identity and position by seeking out clear role definition statements.

This identity and self worth, tied in with the issue of confidence discussed previously is potentially hindered within the content of this thesis as value laden words such as 'mundane tasks', 'dumped on work', 'routine tasks' have been used. At the commencement of the project the assumption appeared to be made that tasks would be shifted to other disciplines depending on education and training and this was a core purpose for the evaluation of the effectiveness of the project. It would appear that the task carried out by individuals is not only impacting on the perception of power in the hierarchy but individual job fulfilment.

"So the doctors want to off load some of the things they think a doctor does not need to do. I would just say that in general might be great but sometimes it is good to have the boring stuff, if you saw your most complex cases for 100% rather than 10% of the time that wouldn't be a lot of funnot necessarily more interesting, so for me if things go to the nurses I think great its 5 minutes. Great so the nurses want to do more exciting stuff so who is going to do the work they want to offload, their dullness"

Source: Rod interview June 1998

So a tension developed between tasks to be performed and who would perform them. Role (job) descriptions started to become more flexible and to an extent meaningless through the process of the developments, although criteria for the community staff nurse, nurse team coordinator and phlebotomist were defined. For the others, roles started to shift and developing trust and confidence during this process was essential to enabling positive self worth and identity to be maintained. Allee (2000) highlights the benefits of developing a 'community of practice' including from the perspective of the community member in changing organisational situations.

It seemed there was a process of belongingness that was necessary to both original teams and to the new team, which as an ideal was developing. To facilitate this was a key role for the nurse team coordinator and this was most acutely noticed during the introduction of the generic community staff nurse role. The following critical incident gives some insight to the development of identity within a new role, the tensions for the rest of the team, and the identity issues that emerged.

"The incident when I went off sick came in and said to Beth that I didn't feel that well, Ann came in and said I looked rough. Couple of things I don't feel happy about doing such as pill

checks, so Beth said she would come in for those, got halfway through the session and had to keep running to the loo, and wasn't giving the patients full attention, so said I would need to go home. Beth said 'you cant be doing this if you are going to have sessions. I never go off sick'. Jan said she felt like crying, and went home. Beth told Ann and Ann phoned Jan, after this Jan said she would rather work with Angela as she was more approachable."

Source: Interview notes May 1998

I listened to this and then asked her

"Sue: how is the reflective journal going?

Jan: " Need to go elsewhere, either gone home or sat in the library and done it.

Sue: How are you doing it?

Jan: Have just written really how the session has gone, haven't written down about Beth, haven't felt so confident because something has happened, or that sort of thing.

Sue: Do you think reflection makes you feel more or less confident?

Jan: It makes me think about what I am doing, I think it is a good thing because it makes me think back and reflect and then think forward as to how I will do it next time."

Source: Interview notes May 1998

We then reflected on the following activity.

"Gave critical incident about grid for Travel vaccinations and payment, threw it away and then had to backtrack on computer. Under pressure to see people quickly whereas on the community you have more time. New registrations good opportunity for health advise, ten minutes is not really enough, Jan asks them if they have got any concerns, but not real time to then answer them, Beth said, ' you don't ask that... Jan says you have to think about your own practice that's really important. I don't feel happy not saying that, still got to think of your own standards, driven by appointment system especially for new registrants, may have to make another appointment.... confidence is building up, lots of little things to remember, but it is all coming together. Not going to be pressurised into doing Baby immunisations until I feel confident in the treatment room. Could be walked on quite easily. Got off to a fairly good start. Cant be task, task, task, because I am actually going to belong to three separate teams, so I want to be involved in each team and belong to each team."

Source: Interview notes. May 1998

This last paragraph corresponds to similar thought patterns as the practice moved forward to an integrated team and as identified in Cycle 2 by November 1999 all the nurses considered themselves part of an integrated team. The shift occurred, by a natural process of evolution, helped by the collaborative and iterative nature of action enquiry. Wenger et al (1998.69) identifies in diagrammatic form a 'community life cycle', suggesting that as communities mature they get better at being a community, and in turn have significant potential for creating knowledge in an organisation.

The other issue that emerged from the discussion of the report was that it was felt not enough had been made of statistics. This was a valid comment and related back to the practice information systems being able to collect appropriate data. The way forward was determined over the next few weeks as to what data would be collected and this was incorporated into the second year of the report. This led me to reflect further

"Aware that I am much more dominant on the soft people management skills rather than the harder resource issues, also that I am much more likely to process data in a qualitative way, so

in the context of both the action enquiry and my job role what am I ignoring because of this natural disposition, and can I learn to actively consider other perspectives of the same issue"

Source: Reflective Journal December 1998.

The next steering group meeting was in June 1999, and I noted that Paul was

'Still stuck in the task orientated approach, although very pleasantly argumentative! Ann lots more assertive with him!'

Source: Reflective Journal June 1999

However at this meeting I noticed that

"I was being asked to facilitate the discussion around aims and purpose of the nursing team, this was ready again for clarification, and should this be my role? I had become much more accepted as part of the practice and needed to be careful that I did not take too much of a leadership role"

Source: Reflective Journal June 1999

A further outcome was noted in my reflective journal.

"Beginning to see that hard and soft skills must be combined – valuable to relate this back to management development and competence."

Source: Reflective Journal June 1999

Focussing on the importance of relationships in leadership can be seen as not so effective in getting tasks completed. The use of the leadership grid (Appendix 3) gave rise to discussion on the need for effectiveness to a significant level on both people and task dimensions. Indeed I would suggest supported by (Covey, 1992; Goleman et al, 2002 Wenger; 1998) that concern for people leads to higher effectiveness in the organisation as a whole.

6.9 Whole people and Whole Organisations

In October 1998, I went to a 'motivating your team session', and made the link with the fact that you cannot motivate your team if you are not motivated yourself. This linked into the enquiry at the practice. Both the nurse team coordinator and the district nurse team leader have personal issues with which they have been coping. This has led me to the conclusion that leadership, in respect of motivation, requires individuals who are not coping with other significant life events. Extracts from my other data sources highlight this as an issue.

"Discussed this briefly with Ann - was the fact that she was able to sort out her issues a fact of being at the practice or not? She has mentioned the support of her work group made it so. Is this an issue for recruitment, if you want somebody to be a good organisational leader, should you test out if they are struggling with personal leadership issue first!! This is probably not politically correct!"

Source: Reflective Journal June 1999

"From my reflective dialogue with several individuals I came to a sense of wondering if people who were undergoing significant change in their personal life were able to cope with change in their work life, and whether or not order and routine in one aspect was a prerequisite for grasping change creatively at work?"

Source: Reflective Journal November 1999

"Can people be effective in the work role, or go beyond the maintenance aspect of their job if they are struggling with multiple personal challenges? During the course of this research I asked myself this question, and what is the expectation in contemporary society that significant life events can overwhelm the capacity to work to ones full potential. This question has bothered me and brings into question the perspective of many modern theorists and policy directives. The implications for recruitment are an area in which strict equal opportunity protocols are monitored. Questions which would identify potential issues cannot be asked but appointing people to key roles when they are struggling to come to terms or sort out the effects of significant life events actually may be more damaging to their persona as they fail to deliver than if they had not been appointed in the first place. But then is this a very reductionist view, and the interrelationship between work and home in a systemic sense would tend to lean to matching the whole person into the context of the purposeful venture of life?"

Source: Reflective Journal August 2000.

Another comment I have heard on several occasions recently is that people do not leave jobs, they leave managers, and this links with much of the literature on transformational and emotional leadership. Dealing sensitively with difficulties in the work place is important if work based stress is to be minimised and a healthy emotional work climate is to be achieved. At the practice this is seen as an overall strength and has been highlighted on several occasions in this thesis. Dealing with the everyday frustrations takes skill and empathy on the part of the leader and recognition of patterns of behaviour that are in place.

"Beth has been on the CPT course, enjoyed it but under strain with that and the family planning, she has got a fortnights holiday in august. She needs to know for example how many hours she is going to be working, and are we going to forget the generic nurse, she is contracted for so many hours but there is a baseline. Limitations with having a student as well. Angela always supportive to Beth although cant see why she is not paid at the same grade."

Source: Transcribed tape, meeting early May 1998

Two weeks later an example of a pattern emerged following an abrupt comment made by Beth re sick leave of Jan who hoped to become the generic nurse. If this happened Beth would revert to her previous contracted hours, losing the overtime that had been a frequent occurrence.

"I thought Beth was totally out of order re Jan's sickness, Jan was obviously poorly, I said this to Beth. Beth must have shared this with Angela, and Angela came to me to defend Beth. I have noticed when Beth does things that are unacceptable she is normally very very nice and jokey. Overly, so and I find it very cloying, why cant she just go and talk to Jan and sort it out."

Source: Transcribed tape, Late May 1999.

This identified that confrontation was avoided within the nursing team, and this was discussed within a future team meeting as part of what practicing being a learning organisation really means. This uncertainty also affected other members of the nursing team, who may not have spoken freely to their colleagues and did identify the stresses in one to one discussions. The person hoping to take on the generic nurse role was also uncertain of the future.

"Sue: Tell me about this generic nurse?"

Jan: Am very enthusiastic about it, I want to do it, the fact that it first started and I went into the Treatment room, and then it was all off, and it wasn't very nicely done, then the Trust said they would not replace my (district nursing) hours, first time I found out was at the nurse meeting, firstly I had a comment from Jo, who just walked in the office and said, 'I don't think its going to happen' well what do you mean? ' Well you will find out about it, and then at the nurse meeting it was said it wouldn't be going ahead, and that I couldn't go part time either, well that was two blows. I felt I should have been told first, but I think we have all learned from that. Now it has come back on, although it is just a pilot, the practice will cover my hours with Ann. This will not happen permanently if the Trust does not replace my hours in the long-term"

Source. Interview with Jan, May 1998

Sensitivity to personal circumstances including employment practices such as temporary contracts is important and may well have an affect on the ability of leaders to be motivational and inspirational. Yet in the everyday working environment balance has to be achieved to ensure that the quantity and quality of work from each employee is enabling a optimum working environment for each individual. This is not an easy task for a leader, and the nurse team coordinator had to deal with situations, identified by her staff as follows;

"When she was temporary, we thought is she going to get the contract? she was ploughing in thinking I have got to give it my all, but she was doing it and not thinking about the team, and we thought is it worth the upset if she is not going to be here anyway. When we first met her we didn't warm to her, we had had so many changes to the team, but never before have we had someone on a temporary contract. Things do work a lot better when we have 'team briefs'. Jo has family problems, but we all have families and when you are at work you are at work, we as a team recognise the dangers that it could all fall apart. In future we would say something sooner, and not let it get to the state it did, we should have intervened sooner. It is a lot happier. Occasionally you can walk into the office and Jo can get uptight if she is under pressure, she needs to learn calm down. Sometimes words with a bit of an edge. For instance you could all be sitting in the office and a colleague walks in and is introduced to Jo and she doesn't even look up, now that to me is rude"

Source: Jan, May 1998

Bridges 1995 discusses emotional shifts, which take place in the change process, and advocates emotional support in the form of time and opportunity for individuals to express the emotional components of the process. Within this study the support processes that emerged have been highlighted, but were not structured in any particular way and certainly were not built in as part of the process. On reflection I played this role, in listening to all the players in the changes, to subjective as well as objective comments and by returning questions to their authors for further clarification.

Within the methodology chapter I was concerned about the 'me' in the research and in Cycle 1 it was evident that the practice was concerned that I would influence the developments. Being aware of this and challenging myself when I seemed to be taking on a leadership role, I recognise that this emotional support as described by Bridges was an essential dynamic in the effectiveness of the change process. I would also like to think that

this support helped Ann to bridge the gap as a middle manager within the organisation and to develop strategies to manage the conflicting demands and to avoid the results of well intended but insufficient personal coping strategies (Oshry, 1995). But Ann chose to leave the post in favour of the District Nursing Sister post in the practice.

6.10 Leadership

The following quote represents the pattern that happened within the practice and can be related back to dialogue in Cycle 1, which identified no systematic role preparation for nurse leaders in the NHS

"The single most important factor in creating high quality service is leadership. We heard that, on promotion to front line management positions, staff received little or no associated leadership training, nor much guidance on what was expected from them in their new role. It was also often unclear as to who held responsibility for the quality of the service delivered."

Source: Mackenzie (2000:24)

This project has identified key issues summarised by the term 'leadership' and through this process of action enquiry I have consolidated my perspective on effective leadership and in the last section of this chapter will challenge myself as to whether I 'practice what I preach'.

This study identifies leadership from a number of perspectives, initially what is expected of a leader, as a tacit assumption within the first months of this project, secondly individual's perceptions of themselves as leaders, with the interface of management, and thirdly the observed everyday lived experience of both leadership and management within the behaviours of the key players in this study.

Styles of leadership and management were different, and this was especially evident when individuals wanted to assert authority to make things happen. Some styles were more effective than others, and authoritarian styles whilst resented did seem to have the required effect in assuring the short term tasks were achieved. However this put at risk the development of confidence and other longer term aspects of a practice that aspired towards having a learning culture.

Re: Primary Healthcare Team meetings.

Further to my memo of the 13th November listing the dates in 1999 when we shall be holding PHCT meetings, I now wish to formalise the fact that you are responsible for the agenda, organisation and minutes of these meetings.

As you know they are vital to the successful team building and information sharing of the practice. I wrote to all concerned on 13th November asking for their ideas; to date I have had Paul's reply and yours. Perhaps you would like to write again to members of the PHCT asking for their views on what subjects are to be covered and reinforcing the importance of these meetings.

Thank you for what you have done to date, but please now put these meetings on a high priority.

Source: Memo from Peter to Ann November 1998, cc'd to all partners.

Personally I believe the tone of this memo was unfortunate, and represented a tension between empowering the nurse lead by giving overall responsibility and leadership for the key meeting in the practice, but also perhaps expressing anxiety by Peter that action would not occur. This potential for generative creativity was initially lost as attention was given to the tone and assumptions of the memo rather than the potential for action. As the project developed these issues could be discussed and underlying anxieties expressed, without using the positional power of a management position. Covey (1992) lists the qualities of a transformational and a transactional manager and makes a case for the supremacy of transformational styles of leadership

"obviously both kinds of leadership are necessary. But transformational leadership must be the parent, as it provides the frame of reference, the strategic boundaries within which transactions take place. Without a clear picture of what kind of transformation is needed, executives and their managers will tend to operate on social and political agendas and timetables."

Source: Covey (1992:287)

During the enquiry there were times when a combination of leadership styles were required to ensure that a 'job got done' but in the most democratic way, recognising that people in positions of authority would be required at times to make unpopular decisions. Throughout this Thesis I have made reference to the Practice Nurse Review, which being the first major tasks for the nurse team co-coordinator was also one for potential conflict. Decision-making took some time, with the perception that decisions should just be made, but I believe the nurse team coordinator handled this as effectively as possible so as to maintain the potential of the whole project being a success.

"Presentation of Practice Nursing Review to Nurses meeting.

Could cut the atmosphere with a knife. Found out earlier that Beth had been putting her version of her own case forward to various nurses, let her know prior to the meeting I was aware of this. Despite long deliberations at regular intervals some aspects of the review are unpopular. Everybody's body language tight and closed.... including mine to begin with. But as I got in to the swing of the presentation I was confident that it WAS the best option, I felt myself physically soften and move forward. With hindsight this affected the team, as they then began to open up ...a sentimental way of describing it but the difference was palpable. The mood became dynamic with everyone wanting to put in his or her opinions. These were sometimes at odds with my own but by the end of the meeting we all acknowledged, by nods and verbal cues that we felt we'd had an open discussion. Later in the day several members of staff who commented approached me favourably on how the meeting had been handled."

Source: Ann reflections on meeting 1998

In 6.5 of this chapter and alluded to in Cycle 4, Elderly Surveillance never really took off! Even though in the Conclusion in chapter 5 it was recognised a strategy had been developed, but strategies need implementation! Was this to do with leadership, and those motivational characteristics of leaders to achieve outcomes? I remember the body language of Ann when she shared with me the following comment.

"Sue: When I left you your objectives had not been fully finalised.

Ann: Well they have now. Elderly Surveillance. (Give away negative body language) Nearly they're a realistic date to start, district nurses plan to take it on. Has got a bit lost. Paul will explain to the two key district nurses but in a different language, totally different language, and sometimes I have to slow him down, top and bottom of it is that Paul has got more ideas about how to develop it, but we are making a mountain out of a molehill, so I spoke to him yesterday and we agreed we are making a mountain out of a molehill, just keep it simple, what are we offering? We cannot possibly offer to meet everybody's needs, lonely old people, but perhaps we can facilitate this. Because of the district nursing sister's sickness it has come back onto me. Very conscious of taking it away from the health visitors because it is included in their workload indicators, and I am on a fixed term contract."

Source: Transcribed interview with Ann May 1998.

Along with the body language this was the first time that I actually noticed Ann looking for reasons not to implement agreed activity, the fixed term contract did not expire until November 1999, and if it was simple could easily have been achieved within this time frame. Being sensitive to body language is highlighted as good leadership practice (Covey 1992,) sometimes being aware of what is said rather than how it is said can affect the decisions of a leader. Within the context of this enquiry this was reflected on in the following scenario.

"For me this meeting had moved from a superficial level. Had two observers there (students) plus me. I wondered if it was fair and put Penny on the spot about phlebotomy and wondered initially if it would have been better to have done it with Penny on her own, but actually changed my mind because it is a group issue, and they all had to own it, and an open frank discussion ensued. They also reinforced Penny and said she had done a good job. Ann told me later that she had indirectly discussed it with Penny before the meeting. Ann said this was a mistake she had made previously with Penny, Penny will say yes to anything and think about it later, but if she is in a group she will say yes but her body language will say no. People were generally pleased for Penny; they weren't really bothered about the phlebotomy. In many ways Ann can empathise with Penny, because she is likely to say Yes but think No. Ann had prepared subconsciously for the meeting and checked the infrastructure was in place so she hadn't dumped on Penny even though it may have seemed like that. I think that this is strength for Ann and needs to be recognised. To Ann it is intuitive and expected in this post; I don't think everybody would automatically do that."

Source: Reflective Journal May 1999

For me some of the issues under the headings in this chapter are intrinsically linked and represent how as leaders we have a significant impact on what is actioned and achieved. This we may not even be aware of until challenged, and for me this challenge is a significant part of the road to personal mastery.

The process of enquiry that identified key questions to be asked about understandings of leadership was for myself as much as for the practice: what did I really mean by leadership and what was my preferred style. Having the opportunity to complete a 360-degree feedback leadership effectiveness analysis enhanced this mini enquiry for myself. (Management Research group, 1999) and this was the same tool being used for senior managers in the

health service rather than in Higher Education. Therefore I anticipated that the criteria and the outcomes would match more readily into the strategic understanding of leadership in the NHS. The feedback was sought in six main areas, each with sub headings;

- Creating a Vision
- Developing followers
- Implementing the Vision
- Following through
- Achieving results
- Team playing.

My scores were compared to my boss's evaluation of my strengths and added to by the perceptions of four of my peers and four of my 'direct reports'. This process helped to clarify my perception of the difference between management and leadership but also helped me to focus on the things I did not pay attention to (Schein, 1974) or marginalised (Midgely, 1992). Brutus et al (1999) suggests that such multisource feedback will lead to individual development. This I found to be helpful and useful for individual development because the things that I personally valued highly were recognised as significant strengths. High scores from all respondents were returned for co-operation, consensus and team playing. All respondents considered me to be innovative, strategic and restrained. The significant area for development from direct reports was 'following through'. This, as I reflected, was fair comment and I therefore now give focussed attention to this aspect of staff support and guidance.

However, in the context of the enquiry was it my role to follow through the developments as the practice identified them, did this conflict with the initiative belonging to and being owned by the practice? Indeed this new awareness about myself enabled me to voice the dilemma and in so doing enable the practice staff to ensure that appropriate follow through activities were given attention, even if, as seen in the data presented, they were not always followed through.

An issue from my work environment caused me to reflect and had resonance to the developments within the practice. These issues, about to be described cover issues of leadership, team working, power and control and people versus task. It links with an observation from the literature (Pritchard , 1995) commending that teams are more effective if the members stay the same in the team, and my challenge of the concept.

This example is from my reflective account but it really identifies issues to do with leadership, how information is gathered, how decisions are made and the impact of structure on individual and team well being.

"Issue to do with largest pathway through the undergraduate framework and Mark's attitude to John re leadership of the Adult division. Did see figures about teaching hours for nursing and midwifery, need 34WTE's we probably have this overall but do not negotiate and plan work loads in a systematic way. I feel that I hold the key to this although Mark's and Jackie's view is totally different and I believe a structural change is necessary to bring about a systems approach to the way we organise and manage the undergraduate portfolio."

Source: Reflective Journal October 1999

The effect on a team when the leader for whatever reason is unable to cope was emphasised as I supervised a 'tree rescue' as part of the Outdoor Experience the next weekend.

"Leader. 'Its awful, I cant do this.'

How does it feel when the leader is not in control, brings the whole group down. I think my research is now bringing me to the part of developing capacity to work with non-functional teams, but also functioning teams within non-functioning organisations. Issues to do with what stifles and creates functionality. The issue of a blame culture seems to be important here, recognising that to move forward we need to take responsibility for the past. We as a management team have not responded to the issues that have developed with the team and are now blaming the leader for the inability to develop team cohesion and his loss of respect from his colleagues

So Mark's apparent attitude that he should be able to cope, Chris's perception that John was a weak manager and that the team should be forced to work. Consequently a lack of alignment between Mark, Jackie and me on the way forward I need to question myself here, is it me against the other two? I have talked to John and offered to intervene but he says he would see that as defeatist. Perhaps it also says something about me wanting to 'band aid' things, which bales people and situations out without real change.

What is the difference between John and Chris and why has Mark listened to Chris. Chris has fought for her staff, and supported her weaker staff, Mark has admitted he has a soft spot for her and gives into her assertive style, in fact he likes assertive, stroppy women. What does that say to me?"

Source: Reflective Journal October 1999

This situation was eventually resolved. I wrote a proposal for restructuring the way the increasingly expanding department could be more affectively managed. This was accepted and introduced. Chris left and moved on to another post following an argument with Mark when he 'did not give her her own way', Mark moved on for promotion. What was left in his wake were people who had been affected by what they perceived was his bullying style of leadership, which caused them to experience stress at work, and also to be less that fully creative and motivated in their roles, due to the effect on both their confidence and self esteem, which links with other findings from this project. This incident among others reinforced the approach that this study had taken to leadership and the management of conflict, although I was aware that I was at that time more likely to avoid than face conflict, and this was part of my development of confidence within my role as a leader and co-enquirer for this project.

This highlighted for me the importance of effective managerial communication as identified by Katz (1955) that must give attention to the human dimension of communication as well as the technical and conceptual aspects.

This learning point was transferred into the practice, and through the practice of dialogue issues of disagreement and misunderstanding surfaced and were dealt with, usually satisfactory.

The total package of leadership skills was starting to become more evident and I found that this was aligned to the work of (Goleman et al, 2002a and b) that had recently been published on emotional leadership. He identifies, following significant research on a global database of 3,871 executives, a repertoire of leadership skills. Suggesting that four of the styles, visionary, coaching, affiliative and democratic create the kind of resonance that boosts performance. Two other styles can be useful in specific situations but should be used sparingly, these are commanding and pacesetting. Mark in the above example used the commanding and pacesetting styles predominantly and this had an adverse effect on sustaining everyday effective performance.

This coincided with an interview about leadership with a member of the Community Trust who, in referring to one of the main change agents in the Trust, commented.

“Excellent knowledge, enthusiasm and creative ideas, but appalling interpersonal skills. Lots of areas are left ignored due to personality clashes. People below feel intimidated, people above will not be intimidated so relationships disintegrate and no action occurs”

Source: Interview with project manager November 2000

This was a misuse of power in a system that had not previously had a history of hierarchy. However, the practices and processes within the organisation needed serious improvement. The leadership style of pacesetting and commanding rather than the styles of visionary, coaching, affiliation and democratic again appeared to hinder rather than boost staff performance. (Goleman et al, 2002b: 53)

This issue of ignoring issues when personality clashes appeared was a challenge for me when working in the Trust.

The following example connects with the second as the same person was in the centre of the dynamic. If I wanted people to work together I needed to do something to get them to talk

and move forward. I was really surprised at the reluctance of people to face issues in open dialogue.

"Meeting with Mel, very weepy and has had a difficult time with Emma – all this project issue is a big can of worms!!"

Source Reflective Journal November 2000

"Had meeting arranged with the Regional Health Authority, re: the Trusts approach to Research and Development? Following a meeting with Andy I am aware that there is no systematic approach to audit, research or development! This meeting gave me insight into the working of the clinical audit department –bit like a primary school!!! Need to use all my charm and knowledge to handle this meeting successfully! Went to get some information from Jane and found her in tears, she said 'it wasn't my fault' and alluded to the fact that she had asked Emma over and over again to intervene, as had Mel, but Emma had refused a meeting which could potentially have resolved the conflict. So it seems to me that Emma had been supportive to Jane over the conflict, but ineffective, and had been ineffective and unsupportive to Mel by just ignoring the issues."

Source: Reflective Journal December 2000

I recognised that to 'practice what I preach' I needed to take action, so called a meeting with all parties present. This was difficult to start with but eventually led to an action plan to enable growth and development of the issues identified. The two would never be friends but were able to recognise the importance of a professional relationship to enable both their job descriptions to be fulfilled for the good of themselves and the organisation

6.11 Practising what I preach.

Throughout the course of this work I have challenged myself to reappraise my values and how I act out in daily life to maintain my integrity as identified by Covey (1992). This has become embedded in my own reflective and reflexive practice, which I hope, emerges from the pages of this thesis; examples of personal challenge are given below;

"Have been aware in the back of my mind that my role ought to be more about facilitating change and empowering people to look with vision and criticality at what they are doing I suppose I am asking the question 'Do I practice what I preach' this motivated me to think about issues to do with Learning Organisations and what they meant for the Centre for Healthcare Education....this became crystallized and affirmed for me following the school review when comments were made about the various stages and level of development of staff. It was inferred that especially the nursing and midwifery staff had not internalized what it meant to develop independent learners, lacked confidence and were not critical of their own behaviour; they felt trapped by circumstances, e.g. lack of resources."

Source: Reflective Journal November 1998

Six months later I noted in my journal

"So in some ways the principles of organisational learning that I am determining from the enquiry at the healthcare practice (and at two other organisations I have been working with) have happened implicitly in the Centre for Healthcare Education, so I have been walking the talk. Does this actually mean that the catalyst is me?"

A couple of weeks later a journal article added to this

"Met RT yesterday, he said some interesting things that made me think. What is my passion – what do I feel very (emotionally) strongly about in the 'doing' context. I said to him that the most important thing for me was personal integrity, if I felt Ok and do Ok then I am Ok and others benefit, (and I do my Christian duty!). This is itself an interesting issue as it is my duty as I interpret it – I make the rules and regulations as to what I think my integrity is!"

Source: Reflective Journal May 1999

And as is to be expected links within the subject headings of this final chapter are apparent.

The issue of organisational structure enhancing or detracting from effective action

"Most of the time, I do act consistently, but make too many assumptions about how other people think, feel know and act. Also the structure although it has some problems is basically OK, but it is HOW we work communicate and trust within the structure that is important. I need to discuss at the away day how we can make more of the informal networks/self managed teams and meeting approaches which we have"

Source: Reflective Journal September 1998

In chapter 2, context for the enquiry I referred to photographs I had selected that were important to me in this research, I believe I have been faithful to these elements of;

Something about myself (the inquirer)

"Quiet thinker, like open spaces. Look to the future – tend to see things clearer in the distance than the here and now. Picture identifies calmness, time and thoughtfulness before action."

Source: Reflective Journal September 1997

The concept of 'space' has been central to my research journey over the last two years. Two issues on reflection have resonance here. The first is the need for seeking meaning in our lives. This tied up for me with the focus of my master's research and how space to explore and experiment, to think and reflect on purpose and meanings of life are fundamental to human life. Secondly the way in which people are whole beings and that issues in professional life cannot be separated from issues in the personal life. To find a space psychologically and physically to explore these dimensions have become important to me and some of the people I have worked with in the context of this enquiry over the past two years

Anxiety or Struggle

"My family, that they will not be pushed out but still feel loved and supported, and that my intentions will be for the right reasons rather than personal gain and prestige."

Source: Reflective Journal September 1997

This says something to me about the way I like to be perceived in the world. Through the interactions with fellow participants I have faced what it means to be properly selfish. There is something that makes me fulfilled in seeing somebody else being treated properly and consequently this then isn't about being selfish. People matter more than things.

Something that will matter.

"Challenging my present perspectives of self worth, esteem etc. and questioning all my values, but developing new dimensions of being that are acceptable (to whom?). Taking time for new growth and development. Seeing results, waiting for new growth and development..."

Felt I ought to choose pictures to do with disability, but I want to focus on the average person rather than the special person. Space was a pattern in my choice of photographs."

Source: Reflective Journal September 1997

These were potentially on reflection my personal objectives for this enquiry, yes they have been fulfilled and I have grown and developed through this process.

6.12. Conclusion

The findings of this study largely support the findings in the literature on effective team working and leadership in primary care when introduced in a participatory and collaborative way. This reinforces the importance of the power of Emotional Intelligence (EI) in leadership and the relationship between people and task. This enquiry has helped us all as participants to understand the importance of wholeness in people, systems and structures, how this can be deliberately facilitated and how the outcomes enhance and benefit personal and professional effectiveness.

Chapter 7: Contribution and Future Directions.

7.1 Introduction

As I complete this thesis and summarise in short statements the key issues that have added to the understanding of team working in Primary Care I am mindful of the following quote.

“Other scenario writers are more inductive, they tend to let the story evolve during the course of their own one or two years of research with little forethought about where the data may take them. They listen to the themes that emerge as different people talk about their observations. If they are successful they produce a work of remarkable insight and power; if not they produce a scattered mismatch of all the things they have heard.”

Source: Arie de Geuss (1998: 64)

My hope is that the narrative of this enquiry will have identified some key issues previously not identified in the development of teamwork in Primary Healthcare.

The process of this enquiry is where the learning and therefore the outcomes took place, many of which I am unaware, as they happened for people and may not have been shared with me or indeed any other members of the team. This process of growth and development prepares the way for future creativity. I am mindful of Carlzon, (1987), a transformational leader of SAS airways, who identified as a leadership imperative the encouragement and facilitation of an organisational vision in which as many stakeholders as possible have participated, in an environment where employees can accept and execute their responsibilities with confidence and finesse.

This environment appears to have been created, through the learning of all participants who have learned to be leaders, learned to be competent and reflective practitioners and most significantly for me have learned to become co-enquirers.

7.2 Key Findings

Figure 9 identifies the variables that have existed within this study that lead to maximising the effectiveness of teamwork in primary care, especially for a nursing team perspective. Leadership is underlined as a key function but its effectiveness is only relative to the other dimensions within the hub and spoke of organisational life.

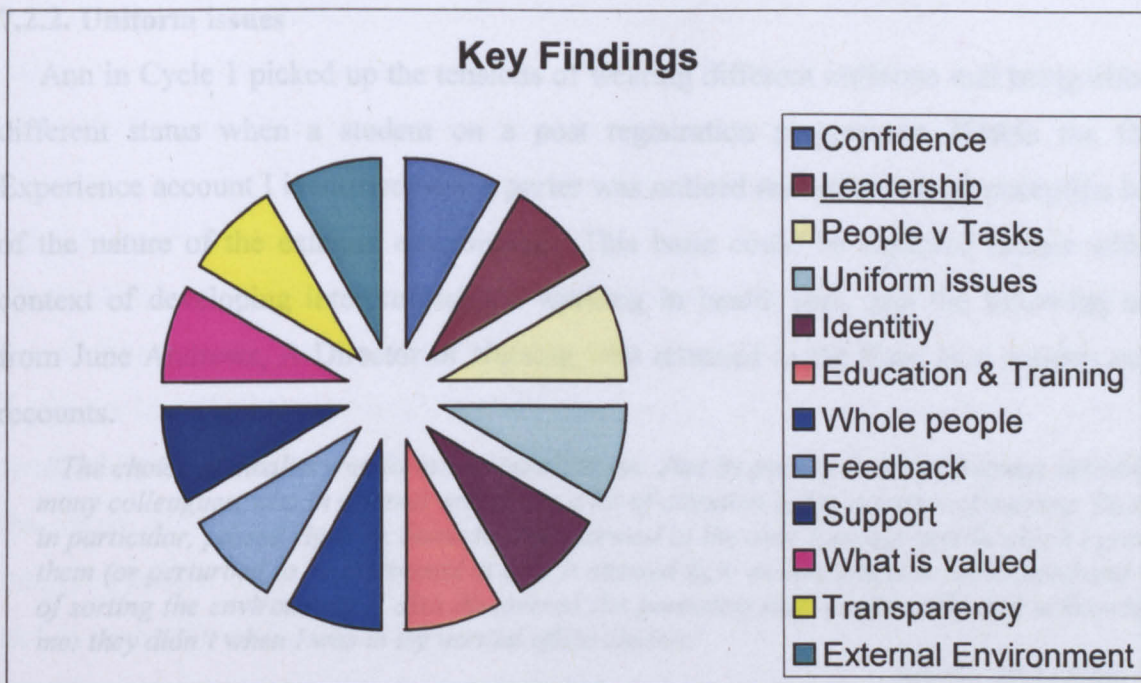


Figure 9 Dimensions for effective teamwork in integrated nursing teams in primary care

The key findings have emerged through the process of recreating by rewriting this enquiry. The findings relate to both the person growth in reflexivity, leadership and communication skill for the participants and myself. Several factors have emerged which I believe demand attention to enable interdisciplinary teams to develop within the primary healthcare sector.

7.2.1 Organisational structure

The most significant finding relates to the interplay of organisational structure that maintains the medical and managerial dominance within an organisation, which has a hidden impact on communication, decision making and what is valued or not valued, explicitly and implicitly within the realm of the activity.

This was not an issue that surfaced during the enquiry but taken for granted from the beginning, that the three teams (medical, admin and nursing) were the correct structure for the practice to move forward initially for nurse integration.

This was not challenged within the initial consultant's report and did not figure as part of the challenge in the main study. The reasons for challenge however have become clear through the pages of this work.

7.2.2. Uniform issues

Ann in Cycle 1 picked up the tensions of wearing different uniforms and being afforded a different status when a student on a post registration programme. Within the Outdoor Experience account I identified how a porter was noticed and valued as an exception because of the nature of the external environment. This issue could be explored further within the context of developing interprofessional working in health care, and the following account from June Andrews, A Director of Nursing who returned to the floor as a nursing auxiliary recounts.

"The choice of auxiliary uniform was ideal for me. Just by putting it on you became invisible to many colleagues, who in general would pay a lot of attention to the director of nursing. Doctors in particular, passed right by. Some looked alarmed at the over familiar way in which I greeted them (or perturbed to be addressed at all). It showed how we use uniforms as a shorthand way of sorting the environment. I also discovered the portering staff would smile and acknowledge me: they didn't when I was in my normal office clothes"

Source: HSJ (2000: 45)

The last sentence highlights an area that has been under explored in respect of the multi-disciplinary team. The literature reviewed tended to make assumptions that these teams comprised of health and social care professionals. At the healthcare practice everybody was included although examples have been referred to in the context of this enquiry where they too needed help in developing confidence and used especially the nurses as an intermediary to solve their issues and to provide a communication channel

7.2.3 Support for middle managers/leaders

Providing support for middle managers in a leadership of change role facilitated through action enquiry would be worthy of further exploration. In this study it has become apparent that really effective support strategies were not in place, either for the Practice Manager or the Nurse Team Coordinator. Garland (HSJ 2000: 49) suggests that

"One of the keys to healthy and effective people in the middle of organisations is that they must be facilitated to create a productive alliance with other middle people in the organisation."

This happened between the lead of the nursing team, and the admin team, but the third team comprised of all the doctors, who were not middle managers but the Directors of the practice. The practice manager through his personal leadership style was perceived to be intimidating to the other middle managers, but he also held the tension between the expectations of the role of practice manager with the lead roles of the 7 GPs who actually owned the business for which he was an employee. Some work has been done by Clark et al (HSJ, 2000: 51) exploring how managers and doctors can be brought together at the beginning of their career. This work included a questionnaire into preferred leadership styles of doctors and managers and found that both doctors and managers indicated a preference for

a coaching style, which combined a high degree of directing with a high degree of supportiveness. The delegating style was the least favoured by both, possibly due to the perception, especially by the managers that they must be seen to be leading.

7.2.4. Interprofessional Education

The outcome of this work would suggest that interprofessional education holds a significant key to future working relationships in healthcare practice. This would help to solve some of the issues identified around medical dominance, power and control and start to develop a new transdisciplinary knowledge base, which will start to challenge the historical difference in the value of Professional Knowledge (Schon, 1991). But this may not be enough, by interprofessional education models which are developing between healthcare professionals and in many institutions across into social work, management and the probation service, the significant part of the workforce who does not access Higher Education will be disadvantaged. In the School of Health at University College Northampton we have a successful and dynamic assistant practitioner division comprising vocational qualifications and the growing cadre of foundation degrees. How to ensure that these future health and social care practitioners are included in our interprofessional learning strategy is an important task to undertake, both for us but within the NHS more widely. Over the last few years we have seen both the creation and the demise of the NHSu that had and still has in its new creation a responsibility for support worker education and to some extent management development. I would suggest that the University sector must engage more willingly within the workforce development debates in Strategic Health Authorities to develop appropriate and effective opportunities for all health and social care workers to develop effective working together skills. This has been achieved using the outdoor environment.

A lot of literature already exists in the realm of interprofessional education in healthcare for example, England, (1979); Jones, (1986); Ryan and McKenna, (1994); Atkins and Walsh, (1997); Howkins and Allison, (1997); Headrick, (1998); Miller et al, (1999); NHS Executive South West, (2000); Barr, (2000); Department of Health, (2001). Many of these programmes are being evaluated and it is hoped that these evaluations will be drawn together to develop a rigorous curriculum for interprofessional education (Glazer, 1974) which includes all healthcare workers regardless of their level indicated by the Knowledge and Skills framework (Department of Health, 2003) to learn together, effectively and appropriately to deliver the integrated care expected by the current government ideology.

7.3 Contribution to theoretical and practical knowledge.

Research has been defined as an activity concerned with validating old and generating new knowledge and understanding Schon (1987). Burns and Grove (1993) question the value of much research that is removed from practical utility and fails to provide a basis for the problem solving demands of practice in the real world. Action research promotes change and the resultant learning is new knowledge applied in that specific situation. Clark (1972) suggests that some aspect of organisational change is a defining feature and Elliot (1991) notes a desire for innovation and implementing change is a prerequisite for action research.

Lewin (1946) the pioneer of action research emphasised that action research goes beyond change alone since it generates knowledge about a social system through a process of change. This is an outcome of this enquiry, which also meets more up to date criteria for action research as raising awareness, empowerment and collaboration. (Bowling 1997)

7.3.1 Contribution to Theoretical Knowledge.

Through the process of this enquiry to create an integrated team in primary care the research question focussed on how this could be achieved to enable a learning community to develop that moved towards the characteristics of double loop learning (Argyris, 1982). The process of data collection, reflection and action has led to the key findings as discussed in the last chapter.

Bruce Tuckman in 1965 developed a model of group development and dynamics, and related this to a stage model of group development, 'forming', 'storming', 'norming' 'and performing'. He later added 'adjourning' to this sequence. Within the process of this enquiry this model has been challenged and extended. The challenge comes to the linear process of team forming leading to team storming (after Tuckman) and I would suggest that in integrated (interprofessional) teams in primary care the forming process has been followed by norming. This process has been by socialisation and allowed for harmonious working relationships as the different disciplines of nursing and other health professionals work independently of each other but within the same practice population. This aligns more to the multiprofessional team as identified by Kenny (2002). The contribution that this work makes to theoretical knowledge is to suggest that 'storming' follows norming as a process of deep learning and critical reflection as interdisciplinary teams are created that have the potential to become high performing teams. Indeed the storming phase is necessary to challenge self and others in the

process of organisational learning and development that leans towards Model 2 or Double loop learning. (Argyris, 1986) and yet cannot be taken for granted in organisations that have not developed the capacity for critical reflection, through dialogue with each other. For individuals to move beyond the safety of single loop and model 1 response a sense of security has to be engendered. The key dynamic for this to occur is personal confidence, and that personal confidence can be developed and maintained by key variables, of inspirational and visionary leadership, clear role expectations, (or the ability to work within parameters to develop a new role), honest communication and trust and respect. This is represented diagrammatically in figure 10, with my contribution identified in red.

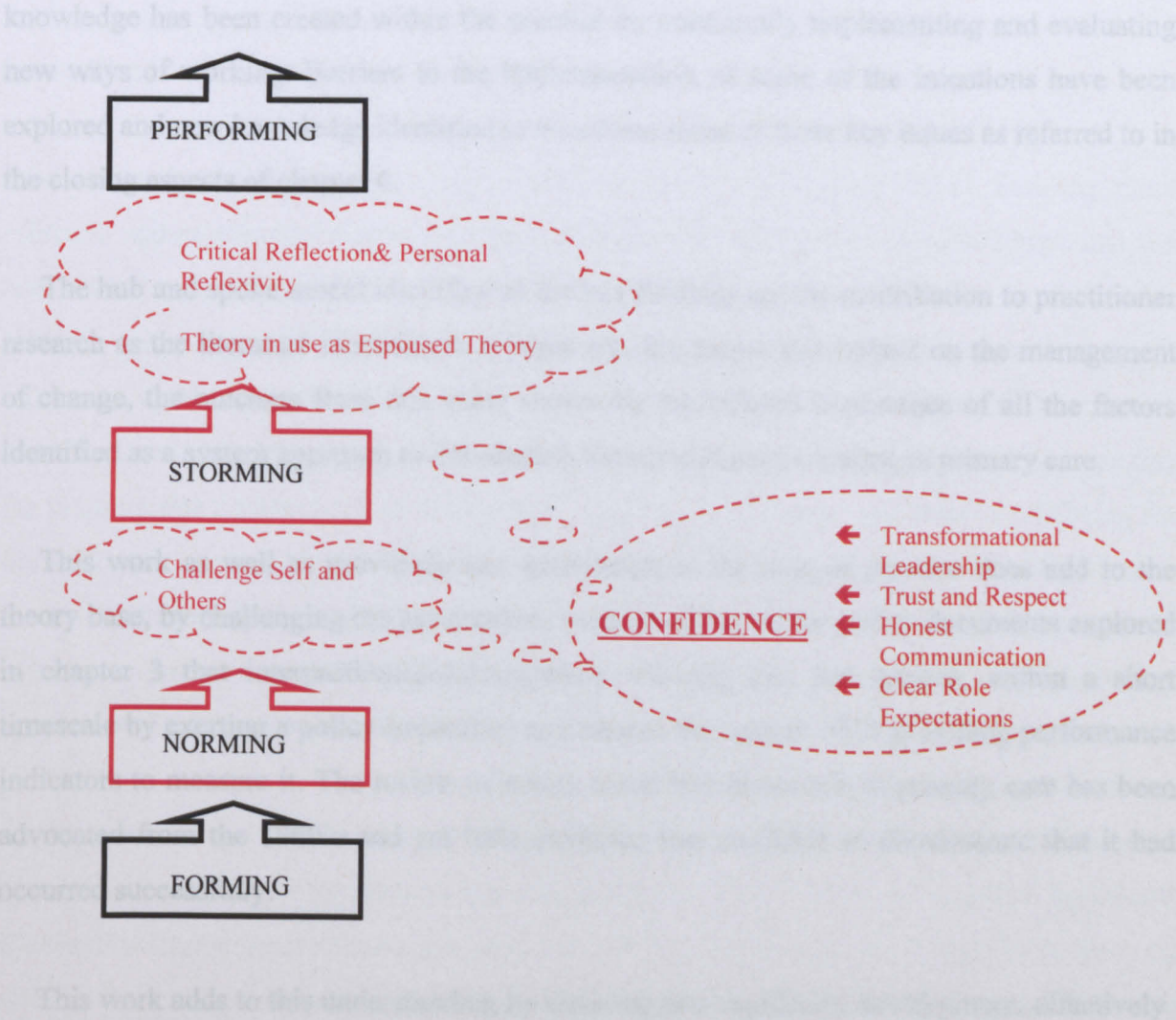


Figure 10: Confidence as a key dynamic for ‘performing’ teams in primary healthcare, modified from Tuckman’s (1965) model

Legend: Red = proposed model
 Black = original Tuckman’s model

Thus this study contributes to the theory of team working and organisational learning as it applies to the development of ‘learning organisations’, based on the practice of effective learning in the Primary Healthcare sector. The importance of confidence can be potentially transferred into any organisation that encompasses individuals from different professional

groups and different educational socialisation, and is relevant to the higher education setting, especially within a healthcare faculty. The re- framing of the importance of ‘storming’ as a precursor to team performance extends the perspective of interpersonal relationships in groups to include the notion of critical reflexivity both from an individual and group perspective and identifies that skills are required for such elements of high challenge.

7.3.2 Contribution to practical knowledge

Through the pages of this thesis it has been demonstrated how as practitioner research new knowledge has been created within the practice by continually implementing and evaluating new ways of working. Barriers to the implementation of some of the intentions have been explored and new knowledge identified to overcome some of these key issues as referred to in the closing aspects of chapter 6.

The hub and spoke model identified as the key findings are the contribution to practitioner research as the literature identifies in a linear way the issues that impact on the management of change, the outcome from this study shows the interrelated importance of all the factors identified as a system approach to introducing interdisciplinary working in primary care.

This work as well as providing new knowledge in the area of practice does add to the theory base, by challenging the assumptions evident within all the policy documents explored in chapter 3 that interprofessional/disciplinary working can just happen, within a short timescale by exerting a policy imperative and then in the current NHS providing performance indicators to measure it. The review of policy noted that teamwork in primary care has been advocated from the 1960’s and yet little evidence was available to demonstrate that it had occurred successfully.

This work adds to this understanding by claiming that significant development, effectively facilitated needs to occur within and between professional groups to ensure a baseline of interprofessional confidence and trust to move the primary care interprofessional practice agenda forward.

Facilitation skills which develop capacity for personal and team reflection would appear to be essential as would a leadership style that values individuals contributions and that can inspire others to develop a shared vision for the future.

Heron (1996) suggests that presentational knowledge is a combination of understanding that comes from experience, practical and theoretical perspectives. This thesis aims to present the narrative of the enquiry with the healthcare practice in a way which identifies the significant key challenges, reflects on the way the process enhanced or hindered change and as such leaves the reader to critically reflect on the content as an opportunity to consider learning that can be transferred into similar contexts where individuals strive to work together to provide a public service within a political framework.

7. 4 Reflection on Enquirer's Journey

As I reflect on this process over the last 7 years I ask myself the questions, of 'what have I learned' and 'what would I have done differently?'

From a professional perspective I have moved further down the road of enabling more effective communication within professional teams in healthcare and as such I hope this has contributed to more effective patient care, by professionals who are happy in their roles within a given organisation. I recognise that as is the nature of this situational context this is only valid within the healthcare setting but I do believe some of the interpersonal elements are transferable to other situations. This I have transferred to my place of work and I do hope that the learning that I have acquired is reflected in my leadership style and leads to wellbeing for the staff that I have organisational responsibility for. This process has ensured that I have reviewed leadership and management styles that stand a chance of working to bring about dynamic organisations and this has added to my knowledge base to justify the leadership approaches I take, and believe in.

The personal me cannot be separated from the professional me, as I am a whole person. These last years have seen several life transitions for me, both my parents had significant illness of a mental health nature and have died and my family has grown and flown the nest, with all the emotions of partings for university and marriage that this encompasses. From the personal perspective the principles of personal leadership have been very helpful and effective in enabling me to manage my family, and myself participate in considerable organisational change and complete this piece of work. Completion is a relief, but the journey was important, interesting, sometimes very heavy going. I feel like I did on climbing Mount Snowdon. A completed achievement but where next?

References

- Ackoff, R.L.(1998) 'A Systemic View of Transformational Leadership'. *Systemic Practice* Vol.1 No 1.
- Adler, A. (1930) 'Individual Psychology.' Translated by S Langer in C. Murchison (Ed) *Psychologies of 1930* pp398-399 Worchester M A. Clark University Press.
- Alimo-Metcalf, B. (1998) '360-Degree Feedback and Leadership Development.' *International Journal of Selection and Assessment*. 6 (1) 35-44
- Allee, V. (2002) 'Knowledge Networks and Communities of Practice.' *OD Practitioner*, 32 (4)
- Allen, S. (2000) 'Report on the Development of an Integrated Nursing Team.' 1997-1999. University College Northampton.
- Allen, S. Clark, S. Toby, J. Smart, D. Moore, F. (2001) 'Developing an Integrated Nursing Team Approach' *Nursing Standard*. March 28.vol5.no 28.
- Allen, S. Toby, J. Smart, D. Moore, F. Clark, S. (2002) 'Working in New Ways'. *Journal of Community Nursing*. Vol 16. Issue 6.
- Argyris, C. Putnam, R. and McClain Smith, D. (1985) *Action Science: Concepts, Methods and Skills for Research and Intervention*. San Francisco Jossey Bass.
- Argyris, C. (1980) *Inner Contradictions of Rigorous Research*. Academic Press. New York
- Argyris, C and Schon, D. (1974) *Theory in Practice: Increasing Professional Effectiveness*. Jossey Bass. San Francisco
- Argyris, C. (1982) 'The Executive Mind and Double Loop Learning'. *Organisational Dynamics*. American Management Association. Amacom Periodicals Division.
- Argyris, C. (1985) *Strategy, Change and Defensive Routines*. Marshall. Pitman. Massachusetts.
- Argyris, C. and Schon, D. (1978) *Organisational Learning*. Jossey Bass. San Francisco California
- Argyris, C. and Schon, D. (1992) *Theory in Practice: Increasing Professional Effectiveness*. Second Edition. Jossey Bass. San Francisco.
- Argyris, C. and Schon, D. (1996) *Organisational Learning 11. Theory, Method and Practice*. Addison Wesley. Reading Massachusetts.
- Aristotle. (1946) *The Politics*. Clarendon.Oxford
- Astrachan, B.M. and McKee, B. (1965) 'The Impact of Staff Conflict on Patient Care and Behaviour.' *British Journal of Medical Psychology* 38: 313-320,
- Atkins, J.M. and Walsh, R.S. (1997) 'Developing Shared Learning in Interprofessional Care Education: for Whose Benefit?' *Nurse Education Today*. 17. 319-324.

- Audit Commission. (1986) *Making a Reality of Community Care*. HMSO London
- Audit Commission (1992a) *Community Care: Managing the Cascade of Change*. HMSO.London
- Audit Commission. (1992b) *The Community Revolution*. HMSO. London
- Axelrood, R. (1990) *The Evolution of Co-operation*. London. Penguin.
- Bales, R.F. (1950) 'A Set of Categories for the Analysis of Small Group Interaction'. *American Sociological Review* Vol. 15. Pp 257-263.
- Baly, M.E (1995) *Nursing and Social Change* London. Routledge.
- Barr, H. (2000) 'New NHS, New Collaboration, New Agenda for Education.' *Journal of Interprofessional Care*. Vol 14. No 1.
- Barr, H. (2002). *Interprofessional Education, Today Yesterday and Tomorrow*. Occasional Paper No 1. Learning and Teaching Support Network. Centre for Health Sciences and Practice.
- Bass, B.M. Avolio, B.J. and Atwater, L. (1996) 'The Transformational and Transactional Leadership of Men and Women'. *Applied Psychology: An International Review*, 45. (1) 5-34.
- Belbin, M. (1981) *Management Teams: Why they Succeed or Fail*. Heinemann Professional, Oxford.
- Benne, K.D. and Sheats, P. (1948) 'Functional Roles of Group Members.' *Journal of Social Issues* Vol.4. Pp 41-49.
- Benner, P. (1984) *From Novice to Expert*. Addison-Wesley. California.
- Bennis, W. (1980) 'Leadership a Beleaguered Species' in Ferguson, S. and Deveraux, S.(Eds) *Intercom: Readings in Organisational Communication*. Rochelle Park. New York
- Berlo, D.K. (1960) *The Process of Communication*, Holt Rinehart and Winston. New York.
- Binney, G. and Williams, C. (1995) *Leaning into the Future*. Nicholas Brearley, London.
- Bohm, D. and Edwards, M. (1991) " *Changing Consciousness- a dialogue of words and pictures*. Harper. San Francisco
- Bohm, D. (1990) *On Dialogue*. Eisenbach-Stangl, P and I
- Bolman, L. G. and Deal, T. E. (1991) *Reframing Organisations: Artistry, Choice and Leadership*. Jossey Bass. San Francisco California.
- Bond, J. Cartlidge, A.M. Gregson, B.A. Philips, P. Armitage, P. Brown, A. Reedy, B. (1987). 'Interprofessional Collaboration in Primary Health Care'. Original Paper, *Journal of the Royal College of General Practitioners*. April 1987

- Bowling, A. (1997) *Research Methods in Health*. Open University Press Buckingham London
- Boyatzis, R.E. (1992) *The Competent Manager: A Model for Effective Performance*. Wiley .New York
- Boyd, E.M. and Fales A.W. (1983) 'Reflective Learning: Key to Learning from Experience.' *Journal of Humanistic Psychology* 23(2) 99-117
- Black, S. Hagel, D. (1995) 'Working Together in Primary Care; an Integrated Team Approach.' *Health visitor* 69 (7) 280-283
- Blaikie, N. (1993) *Approaches to Social Enquiry*. Polity Press. Blackwell. London
- Block.P. (1993) *Stewardship*. Berrett- Koehler. San Francisco.
- Bridges, W. (1995) *Managing Transitions: Making the Most of Change*. Nicholas Brearly. San Francisco California.
- Brookfield, S. B. (1994) 'Self directed learning' in YMCA George Williams College ICE301 *Adult and Community Education Unit 2: Approaching adult education*, London: YMCA George Williams College.
- Brutus, S. London, M. and Martineau, J. (1999) 'The Impact of 360-degree Feedback on Planning for Career Development'. *The Journal of Management Development* Vol 18. No 8 1999 pp 676 – 693. MCB University Press.
- Bucknall, T. and Thomas, S. (1997.) 'Nurses' Reflections on Problems Associated with Decision Making in Critical Care Settings.' *Journal of Advanced Nursing* 25. 229-237
- Bull, J. (1998) 'Integrated Nursing, a Review of the Literature'. *British Journal of Community Nursing*. Vol 3. No 3.
- Burns, N. and Grove, S.K (1993) *The Practice of Nursing Research*. Second edition W B Saunders Philadelphia
- Buzan, T. (1993) *The Mind Map Book: Radiant Thinking-the Major Evolution in Human Thought*. BBC Publications. London
- Carlzon, J. (1987) *Moments of Truth* Ballinger Cambridge. Massachusetts.
- Carr, W. and Kemmis, S. (1986) *Becoming Critical*. Falmer Press. London
- Cayer M. 'Bohm's Dialogue and Action Science'. *Journal of Humanistic Psychology*. Vol .37 No2 Spring 41-66. Sage
- Checkland, P. (1981) *Systems Thinking, Systems Practice*. Wiley, New York
- Chenail, R.J. and P.Maioine (1997) *Sensemaking in clinical qualitative research*. <http://www.nova.edu/ssss/QR/QR3-1/sense.html>
- Cherniss, C. and Goleman, D. (Eds) (2001) *The Emotionally Intelligent Workplace*. Jossey Bass. San Francisco.

Clark, P.A. (1972) *Action Research and Organisational Change*. Harper and Row London

Clegg, S and Hardy, C (1997) *Studying Organisations. Theory and Method*. Sage. London

Cook, M. J. (2000) *Uncovering the Attributes of Effective Clinical Nurse Leaders: a Grounded Theory Approach*, Ed D Thesis University of Lincoln and Humberside.

Cook, M.J. (2001) 'The Attributes of Effective Clinical Nurse Leaders. *Nursing Standard*, 15,35,33-36.

Council of Europe Committee of Ministers 1989. Recommendation No R (89) 13 adopted on 24th October 1989.

Covey, S. (1989) *The Seven Habits of Highly Effective People*. Simon and Schuster UK.

Covey, S. (1992) *Principle Centred Leadership*. Simon and Schuster. UK.

Creative Healthcare Management. (1999) *Leading an Empowered Organisation*. Creative Healthcare Management. Minneapolis

Cuff, E.C. and Payne, G.C.E. (1979) *Perspectives in Sociology*. Allen and Unwin. London.

Cumberledge Report. (1986) *Neighbourhood Nursing: A Focus for Care*. Department of Health and Social Security. London. HMSO .1986

Cummings, T. Mohrman, S. Mohrman, A. And Ledford, G. (1985) 'Organisation Design for the Future', in *Doing Research that is useful for Theory and Practice*, Lawler. (Ed) Jossey Bass, San Francisco.

Cunningham, C.and Whitby, E. (1997) 'Power Redistribution.' *Health Management*. September 14-15.

Davies, C. 'Hospital Centred Healthcare; Policies and Politics in the National Health Service.' In Atkinson, Dingwall, R. Murcott, A. (Eds) (1979) *Prospects for the National Health*. Croom Helm. London.

Davies, H. T.O. and Nutley, S.M. (2000.) 'Developing Learning Organisations in the New NHS.' *British Medical Journal* 320. 998-1001.

Davis, J, Milburn, P. Murphy, T. and Woodhouse, M. (1992) *Successful Team Building: How to Create Teams which really work*. Kogan Page London

Dawson, S.J.N.D. (1996). *Analysing Organisations*. Hampshire. Macmillan

De Geuss, A. (1998) *The Living Company, Growth, Learning and Longevity in Business*. Nicholas Brearly Publishing. London

Denzin, N.K. and Lincoln, Y.S. (Eds) (1994) *Handbook of Qualitative Research*. Sage. London

Department of Health (1987) *Promoting Better Health* HMSO London

Department of Health, (1990) *Nursing in the Community: Report of the Working Group*. London HMSO (known as the Roy Report)

Department of Health and Social Security (1990) *NHS and Community Care Act*. HMSO London

Department of Health (1996) *Primary Care: Delivering the Future*. HMSO London

Department of Health (1997) *The New NHS Modern-Dependable*. HMSO. London.

Department of Health (1998) *Saving lives-Our Healthier Nation* HMSO.London

Department of Health (1998) *A First Class service. Quality in the New NHS*. HMSO London

Department of Health (1999) *Making a Difference* HMSO.London

Department of Health (1999) *National Service Framework, Mental Health*. HMSO London

Department of Health. (2000) *Learning Together, Working Together* HMSO. London

Department of Health (2000) *Improving Working Lives*. HMSO.London.

Department of Health (2001) *National Service Framework; Care of Older People*. HMSO London

Department of Health (2003) *Knowledge and Skills Framework* HMSO. London

Dongas. G. (1982) *Policy Making for the Mentally Handicapped*. Gower. Aldershot

Donnellon, A. (1996). *Team Talk*. Harvard Business School Press. Boston

Dopson, S. and Mark, A.L.(Eds) (2003) *Leading HealthCare Organisations*. Palgrave Macmillan. Basingstoke.

Drucker, P. (1989) *Managing for Results*. Heinemann Professional. London

Dumas, R.G. (1986) *Preparing Adults for Leadership Roles in the 1980's and 1990's* Presented at the University of Michigan National Nursing Conference on Leadership. Ann Arbor September 17th 1986

Easterby Smith, (1997) 'Disciplines of Organisational Learning: Contributions and Critiques.' *Human Relations* 50. Pp 1085-1113.

Easterby Smith, M. Araujo, L. and Burgoyne, J. (Eds) (1998) *Organizational Learning: Developments in Theory and Practice*. Sage. London.

Easterby-Smith. M. Thorpe, R. Lowe.A. (2002) *Management Research. An Introduction*. Second Edition. Sage. London

Eddy, W.B. (1985) *The Manager and the Working Group*. Praeger publishers. New York

Elliot, J. (1991) *Action Research for Educational Change* Open University Press
Buckingham

England, H. (ed) (1979) *Education for Co-operation in Health and Social work: Papers from the Symposium in Interprofessional Learning*. University of Nottingham, July.
RCGP. London

Fiol, C.M and Lyles, M.A. (1985) 'Organizational Learning' *Academy of Management Review*. Vol 10 pp 803_813

Fisher, D. and Torbert, W. (1995) *Personal and Organisational Transformations: the true challenge of Continual Quality Improvement* Mc Graw Hill, London

Freire, P. (1972) *Pedagogy of the Oppressed*, London: Penguin.

French, W. L. Kast, F. E. and Rosenwieg, J.E. (1985) *Understanding Human Behaviour in Organisations*. Harper and Row. London

Freeman, M. Miller, C. and Ross, N. (2000) 'The impact of individual philosophies of teamwork on multiprofessional practice and the implications for education.' *Journal of Interprofessional Care*. Vol 14, no 3 2000

Fromm, E. (1968) *The Nature of Man*. Macmillan. New York

Gadamer, H. (1975) *Truth and Method*. Sheed and Ward. London

Garfinkel, H. (1967) *Studies in Ethnomethodology*. Englewood Cliffs. Prentice Hall. New Jersey.

Gair, G. Hartery, T.(2001) 'Medical Dominance in Multidisciplinary Teamwork: a Case Study of Discharge Decision Making in a Geriatric Assessment Unit'. *Journal of Nursing Management* , 9 3-11

Garvin, D. A. (1993) 'Building a Learning Organisation' *Harvard Business Review*, 71(4) pp 78-91

Gerrish, K. (1999) 'Teamwork in Primary Care: an Evaluation of the Contribution of Integrated Nursing Teams.' *Health and Social Care in the Community* 7 (5) 367-365

Giddens, A. (1998) *The Third Way and the Renewal of Democracy*. Polity Press. Cambridge.

Glazer, N. (1974) The Schools of the Minor Professions *Minerva* XII (3) pg. 363.)
In Schon, D. (1992) 'The Crisis of Interprofessional Knowledge and the Pursuit of an Epistemology of Practice' *Journal of Interprofessional Care* 'vol. 6 no 1.

Glyn Jones, E. Rapport, F. Kinnarsley P. (1998) 'Primary Health Care Teams Re-engineered'. *Journal of Interprofessional Care*, Vol. 12, no 2

Glyn Jones Consultancy Ltd. (1997) *A Report into the Development of an Integrated Nursing Team*. First Draft. July.

Goleman, D. Boyatzis, R. Mc Kee, A. (2002) *Primal Leadership*. Harvard Business School Press. Boston

Goleman, D. Boyatzis, R and McKee, A. (2002). *The New Leaders. Transforming the Art of Leadership into the Science of Results*. Time Warner Books, Great Britain.

Gregson, B. Carlidge, A. and Bond, S. (1991) *Interprofessional Collaboration in Primary Health Care Organisations*. Royal College of General Practitioners. Occasional Paper 52. London.

Griffin, D. Shaw, P and Stacey, R. (Undated) *Speaking of Complexity in Management Theory and Practice*. Complexity and Management Centre. Business School. University of Hertfordshire

Griffith Sir R. (1988) *Community Health Care- Agenda for action*. HMSO London

Guba, E. G. and Lincoln, Y.S. (1989) *Fourth Generation Evaluation*. Newbury Park, Sage, California.

Guzzo, R.A and Shea G.P. (1992) 'Group Performance and Intergroup Relations' in M D Dunette and L.M. Hough (Eds) . *Handbook of Industrial and Organisational Psychology*, Vol, 3 pp239-313. Consulting Psychologist Press. Paulo. Alto, California

Hackman, J.R .1990 *Groups that Work (and those that don't): Creating Conditions for Effective Teamwork*. Jossey Bass. California

Habermas, J. (1971) *Towards a Rational Society*. Heinemann. London.

Handy, C. (1990) *Understanding Organisations* .BBC Books London

Harding Report 1981, *The Primary Health Care Team: Report of a Joint Working Group of the Standing Medical Advisory Committee and the Standing Nursing and Midwifery Advisory Committee*. Department of Health and Social Security. HMSO. London

Hayward, J. (1997) in Cayer M. 'Bohm's Dialogue and Action Science'. *Journal of Humanistic Psychology* Vol 37 no2 Spring 41-66. Sage

Headrick, L.A. Wilcock, P.and Batalden, P. (1998) 'Interprofessional Working and Continuing Medical Education'. *British Medical Journal*. Vol 316 no.7133 p771.

Health Service Journal (HSJ) in conjunction with Professional Nurse. (2000) *Leadership in the NHS*. EMAP Public Sector Management. London

Heidegger, M. (1962) *Kant and the Problem of Metaphysics*, J.S. Churchill. (Translated) Bloomington Indiana.

Heron, J (1996) *Co-operative Inquiry: Research into the Human Condition*, London, Sage Publications, 1996

Hersey, P. and Blanchard, K. (1993) *Management of Organizational Behaviour Utilizing Human Resources*. 6th edition Englewood Cliffs NJ Prentice-Hall

- Hobden-Clarke, L.A. Law, S.A.T. (1997) *Conflict in General Practice*. Financial Times Healthcare, Pearson publications.
- Hofstede, G. (1984) *Cultures and Consequences*. Sage publications. London
- Holman, D. and Thorpe, R. (2003) *Management and Language*. Sage publications London.
- Howkins, E. and Allison, A. (1997) 'Shared Learning for Primary Health Care Teams, a Success Story.' *Nurse Education Today* 1997 17,225-231 Pearson Professional Ltd.
- House, E.R. (1990) 'Methodology and Justice'. In Sirotnik (Ed) *Evaluation and Social Justice*. Pp23-36. Jossey Bass. San Francisco.
- Iles, V. Sutherland, K. (2001) *Managing Change in the NHS. Organisational Change, a Review for Healthcare Managers, Professionals and Researchers*. National Coordinating Centre for NHS Service Delivery and Organisation Research and Development.
- Inkeles, A. (1964) *What is Sociology?* Englewood Cliffs. Prentice Hall. New Jersey.
- Isaacs, W. N. (1993). 'Taking flight: Dialogue, Collective Thinking and Organisational Learning' *Organisational Dynamics* Vol 22 no 2 autumn 40-51
- Jackson, M.C. and Keys, P (1984) 'Towards a System of Systems Methodologies.' *Journal of Operational Research Society*.. 35,473-486
- Jarvis, P. (1987) *Twentieth Century Thinkers in Adult Education*, London: Croom Helm.
- Jenkins, P. (1979) *Patients First*. HMSO. London
- Johnson, G, Scholes, J (1999) *Exploring Corporate Strategy*. 5th Edition, Prentice Hall. London
- Jones, R. V. H. (1986) *Working Together, Learning Together*. Royal College of General practitioners. Occasional paper 33
- Jones, R.V.H. (1992) 'Teamwork in Primary Care, How much do we know about it?' *Journal of Interprofessional Care* Vol 6 no1
- Kakabadse, A and Kakabadse, N. (1999) *Essence of Leadership*. International Thompson Business Press. London
- Kant, I. (1787) *The Critique of Pure Reason*. 2nd edition (translated by Smith, N.K) and published in 1933 Macmillan. Basingstoke
- Kanter, R.M. (1989) *When Giants Learn to Dance*. Simon and Shuster. New York
- Katz, R. L. (1955) 'Skills of an Effective Administrator.' *Harvard Business Review* Jan/Feb pp.33-42
- Katzenbach, J. and Smith, D. (1993) 'The Discipline of Teams.' *Harvard Business Review* March-April pp111-120

- Kelly, G. (1963) *A Theory of Personality*. Norton. New York
- Kenny, G. (2002) 'Interprofessional Working, Opportunities and Challenges.' *Nursing Standard*. 17, 6, 33-35.
- Kenny, D. T. and Adamson B. J. (1992) 'Medicine and the Health Professions, Issues of Dominance, Autonomy and Authority. *Australian Health review* 15. 319-335
- Kesby, S. (2002) 'Nursing Care and Collaborative Practice.' *Journal of Clinical Nursing* Volume 11 Issue 3 Page 357. Blackwell.
- Knowles, M. S. (1973; 1990) *The Adult Learner. A neglected species* (4e), Houston: Gulf Publishing
- Korac-Kakabadse, N. and Kouzmin, A., (1997), 'From the "Captains of the Ship" to "Architects of Organisational Arks": Communication Innovations, Globalisation and the "Withering Away" of Leadership Steering', in Garnett, J.L. and Kouzmin, A., (Eds.), *Handbook of Administrative Communication*, Marcel Dekker, New York, pp. 681-716.
- Kuhn, T.S. (1970) *The Structure of Scientific Revolutions*. Second Edition.
- Lawrence, G. (1970) *Social processes in Task Oriented Discussions*. Spode House Review 6 (71) 3-11
- Leicester Terrace Healthcare Centre. (1996) Practice Development Plan
- Leicester Terrace Healthcare Centre. (1998) Practice Development Plan
- Lewin, K. (1946) 'Action Research and Minority Problems' *Journal of Social Issues*. 2 34-46.
- Lincoln, Y.S. (1995) 'The Sixth Moment: Emerging problems in Qualitative Research. Studies'. *Symbolic Interaction*, Volume 19. Pp37-55.
- Lincoln, Y.S. and Guba, E.G. (1989) 'Ethics: The failure of Positivist Science.' *Review of Higher Education*, 12, 221-241
- Lindeman, E. C. (1926) *The Meaning of Adult Education* (1989 edn), Norman: University of Oklahoma.
- Lok, P. and Crawford, J. (1999) 'The Relationship between Commitment and Organisational Culture, Subculture, Leadership Style and Job Satisfaction in Organisational Change and Development.' *Leadership and Organizational Development Journal* 20/7 1999 365-373 MCB University Press
- Lundin, C. Paul, H. and Christenson, J. (2000) *Fish. A Remarkable Way to Boost Morale and Improve Results*. Hodder and Stoughton. London
- Mackenzie, G (2000) 'Why Changing Culture is the Hardest Part of any Change Programme.' *NHS Magazine*. Autumn

Management Research Group (1999) *Leadership Effectiveness Analysis*. Management Research Group. Belgium

Margerison, C. and McCann, D. (1990) *Team Management*. WH Allen. London

Marsh, G.N. (1991) 'Caring for Larger Lists.' *British Medical Journal* 303,1312-1316),

Maslow, A.H. (1943) 'A Theory of Human Motivation' *Psychological review* July pp 370-96.

McClelland, D. (1975) *Power, the Inner experience*. New York Irvington.

McClelland, D. (1976) 'Power is the Great Motivation' *Harvard Business Review* 54(2) 100-110

McDaniel, C. Stumpf, L. (1993) 'The Organisational Culture'. *Journal of Nursing Administration* 4: 54-60

McFadzean, E. (1999) 'Encouraging Creative Thinking' *Leadership and Organisation and Development Journal* 20/7199 374-383

McGill, M. Slocum, J. and Lei, D. (1993.) 'Management Practices in Learning Organisations'. *Organisational Dynamics* Autumn 5-17

McIntosh.J. Dingwall, R. (1978) Teamwork in theory and practice, In: Dingwall,R. McIntosh.J (eds) *Readings in the sociology of nursing*. Churchill Livingstone. Edinburgh

McNiff, J. (2000) *Action Research in Organisations*. Routledge, London

McWhinney, (1992) *Research Methods in Primary Care*. Sage London

Mead, G.H. (1934) *Mind, Self and Society*. University of Chicago Press. Chicago.

Mezirow, J. Ed. (1990) *Fostering Critical Reflection in Adulthood*. San Francisco Jossey Bass

Midgley, G. (1992) 'Pluralism and the Legitimation of Systems Science'. *Systems Practice*, Vol 5 No 2 1992

Midgley G (1992) 'The Sacred and Profane in Critical Systems Thinking.' *Systems Practice* Vol 5 No 1. 1992

Miller, C. Ross, N. Freeman, M. (1999) *Researching Professional Education Shared learning and Clinical Teamwork; New Directions in Education for Multiprofessional Practice*. English National Board for Nursing, Midwifery and Health Visiting. Jill Rogers Associates Cambridge. printed by Chiltern Press. Luton.

Morgan, M. Hanson, D. (1996) 'Shared Ownership' *Nursing Times* 92 (38): 32-33

Mortenson, C.D. (1972) *Communication. The Study of Human Interaction*. New York McGraw Hill.

- Mullins, L. (1990) *Management and Organisational Behaviour*. Second Edition. Pitman. London
- Nevis, E. DiBella, A. and Gould, J. (1995) 'Understanding Organisations as Learning Systems'. *Sloan Management Review* Winter 73-85
- NHS Executive (1994) *Developing NHS purchasing and GP Fundholding: towards a primary care led NHS*. Department of Health, Leeds
- NHS Executive (1996) *Primary Care: The Future*. Department of Health, Leeds
- NHS Management Executive (1993) *Nursing in Primary Care – New World, New Opportunities*. NHSME Leeds.
- NHS Executive (1999) *Clinical Governance: Quality in the new NHS*. Department of Health. Leeds
- NHS Executive. (2000) South West. *Interprofessional Education Improving Health and Social Care*. Learning from a conference held on 16th –17th November 2000. Royal Bath Hotel, Bournemouth
- NHS Executive (2002) ' *Making a Difference: Integrated working in primary care,*' Department of Health.
- Northcott, N. and Dolan, T. (2002) 'Crisis Management, Creating Order out of Chaos'. In Young, A. and Cooke, M.(Eds) *Managing and Implementing Decisions in Healthcare*. Bailliere Tindall. London.
- Onyet, S. Pillinger, T. and Muijen, M. (1996) *Making Community Mental Health Teams work*. Sainsbury Centre for Mental Health. London
- Oshry, B. (1995) *Seeing systems: Unlocking the Mysteries of Organisational Life*. San Francisco California. Berrett. Koehler
- Ovretveit, J. (1993) *Co-ordinating Community Care* Buckingham, Open University Press Milton Keynes.
- Ovretveit, J. (1996) 'Five Ways to Describe a Multidisciplinary Team'. *Journal of Interprofessional Care*, 10,189-198.
- Owen, A. (1998) 'Self Managed Teams; the West Berkshire Approach' *Health Visitor*. Vol 71. number 1 January .
- Partington, D. and Harris, H. (1999) 'Team Role Balance and Team Performance: An Empirical Study.' *The Journal of Management Development* vol. 8 no 8 1999. P 694 – 705
- Pedler, M.J. Burgoyne and Boydell, T (1997) *The Learning Company, a Strategy for Sustainable Development*. Second edition. Mc Graw Hill U K Ltd. London.

- Peters, M. and Marshall, J. (1991) 'Education and Empowerment: Postmodernism and the Critique of Humanism.' *Education and Society* 9 123-134
- Peters, T and Waterman, R.H. (1982) *In Search of Excellence*. Harper and Row .New York.
- Pfeiffer, J.W. and Jones 1974 (eds) *A Handbook of Structured Experiences for Human Relations Training*. Vol 1 revised, University Associates incorporated. San Diego CA
- Popper, K. (1972) *Objective Knowledge* .Oxford University Press
- Pratt, J. Gordon, P. Plampling, D. (1999) *Working Whole Systems, putting Theory into Practice in organisations*. Kings Fund London
- Pritchard, P. (1995) 'Learning to Work Effectively in Teams'. In Owens, P.Carrier, J. Horder, J. (Eds) *Interprofessional Issues in Community and Primary Health Care*. Macmillan. Basingstoke
- Punch, M. (1986) *The Politics and Ethics of Field Work*. Sage. Beverley Hills.
- Rasberry, R. and Lemoine, L. (1986) *Effective Managerial Communication* Wadsworth Massachusetts USA
- Rawson, D. (1991) 'Models of Interprofessional Work Likely Theories and Possibilities' in Leathard, A (Ed) *Going Interprofessional, Working Together for Health and Welfare*. Routledge. London
- Reason. P. (1998) *Human Enquiry in Action*. Sage. London
- Reason,P. Bradbury, H. (2001) *Handbook of Action Research* Sage. London
- Richardson (1996) *Handbook of Qualitative Research Methods*. Biddles. Guildford
- Rogers, C. and Freiberg, H. J. (1993) *Freedom to Learn* (3rd edn.), New York: Merrill
- Roth, G.L. and Kleiner A.1995. " *Learning Histories: a Formal Process for Organisational Learning*." Conference proceedings, Systems thinking in Action conference. Boston
- Royal College of General Practitioners. (1985) *Quality in General Practice: Policy Statement (2)*. Royal College of General Practitioners. London
- Ryan, A. McKenna, H. (1994) 'A Comparative Study of the Attitudes of Nursing and Medical Students to Aspects of Patient Care and the Nurses Role in Organising that Care'. *Journal of Advanced Nursing*. 19, 114-123.
- Saint- Onge, H. and Wallace, D. (2003) *Leveraging Communities of Practice for Strategic Advantage*. Butterworth-Heinemann. USA
- Schein, E. (1974) *Professional Education*. Mc Graw Hill. New York
- Schien, E.H. (1993). 'On Dialogue, Culture and Organisational Learning.' *Organisational dynamics* Vol 22 no 2 autumn pp 40-51

- Schon, D. (1983) *The Reflective Practitioner*. Basic Books. New York
- Schon, D. (1991) *How Professionals Think in Action*. Ashgate Aldershot
- Schon, D. (1987) *Educating the Reflective Practitioner*. Jossey Bass. San Francisco
- Schramm, W. (1972) *The Nature of Communication between Humans. The Processes and effect of Mass Communication*. Urbana, IL: University of Illinois press 1972pp7-53
- Senge, P (1990) *The Fifth Discipline: The Art and Practice of the Learning Organisation*. Century. UK.
- Senge, P. Kleiner, A. Roberts, C. Ross, R. and Smith, B., (1994) *The Fifth Discipline Fieldbook*. Nicholas Brearley Publishing. London.
- Seymour, E. and Buscheroff, J. R. (1991) 'Sources and consequences of satisfaction and dissatisfaction in nursing: findings from a national survey'. In Senge, P (1990) *The Fifth Discipline: The Art and Practice of the Learning Organisation*. Century. UK. sample'. *International Journal of Nursing Studies* 28 109-124
- Sibley, M. (1997) *Primary Health Care*. April Volume 7 no 3 1997
- Simms, L. (1991) 'The Professional Practice of Nursing Administration'. *Integrated Nursing Practice. Journal of Advanced Nursing*. Vol 21 no5 May
- Simon, H. (1976) *Administrative Behaviour* 2nd Ed. Free Press New York
- Smith, J.K. (1990) 'Alternative Research Paradigms and the Problem of Criteria.' In Guba, E.G. (Ed) *The Paradigm Dialogue*, 167-187. Newbury Park. Sage. California.
- Social Services Committee (1987) *Primary Health Care*. HMSO London
- Spencer and Pruss.A (1992) *Managing Your Team*, Piatkus London
- Standing Medical Advisory Committee (1963). *The Fieldwork of the Family Doctor*. (the Gillie Report). HMSO. London.
- Tannebaum, R. and Schmidt, W.H. (1958) 'How to choose a Leadership Pattern' *Harvard Business Review* March/April 1958:96
- Torbert, W. (1991) *The Power of Balance: Transforming Self, Society and Scientific Enquiry*. Sage. Thousand Oaks. California
- Torbert, W. and Associates (2004) *Action Inquiry: The Secret of Timely and Transforming Leadership*, Berrett-Koehler, San Francisco;
<http://www2.bc.edu/~torbert/>
- Tuckman, B. (1965) 'Development Sequence in Small Groups.' *Psychological Bulletin* Vol 63. Pp384-389.
- Vaughan, B. (2002), 'Cross Boundary Working: Luxury or necessity?' *Journal of Clinical Nursing*; 11: 295-296. Blackwell Science limited

Vince, R. (1996) *Managing Change: Reflections on Equality and Management Learning*. The Policy Press. Bristol

Wass, V.J.Wells, P.E.(1994) *Principles and Practice in Business and Management Research*. Dartmouth. Aldershot.

Weil, S. (1998) 'Rhetoric's and Realities in Public Service Organisations: Systemic Practice and Organisational Learning as /Critically Reflexive Action Research (CRAR)'. *Systemic Practice and Action Research*. Vol 11. No.1, 37-62. Plenum. New York

Wenger, E. (1998) *Communities of Practice* Cambridge University Press.

West, M. (1994) *Effective Teamwork*. The British Psychological Society. Leicester.

West, M. (1995) *The Effectiveness of Team Working in Primary Health Care*. A report to the Health Education Authority, Sheffield: Institute of Work Psychology.

West, M.A. and Poulton, B.C. (1997) 'A failure of Function: Teamwork in Primary Health Care.' *Journal of Interprofessional Care* vol.11 no 2

Wilber, K. (1995) *Sex, Ecology and Spirituality*. Shambhala. Boston

Winter, R.(1989) *Learning from Experience: Principles and Practice in Action Research*. Falmer Press. London

Winter, R. Buck, A. and Sobiechowska, P. (1999) *Professional experience and the Investigative imagination: the ART of reflective writing*, Routledge 1999

Woodcock, M. (1989) *Team Development Manual*, Gower, Aldershot.

Young, L. (1997) 'Improved Primary Health Care through Integrated Nursing'. *Primary Health Care*. July vol7 no6 1997.

Zuber-Skerritt, O. (1996) *New Directions in Action Research*. Falmer. London.

SUMMARY OF MAIN FINDINGS / RECOMMENDATIONS of the 'Glynn Jones' report.

1. The practice computer system is capable of producing information, which will be useful in assessing the impact of any movement of workload. **It is recommended that the Practice establish routine reports, which provide key indicators for workload to be monitored.**
2. There is pressure to run additional clinics for target groups. **It is recommended therefore that all clinics are periodically reviewed to ensure that they are achieving what they were set up to achieve with regard to the target groups and numbers seen.**
3. The Comcare system has the potential to provide information, which could be a useful management tool. This will be particularly important to evaluate the potential changes that may result from this project. **It is recommended that the Practice establish key reports that it would like the Comcare system to provide on a routine basis.**
4. **If the conditions for developing tasks/functions from GPs to nurses can be satisfied and there is a will on the part of doctors to 'let go' of some traditional areas of GP workload, then the potential exists for a more efficient and effective use of professional practice resources.**
5. **It is therefore recommended that on the basis of the findings of the report the Practice considers the movement of some areas of care totally to nursing staff.**
6. **The majority of staff believes that the existing boundaries between the different nursing groups could be changed to enable greater continuity of care.**
7. **It is recommended that the suggestions for achieving greater integration of nursing resources should be considered and pursued.**
8. **Inappropriate use of nursing type has been identified and every effort should be made to utilise the appropriate type and grade of staff.**
9. **It is recommended that the Practice consider the appointment of a 'generic nurse' working within clear guidelines. A multi-disciplinary nursing group should look to define the role and the parameters for use within the Practice.**
10. **While there are a number of concerns, it is recommended that a Lead Nurse is appointed with suitable qualifications and experience to lead the nursing team and to facilitate the process of change.**
11. **It is recommended that a multi-disciplinary nursing group is formed to consider the areas highlighted for collaboration.**
12. **It is recommended that, as part of the Practice development, the Practice carries out patient surveys to recognise needs of their patients.**
13. **In order to target limited resources in the most appropriate way the Practice needs to build up a practice profile.**

- 14. The future needs of identified high-risk groups may require the Practice to redirect resources from existing groups. The Practice will have to consider those areas, which should be targeted less as well as those, which should be targeted more.**
- 15. Additional information is required to assess the potential for running the additional clinics that have been identified.**
- 16. It is recommended that the feasibility of shifting accommodation to locate all the nurses in the same part of the building should be examined.**

Appendix 2

Nurse Questionnaire September 1998

Please will you each consider the answers to the following questions as part of the Evaluation of the Nurse Team Coordinator Role?

Thanks

- What do you consider is the primary purpose of the nurse team coordinator?
- Do you think this is being fulfilled?
- What do you think are the differences between leadership and management?
- What of the above qualities are needed to perform this role?
- What do you mean by an integrated nursing team?
- What do you think are the main strengths of the present nursing team at Leicester Terrace?
- What do you think are the key developmental tasks for the nursing team at Leicester Terrace?
- How would you describe communication within the nursing team at Leicester Terrace?
- How would you describe the relationship with all the other members of the Primary Health Care Team?

Thanks.

Please also would you take time to complete the attached questionnaire on leadership and return it to me?

This reply can be anonymous, but if you choose to identify yourself the response will be kept confidential.

Appendix 3

LEADERSHIP QUESTIONNAIRE

The following items describe aspects of leadership behaviour. Respond to each item according to the way you would most likely act if you were leader of a work group. Circle whether you would most likely behave in the described way:
always (A); frequently (F); occasionally (O); seldom (S); or never (N).

Scoring

1. Circle the item number for items 8, 12, 17, 18, 19, 30, 34 and 35
2. Write the number 1 in front of a *circled item number* if you responded S (seldom) or N (never) to that item.
3. Also write a number 1 in front of *item numbers not circled* if you responded A (always) or F (frequently).
4. Circle the number 1s which you have written in front of the following items: 3, 5, 8, 10, 15, 18, 19, 22, 24, 26, 28, 30, 32, 34 and 35.
5. *Count the circled number 1s.* This is your score for concern for people. Record the score in the blank following the letter P at the end of the questionnaire.
6. *Count the uncircled number 1s.* This is your score for concern for task. Record this number in the blank following the letter T.

A F O S N	1.	I would most likely act as the spokesperson of the group
A F O S N	2.	I would encourage overtime work
A F O S N	3.	I would allow members complete freedom in their work
A F O S N	4.	I would encourage the use of uniform procedures
A F O S N	5.	I would permit the members to use their own judgement in solving problems
A F O S N	6.	I would stress being ahead of competing groups
A F O S N	7.	I would speak as a representative of the group
A F O S N	8.	I would needle people for greater effort
A F O S N	9.	I would try out my ideas in the group
A F O S N	10.	I would let the members do their work the way they think best
A F O S N	11.	I would be working hard for a promotion
A F O S N	12.	I would tolerate postponement and uncertainty
A F O S N	13.	I would speak for the group if there were visitors present
A F O S N	14.	I would keep the work moving at a rapid pace
A F O S N	15.	I would turn the members loose on a job and let them go to it
A F O S N	16.	I would settle conflicts when they occur in the group
A F O S N	17.	I would get swamped by details
A F O S N	18.	I would represent the group at outside meetings
A F O S N	19.	I would be reluctant to allow the members any freedom of action
A F O S N	20.	I would decide what should be done and how it should be done
A F O S N	21.	I would push for increased production
A F O S N	22.	I would let some members have authority which I could keep
A F O S N	23.	Things would usually turn out as I had predicted
A F O S N	24.	I would allow the group a high degree of initiative
A F O S N	25.	I would assign group members to particular tasks
A F O S N	26.	I would be willing to make changes
A F O S N	27.	I would ask the members to work harder
A F O S N	28.	I would trust the group members to exercise good judgement
A F O S N	29.	I would schedule the work to be done
A F O S N	30.	I would refuse to explain my actions

- A F O S N 31. I would persuade others that my ideas are to their advantage
A F O S N 32. I would permit the group to set its own pace
A F O S N 33. I would urge the group to beat its previous record
A F O S N 34. I would act without consulting the group
A F O S N 35. I would ask that group members follow standard rules and regulations

T _____ P _____

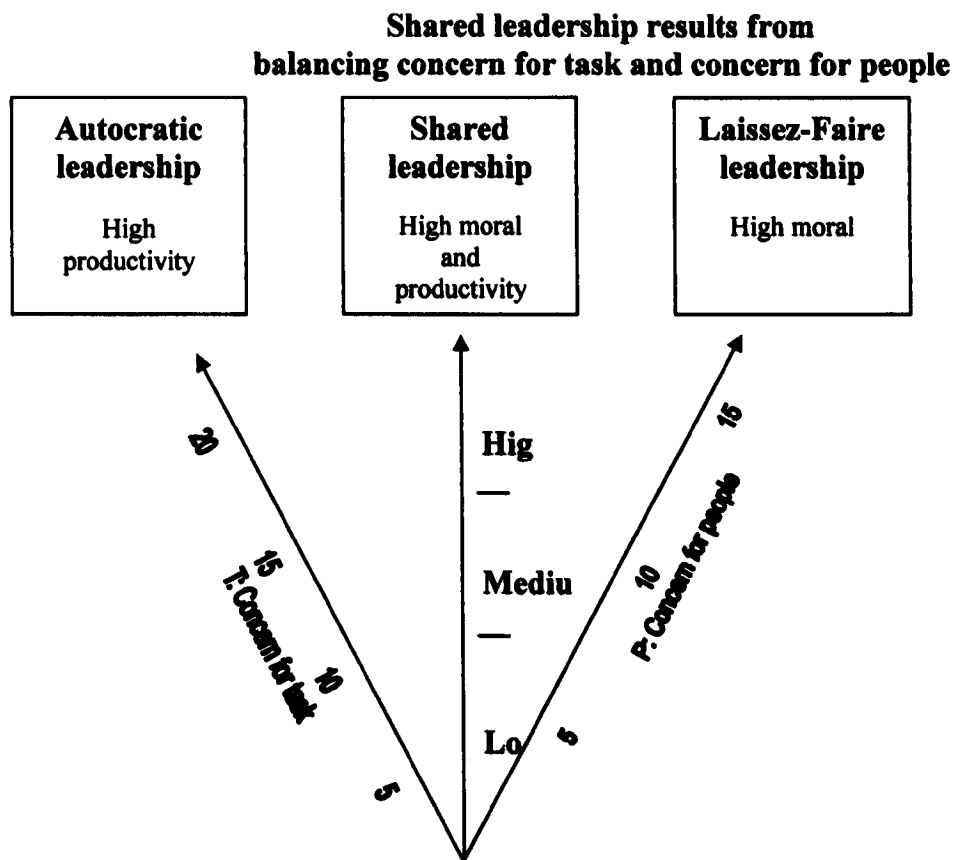
ORGANISATIONAL PROCESSES AND THE EXECUTION OF WORK

Interpretation: T - P LEADERSHIP STYLE PROFILE SHEET

To determine your style of leadership, mark your score on the *concern for task dimension* (T) on the left-hand arrow below.

Next, move to the right-hand arrow and mark your score on the *concern for people dimension* (P).

Draw a straight line that intersects the P and T scores. The point at which that line crosses the *shared leadership* arrow indicates your score on that dimension.



Source: Pfeiffer J W and Jones J E (eds) *A Handbook of Structured Experiences for Human Relations Training*
Vol 1. revised. University Associates Inc., San Diego CA (1974) p12

Compare your style on the T - P Profile Sheet with your score from Assignment 1.

**EVALUATION STUDY: LEICESTER TERRACE HEALTHCARE CENTRE,
OCTOBER 1999**

The final report on the integrated nursing project that commenced in January 1998 is due in December of this year. This questionnaire follows on from the questionnaire in September 1998 and in part will ask similar questions. The same questions are being asked to all members of the primary healthcare team.

Please take time to respond thoughtfully as this will enhance the depth of the overall study. Some questions will ask you to respond on a scale of one to ten, where one is low and ten is high. Please put a cross on the line at the appropriate place.

Please could you respond by **31 October 1999** using the stamp addressed envelope provided.

Thank you very much in anticipation.

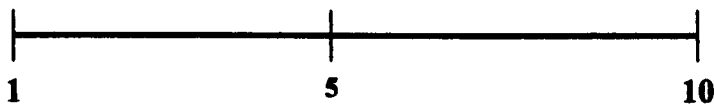
What is your job at Leicester Terrace? Please circle or delete as appropriate

Administration / Nursing / Doctor / Reception / Other (Please identify)

How many years have you been in this role?

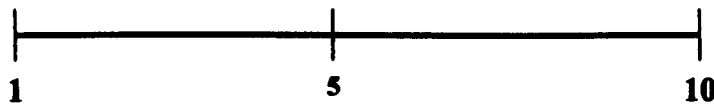
ON A SCALE OF ONE TO TEN PLEASE STATE:

How you feel teamwork in the Practice has improved over the last two years



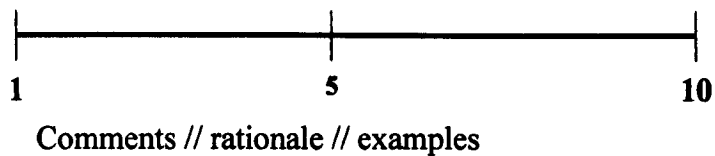
Comments // rationale // examples

How you feel communication in the Practice has improved over the last two years



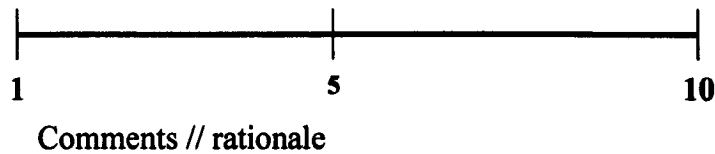
Comments // rationale // examples

As an individual, how much you feel your contribution is valued

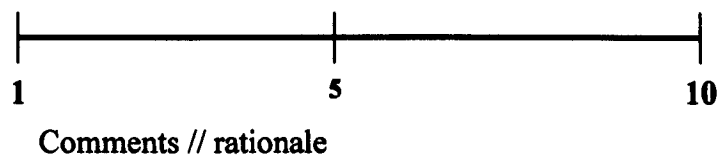


How clear you are about:

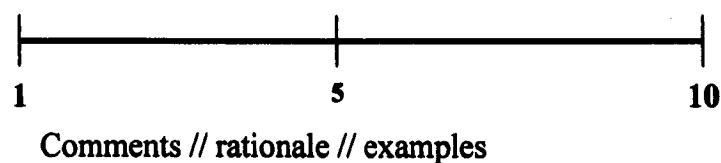
The objectives of your individual team?



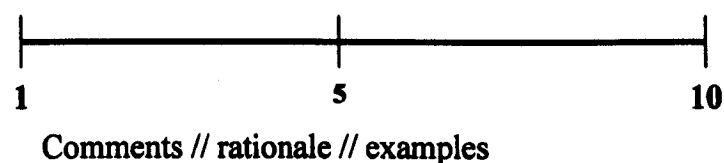
The objectives of the primary health care team?



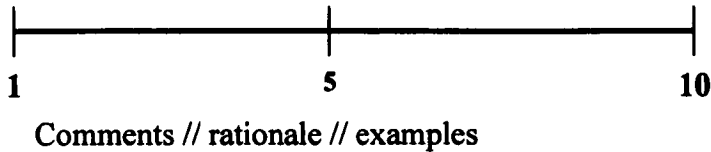
Your involvement in developing those objectives?



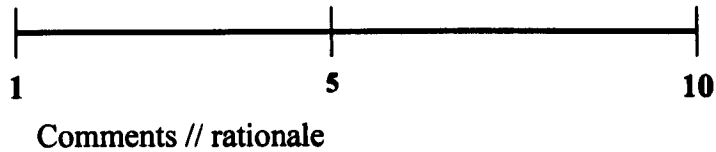
To what extent do you feel you get accurate feedback on your performance?



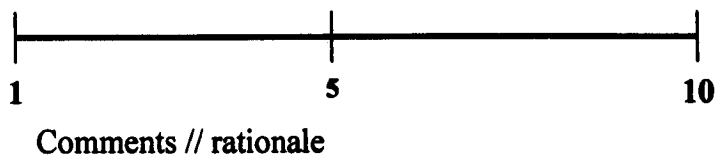
To what extent you are able as an individual to contribute towards the development of your role within the overall aims of your team?



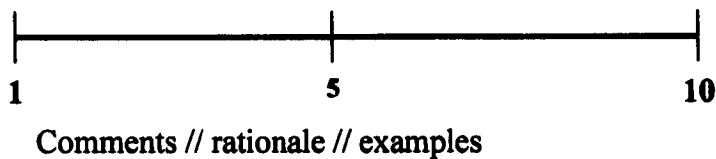
To what extent do you understand the role of other members of your team?



To what extent do you understand the role of other members of the Practice?



The extent to which your understanding of reflective practice has increased



What have been your individual achievements over the past two years?

How has your job developed over the past two years?

In which areas would you like it to develop further?

To what extent do you feel the Practice Nurses, District Nurses and Health Visitors work together at Leicester Terrace?

1

5

10

Comments // rationale // examples

List the achievements of this team over the past two years

In one sentence describe the nursing team at Leicester Terrace

To what extent has the integrated nursing team affected the patients at Leicester Terrace?

1

5

10

Give reasons for your response

What, to you, is the most important development over the last two years relating to the integrated nursing team?

What are the challenges or opportunities for the immediate future?

What are the qualities required of the nurse team coordinator in the Practice at Leicester Terrace?

Thank you very much

Please add any other additional comments you may wish to make.

Appendix 5

Prompt questions for meetings with GP's September 1998

- What do you consider is the primary purpose of the NTC role?
- Do you think this is being fulfilled?
- What do you think about differences between leadership and management?
- Where do you think strengths lie?
- What do you mean by an integrated nursing team?
- What are the main strengths of the present nursing team, (who do they mean by nurses)?
- What are the key developmental tasks for the nursing team?
- What is your lead responsibility in the practice?
- Tell me how you work with the nursing team to meet the expectations of your lead responsibility.
- Is there anything else you want to tell me?

Table Team role definitions for the management of depression

	Practice nurse	Health visitor	CPN	Social Worker	Counsellor	District nurse	GP
Client group	Everyone F > M Elderly > young	Especially young mums, families and carers Report to GP if Edinburgh Scale > 14	65 years refer to CPN (psychogeriatric) < 16, or < 18 if in full-time education, to child guidance*	18-65 years Enduring/severe mental illness	16-65 years F > M All except psychotic symptoms	Elderly Post-hospital Carers Terminally ill	All F > M
Assessment	Recognition Listening Facilitating Feelings Hospital Anxiety Depression Scale New Patient Q Elderly Surveillance Questionnaire	Routine use of Edinburgh Post Natal Depression Scale Gut feeling HAD Scale if appropriate	Scales Coping mechanisms Patient's view Trigger Issues Support available	Risk assessment of needs such as social, finance, accommodation, occupation and carers' needs	Psychological formulation of symptomatology, treatment options and resources and long-term management advice	HAD Scale Elderly Surveillance Questionnaire	Suicidality GDS Severity/ HAD Scale Patient's view Support Social context Medication
Severity	Mild	Mild-moderate	Severe-moderate	Moderate-severe	Moderate-severe	Mild	All
When to refer/follow	Suicidality Complex issues Failing to improve or inappropriate	Suicidality Complex issues Failing to improve or inappropriate	Neglect Safety issues Failure to improve*	Patient wishes Complex social needs Family issues	Suicidality = moderate Complex issues Failure to improve	Suicidality Complex issues Failure to improve	Safety issues Patient wishes Family pressure

When to receive referrals	For advice and talking through An educational role coordination of patient library leaflets	Mothers of young children. Help with postnatal depression	Moderate-severe especially at risk of self-harm	Advice regarding child care, benefits and accommodation	Problems with relationships, stress, anxiety and depression, mild eating disorders and post-traumatic stress disorder	People with other nursing needs impinging on their mood, for example physical disabilities	Confirm diagnosis or if uncertain diagnosis Multiaxial assessment Concern for other members of PHCT Medication
How do people refer	Via receptionist	Via pigeonhole	Letter to CMHT Faxed if urgent	Letter to CMHT Faxed if urgent	Letter secretary	Via Community Nursing Book in reception	Via receptionist
Suicidal assessment dealing with suicidal people	Able to recognise when people may be suicidal – refer to GP	Able to recognise when people may be suicidal – refer to GP	Able to carry out risk assessment and monitor suicidal behaviour	Able to carry out risk assessment and monitor suicidal behaviour	Able to support people with suicidal behaviour and liaise with CMHT but not an emergency service	Able to recognise when people may be suicidal – refer to GP	Able to carry out risk assessment and assist with shared care of patient with CMHT
Advice and information	Provide and describe various leaflets Follow-up offered	Advice on child care agencies Carers' support Follow-up and support young mothers	Provide advice on other agencies especially liaison with CMHT and voluntary agencies including CMHT groups	Provide advice on other agencies especially liaison with CMHT and voluntary agencies including CMHT groups	Direct via leaflets Indirect via agencies	Information via self-help groups and local agencies especially the elderly Support of carers	Able to provide the leaflets and diaries relevant to current issue Appropriate use of audio tapes and net-working with voluntary agencies

Medication	Awareness of side-effects encourage compliance	Awareness of side-effects encourage compliance	Good knowledge of medication, side-effects and dose Able to provide supervision of medication	Encourage compliance Discuss with GP where necessary	Encourage compliance Discuss with GP where necessary	Encourage compliance Support advice on side-effects	Prescribe medication Monitor medication Awareness of side-effects and interactions with other medication
------------	--	--	--	---	---	--	--

* See CPN Operational Policy Document