

Evidence



Shared Leadership for Change Award Scheme

Evaluation and final report to the Health Foundation

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Executive summary

This is the final report of the evaluation of the Health Foundation's Shared Leadership for Change award scheme.

The scheme

The scheme was a relatively simple and low-cost intervention, designed to test a hypothesis that provision of structured support to teams to improve functioning, using a model called 'shared leadership', would lead to improvements in team processes and patient outcomes. While the latter was unproven, the former was largely substantiated.

The scheme focused on diabetes managed clinical networks (MCNs). Six multidisciplinary diabetes teams were selected to take part in the scheme in summer 2005.

Characteristics of teams exhibiting shared leadership:

- team members have a shared vision
- there is a strategy and plans for implementation are in place
- team members are jointly accountable for progress
- team processes are fit for purpose
- there is a recognised leader, but responsibility for outcomes is shared
- teams are not dependent on one or two key individuals
- teams have identified key stakeholders and means by which they keep in touch.

The scheme was delivered between October 2005 and July 2007 and comprised flexible support from an independent leadership development consultant (LDC), to improve team effectiveness, and three shared learning events.

The evaluation

The independent evaluation drew on quantitative and qualitative data to understand processes and outcomes. It sought to be 'summative', to establish whether the initiative had worked, and 'formative', to help it perform better as it proceeded. For evaluation purposes, each team was assigned a comparator group to facilitate the assessment of the outcomes.

Benefits attributable to the scheme

Significant differences between comparator and award teams on about half of the indices of teamwork development and self-reported improvements in skills and abilities indicate that the scheme delivered tangible results.

All the teams reported a benefit in shared leadership from the intervention: increased levels of activity and achievement, improvements in team processes, a focus on outcome, increased status within the local health community and an ability to sustain performance at a time of turbulence in the healthcare system.

Less sophisticated teams benefited from some basic tools, for example meetings skills and action plans. The more sophisticated teams were able to focus on extending their roles as educators of professionals and patients, and on widening their influence.

The scheme was described as a 'lifeline' for teams which underwent significant changes in leadership and membership.

Team members reported improvements in confidence and influencing skills, contributing to a cascade effect through individual participants using newly acquired skills in other contexts. Improvements in cross-boundary working were reported by four teams.

Impact on services and patient-level outcomes

There is evidence that the scheme led to service improvements, although it is difficult to attribute these directly to the award initiative. Follow-up with two teams in October 2008 indicated that these improvements have been sustained.

There was no quantifiable improvement in patient-level outcomes within the duration of the scheme. If these were to accrue, participants expected this would take longer than 18 months.

Factors enabling teams to make best use of the intervention were:

- Stability of team membership – rapid turnover of team members had a deleterious impact. In particular, in the absence of succession planning, loss of the team leader stalled progress.
- Agreement on who needed to be in the core team which was the focus of the intervention.
- Willingness of the team leader to embrace the theory of change underlying the intervention, and to learn from it.
- Commitment of time and energy from individual team members.
- Stability in the external context to progress interventions. The Welsh and Scottish teams enjoyed the advantage of a stable environment, while primary care trust (PCT) restructuring in England hampered progress for all four teams.

Challenges in delivering leadership development to teams included identification of the core team, changes in team personnel, and finding times and places for development sessions which minimised disruption to members' clinical duties.

Areas for improvement in future schemes

- Clarity about the nature of the scheme: some teams had not fully grasped the implications of participation, in particular opportunity costs in terms of time commitment.
- Clarity about the definition of 'shared leadership': the Health Foundation's definition was insufficiently clear at the outset and this caused some confusion.

- More structured opportunities for learning across teams: the greatest value of the shared learning events was reported to be learning from, and interacting with, other teams.
- Measurement of outcomes: if measurable service improvement or clinical outcomes had been expected, these should have been made explicit by the Health Foundation at the outset, with some baseline measurements in place.

Lessons for the healthcare system

- Clinical networks will benefit from expert help in teamwork and relationship management if they are to realise their full potential.
- Senior clinicians in positions of team leadership benefit from support to understand the principles of effective meetings and teamwork.
- Dedicated administrative support is likely to more than repay the investment.
- Measurable improvements in quality of services and patient outcomes will take longer than 18 months to emerge from investment in team development.
- Teams can be over reliant on charismatic and passionate individual leaders. Succession planning is vital.
- Structural systemic change creates barriers. External turbulence in the NHS meant that English teams had to expend time and energy on survival. The Welsh and Scottish teams had the benefit of a more stable environment.

In the light of the importance accorded to clinical leadership in the Darzi Review (DH 2008), these findings are of particular and practical significance.

Structure of the report

The report is structured in two parts:

Part 1: Scheme and evaluation findings:

- Section 1 introduces the scheme, its rationale and the context for the intervention.
- Section 2 describes the evaluation and its methodology.
- Section 3 summarises the findings from the evaluation.
- Section 4 comprises case studies of each participating team, covering team membership, context, progress through the scheme and outcomes.
- Section 5 provides theoretical contextualisation and further discussion of lessons from this evaluation for sponsors of improvement initiatives and for the healthcare system.

Part 2: Details of the evaluation methodology and its results:

- Appendix 1 reports the findings from the results of interviews with team members.
- Appendix 2 reports the findings from the patient interviews.
- Appendix 3 gives the results of the questionnaire-based surveys.

PART 1:
SCHEME AND EVALUATION FINDINGS

Section 1

The Shared Leadership for Change award scheme: rationale and policy context (Walmsley)

The award scheme

The Shared Leadership for Change award scheme (the scheme) was set up by the Health Foundation (the Foundation) to test the hypothesis that developing 'shared leadership' would lead to improvements in team functioning and patient care. It was informed by the Foundation's long-standing commitment to fostering clinical leadership, a pertinent issue in view of the significance accorded to this in the Darzi Review (DH 2008). The scheme was approved by the Foundation's Board in March 2005, selection took place in summer 2005, and delivery of the scheme began in October 2005 continuing until July 2007.

Shared leadership: the rationale for intervention

The Foundation's first shared leadership initiative was part of its strategic aim 'Developing leaders to improve health and healthcare services'. It was characterised by the Foundation's aim to 'distribute leadership capacity at clinical leads and middle management levels', at the level in organisations where services are being developed, delivered and evaluated, rather than at director level, and to provide leadership development tailored to the context in which teams were working.

The rationale for the focus on teams was that to date most leadership development, both delivered by the Foundation and in other areas of healthcare, had been focused on individuals. A review of the research literature commissioned by the Foundation (European Nursing Leadership Foundation 2005), alongside consultation with key stakeholders, highlighted that there was value in testing a hypothesis that provision of greater support and development to teams working within complex health services, in particular to their clinical leaders, might contribute to improvements in clinical care. The literature indicated increasing recognition that developing individual leaders goes only some way to generating the type of changes in

professionals' behaviour which are essential if complex systems are to deliver sustainable improvement. Shortell, a distinguished US academic, provided this critique of an individualised approach to developing individual leaders as a means of organisational change:

The underlying assumption appears to be that developing the leadership knowledge and skills of individuals will enable these individuals to effectively change their organizations... This is an overly simplistic view of how organizations change. Leadership development programs based on the individual alone may well assist those people with their own career development but will leave the organisations with which they are affiliated fundamentally unchanged. (Shortell 2002, p 193)

Shared leadership as a concept made its first appearance in the leadership research literature in the late 1990s/early 2000s. The concept is also referred to as 'collective', 'distributed' or 'blended' leadership (see, for example, Collinson and Collinson 2006). It implies leadership as a collective, as well as an individual, activity and as something that permeates through all levels of an organisation (Horne and Stedman Jones 2001), and as an organisational, rather than personal, property.

The shared leadership concept challenges the idea that leadership is the property of an individual. Bolden (2005), for example, proposes leadership as a collective and emergent process, contextually situated rather than something individual and prescribed. He argues that the qualities of individual leaders are less important than the underlying processes that give rise to effective transformational organisations: 'Whilst leadership can undoubtedly be instrumental in organizational performance the development of a small number of individuals in isolation is unlikely to result in marked improvements' (Bolden 2005, p 3).

Mannion, Davies et al (2003) also pursued this theme, arguing that in high-performing trusts, 'transactional' leadership (strong top-down management with an emphasis on establishing robust systems for monitoring and improving performance) is well established. The next step in driving improvement is to develop transformational leadership (participatory and devolved styles) throughout the organisation.

Clinical leadership has been cited as an important challenge for the NHS (DH 2008). The Foundation has privileged clinical leadership in its programmes but has taken a multidisciplinary approach as one of its distinguishing features and includes managers, as well as clinicians, in most (not all) of its schemes. The rationale for this approach is the pluralistic cultures which characterise healthcare and other public service organisations (Attwood, Pedler et al 2003), putting a premium on processes which enable people to listen and learn across professional silos. Edmonstone (2005) argues that the value of multidisciplinary approaches to leadership development lies in the importance of aligning the clinicians' focus on patients, client group or service with the managers' focus on the needs of the organisation. Many of the tensions in healthcare have been attributed to divisions between managers and clinicians.

Furthermore, while managerial cultures accept hierarchical relationships, professionals start with an assumption of 'elective' or representative leadership, in which all within a given professional group are theoretically equal – and equally valuable (Edmonstone 2005, p 6). Thus clinical leadership cannot proceed by formal authority alone. Leaders in clinical contexts need to facilitate debate, discussion and resultant action. While this undoubtedly overstates the contrasts between managerial and clinical cultural practices, it is a helpful generalisation.

Team working within healthcare organisations is complex and challenging. An added dimension of complexity is the challenge of effective team working across professional and organisational boundaries, particularly between primary, secondary and tertiary care. Edmonstone and Western (2002) note that the concept of shared leadership sits comfortably with recent developments in healthcare such as the development of managed clinical networks (MCNs). Research into team-focused leadership development programmes in the NHS indicated value (see, for example, Heiberg, Helljesen et al 2002; MacFarlane 2002; Borrill,

West et al 2003). Such programmes were characterised by their work with teams in context and tailored development to the needs of the organisation(s) and the tasks.

Since the Shared Leadership for Change Initiative began in 2005, interest in team development approaches as a means of delivering more effective clinical care appears to have gained momentum. Giddings and Williamson (2007), for example, stress the importance of this development for surgical teams. They note that performance reviews by the Royal College of Surgeons have identified a number of common themes strongly suggesting the need to improve understanding of effective team working and the major implications for patient safety. The performance reviews found that, while the technical competence of teams was rarely in question, non-technical skills in communication, working with others and personal insights were frequently highlighted as areas for improvement. To address this, they argue for significant investment in interprofessional education and training for surgical teams, backed by commitment at all levels of management:

Team working in healthcare is inherently problematic. Teams in healthcare almost always exceed the size known to be ideal, often by a factor of ten, and their interfaces with other teams are indistinct and dynamic. Demands on staff are unpredictable and sometimes 'unreasonable'. This, with the absence of any team training for many of the most influential staff, may help to explain why true team working in the NHS is comparatively rare. (Giddings and Williamson 2007)

In the light of emerging evidence that contextualised support to teams could drive improvement, it was an important step for the Foundation in extending its 'developing leaders' portfolio.

Shared leadership and managed clinical networks

Diabetes MCNs were chosen as the focus for the scheme. They evolved in recognition of the importance of co-ordinating care across multidisciplinary and organisational boundaries, and are seen to have considerable, though sometimes unrealised, potential. A study conducted by the Office for Public Management in 2002 observed that:

By producing integrated services that span organisational and professional boundaries, clinical networks hold out the promise of delivering rapid and focused change that will raise clinical quality, improve the patient experience, identify future needs for education and training and ensure the best use of human and physical resources. But as the NHS begins to move to this new pattern of organising care, questions are being raised about how clinical networks will fit in with the rest of the service. (OPM 2002)

This view is reinforced by a study of five cancer MCNs conducted by Addicott and colleagues (2007) which found that all except one network had faced significant difficulties in working together effectively, including issues such as overt and covert resistance to the concept of MCNs, inter-organisational politics, and poor communication and knowledge sharing. The more productive network had successfully built on relationships created before the MCN was set up. This network was steered by a small group of highly motivated individuals. The researchers hypothesised that this shared sense of purpose and drive played a significant role in the network's success. The study highlights the value of attention to fostering the leadership skills of clinicians.

Why diabetes managed clinical networks?

The Foundation decided to make diabetes MCNs the focus of its first Shared Leadership for Change Initiative following consultations with stakeholders. Diabetes is an area of priority need given the growth in the number of reported cases. There are long-established clinical networks in existence particularly in Scotland but also, following the National Service Framework (NSF) and

the setting up of the National Diabetes Support Team, in England. Both Scotland and England have developed national networks of MCNs and therefore any improvements attributable to the intervention would have a ready dissemination route. The National Diabetes Support Team and the Scottish Diabetes Group enthusiastically backed the initiative, and the support of Diabetes UK, which has national coverage, was an additional advantage. Furthermore, active monitoring of the NSF, and inclusion in the Quality and Outcomes Framework (QOF), mean that there are established benchmarks of acceptable practice for diabetes care.

It was hypothesised by those responsible for developing the scheme that there were likely to be significant gains for patient care if diabetes clinical networks were able to develop into more effective teams, displaying the characteristics of 'shared leadership'. This was important in the context of NHS reforms (DH 2006a) which require that services traditionally delivered by consultants in secondary care settings shift to be delivered by primary care, particularly by general practitioners (GPs) and their staff. It was anticipated that these networks of diabetes specialists were crucial in enabling less specialist staff to deliver good-quality services. In particular, it was hypothesised that their role as educators and repositories of specialist expertise would need to develop, in other words, they would need to become clinical leaders.

The scheme

The scheme approved by the Health Foundation Board was described as follows:

The initiative aimed to test an approach to organisational and team development which involves providing high-quality leadership development to teams engaged in a variety of projects designed to improve the quality of health and healthcare. Specifically, we set out to test the hypothesis that context-specific leadership development focused on teams furthers the Foundation's objective to improve health and the quality of healthcare for the people of the United Kingdom. (The Health Foundation 2004)

The intervention was characterised by:

- being aimed at whole teams rather than individuals or team leaders
- seeking to distribute leadership capacity to clinical leads and at middle management levels
- being tailored to the context in which the teams are working delivered primarily on site.

For the purpose of this scheme a team embodying shared leadership was defined as one which displayed the following characteristics:

- team members have a shared vision
- there is a strategy and plans for implementation are in place
- team members are jointly accountable for progress
- team processes are fit for purpose
- there is a recognised leader, but responsibility for outcomes is shared
- teams are not dependent on one or two key individuals
- teams have identified key stakeholders and means by which they keep in touch.

The scheme was intended to assist teams to develop these characteristics. The delivery of leadership development to the whole team, tailored to the local context, was the scheme's unique aspect.

The Health Foundation's vision: what would success look like

If the Shared Leadership for Change scheme was to be demonstrably successful, the Foundation expected that its outcomes would be:

- sustainable improvement in the quality of diabetes care
- high-performing teams which maintain their performance beyond the duration of the award
- a policy commitment at the highest levels to systematically invest in team development when initiating major changes designed to deliver improvements in quality
- effective dissemination via an end of award conference and publications in the weekly health press and in refereed journals.

The Foundation described the real prize for such an investment as an evidence-based demonstration that support for high-performing teams, and their clinical leaders, is a necessary prerequisite if the increasingly complex web of agencies working in the healthcare arena is to deliver. Recognition of this prerequisite would lead to the adoption of such strategies within the wider NHS.

Leadership development and the leadership development consultants

The main focus of the scheme was provision of leadership development for selected teams over a period of 18 months. Each team was assigned an individual leadership development consultant (LDC) to work with them to develop and improve their team working and personal skills.

The LDCs were experienced independent practitioners who specialised in leadership development. They were selected to deliver this scheme through a formal process of written application, shortlist and interview. Expertise in healthcare and knowledge of diabetes were not essential prerequisites for selection. A comprehensive programme of staff development and quality assurance was introduced to support consistency and quality of delivery. The LDCs met four times a year for development days run by the Foundation. These aimed to ensure that consultants were supported to develop a common approach, had a full understanding of the Foundation's intentions in running the scheme, and could bring challenges and difficulties to an expert group for assistance. Quality assurance comprised a review of the quality of their written reports and of their contributions to the development days, and any feedback from participants or the evaluation team.

Each LDC was commissioned to work with the team assigned to them, establish what was needed in terms of development activity and to set up bespoke plans with their own teams. Quarterly written progress reports were created using a template.

It was an inherent principle that LDCs needed to tailor their interventions to the needs of each team. Indeed this was a key benefit of the scheme, in contrast to adopting a 'sheep dip' approach, which failed to take into account the widely differing contexts in which teams work in the NHS. Each LDC negotiated a timetable to minimise additional demands on the teams. The task for the Foundation was to ensure that there was an appropriate balance between flexibility and responsiveness to each context in addition to a common, rigorously quality assured approach.

The role of the leadership development consultant

The role of the leadership development consultant (LDC) is to work with clinical teams to ensure that the following characteristics of effective teams are in place and sustainable. That:

- there is a recognised leader who, though accepting leadership, can move around the team according to need and expertise
- the leader is prepared to direct, where appropriate
- a shared vision is developed through the process of agreeing success criteria
- team members are motivated
- positive behaviour is rewarded and action is taken to deal with inappropriate behaviour
- there is clarity of purpose, details of execution
- the teams are accountable for delivering agreed goals
- there are clear reporting lines to senior team
- concerns are voiced and listened to and, where appropriate, passed up to the senior team
- team members are valued, their development is taken seriously
- accountability to patients is developed
- ways of measuring improvements are in place
- the leader is replaceable – this is not a person-dependent system.

The LDC is not a permanent addition to the team – they will need to work to ensure any changes are sustainable after the assignment ends.

LDCs will be expected to agree success criteria with each team to which they are assigned. These criteria will need to be approved by the senior executive team in each locality and should, in time, be shared with, and modified by, patients.

Shared learning events

In addition to the work with individual LDCs, the Foundation provided three large conference-type shared learning events planned and organised by the Foundation's Developing Leaders Team, and supported by LDCs. The events enabled teams to come together, share experiences and attend masterclasses. One of these events took place at the beginning of the scheme, the second after 11 months, and the third at the end.

The award holders

Selection

The six teams to participate in the Shared Leadership for Change (Diabetes) Scheme were selected through written application in response to a nationwide marketing initiative. In total, 27 applications were received of which 10 were selected by an internal team for a site visit during the summer of 2005. The Foundation's principle of selecting teams assessed to be relatively high performing – either 'the best' or 'those with the potential to be the best' – was applied. At the site visits the teams were assessed by panels comprising of the Foundation's staff, who were responsible for designing the scheme, plus at least one expert in diabetes service development. Teams were assessed as high, medium or low against the following criteria:

- the team and quality of leadership
- vision (what will success look like?)
- patient involvement
- strategies and partnerships
- openness and transparency
- organisational support, sustainability and believability.

The Health Foundation made the final decisions on the basis of written site visit assessments. Given the Foundation's commitment to selecting those with the potential to be the best, some flexibility was applied in selecting the six sites. A range of differing size sites was sought with a commitment to inclusion of areas with particular challenges, for example ethnic diversity.

The successful award holders at the outset

Six teams were selected. Two of these, the teams from Scotland and Wales, were established diabetes MCNs and part of the formal structure of services in their respective regions. These were:

- the Lothian Diabetes Network
- the Carmarthenshire Diabetes Network.

The English teams varied widely. Not all were formally constituted as MCNs.

- The Newham Diabetes Team was a mixture of health professionals from Newham University Hospitals NHS Trust (NUHT) and Newham Primary Care Trust (NPCT).
- The Southport Team, was part of the Southport, Formby and West Lancashire Diabetes Clinical Network.
- The North Bradford Team was based at the North Bradford Satellite Centre, an intermediate service of a type not found in many areas.
- The East Berkshire Team was a loosely configured network covering three primary care trusts (PCTs) – Windsor and Maidenhead, Bracknell, and Slough – soon to be merged into one, East Berkshire PCT.

Two teams were hospital based, with representation from community-based GPs with a special interest in diabetes – Lothian and Carmarthenshire. Three teams – Newham, Southport and East Berkshire – had representation from acute and primary care, and were based in community sites. The North Bradford Team was comprised primarily of the team working at the satellite centre, with one PCT member.

Formal leadership was invariably with doctors, in four cases (Lothian, Carmarthenshire, East Berkshire and Newham) consultant diabetologists, and in the other two sites GPs were the leaders of the site visit teams.

All teams included a range of health professionals consisting of dietitians, podiatrists, diabetes specialist nurses (DSNs), and community-based doctors. Lothian and Southport included commissioners at the outset and had dedicated time from a network manager who was a team member.

The other represented roles included two patient representatives, and one each of health promotion officer, administrator/secretary, and assistant director of nursing.

Teams or loose networks?

The scheme was intended to improve team functioning. The teams which were successful in gaining a place on the scheme varied, from clinical networks well established as part of the governance structure of the local health economy covering wide geographical areas (such as the Lothian team) to teams which had very local remits (for example North Bradford and Southport). It is debatable whether any of the successful applicants were functioning teams at the outset, using the characteristics listed on page 6. In all instances, the individuals in the teams were familiar with each other at the time of application, and had all worked together in some context, usually shared clinics, or meetings of a local diabetes network or local

implementation team (LIT). Five of the six had an identified individual clinical leader. Most had a written strategy. At the site visits they had demonstrated a capacity to work together on a challenging task in a limited time. They were not, however, established teams in the sense of working together as one on a daily basis or having a strong sense of team identity.

Section 2

The evaluation of the shared leadership scheme (Burgoyne and Williams)

Introduction

The Health Foundation commissioned an independent external evaluation of the scheme to test its hypothesis that provision of skilled support to develop teams with the characteristics of shared leadership would improve the quality of healthcare.

A 'critical realist' (Pawson 1997) and a 'utilization focused' (Patton 1997) approach to evaluation was adopted. The 'critical realist' approach offers a synthesis between the positivist approach to research manifest, for example, in the clinical trials model of medical research, and at the other extreme of social constructionisms, research as qualitative storytelling. The former assumes the world is a predictable machine, the rules of which can be discovered by experimentation, the latter that the world is an evolving cultural pattern of meaning that can only be captured as stories and pictures at points in time. The critical realist approach regards the world as an open system with emergent properties – for which there is arguably evidence: that there are 'event regularities', which undermine the extreme social constructionist position, but at the same time organisational phenomena, at least, remain stubbornly resistant to being described as regular and predictable machines.

As phenomena progress from the domains of the physical through the zoological and biological to the psychological, social and anthropological sciences, what 'works' progresses from the positivist to the constructionist.

Organisational phenomena are not at any one point on this scale but involve elements from across the full spectrum.

For evaluation this means that change attempts may (or may not) trigger mechanisms that lead to outcomes (desired or otherwise) but this depends very much on context – which include other mechanisms at work. This is why the evaluation mixes the qualitative and the quantitative, and looks inside the black box to observe processes but also outside to see relations between inputs and outputs.

The utilisation-focused element to the evaluation means taking the view that evaluation is for a purpose, and one should clarify that purpose and design the evaluation to deliver against it.

It also involves recognising the need to balance formative and summative evaluation – the need to improve and prove (Easterby-Smith 1994) the value of the initiative being evaluated, and that timing is important – evaluation results need to be available in time to inform decisions that have to be made at certain points in a process. In taking this approach it is necessary that the sense of purpose and how it is to be achieved may change over the life of a project and its evaluation, for many reasons, including the effect of the formative evaluation itself. The purpose and output of the evaluation therefore has to be regularly re-negotiated and re-planned, as has been the case in this project.

Methodology of the evaluation

The evaluation comprised of the following elements:

- interviews with award teams
- interviews with patients
- interviews with LDCs
- questionnaire surveys of award teams
- analysis of QOF data
- review of LDC quarterly reports and other documentation
- ongoing feedback to the Foundation and to LDCs.

Comparator teams, teams which as far as possible matched the award holding teams in terms of composition, focus and geographical scope, were located for five of the six teams. These teams were surveyed using the questionnaire developed for the participating teams at the beginning and end of the scheme period. This was an attempt to provide comparisons between teams involved in the scheme and those which did not experience support for team development.

Questionnaire surveys

A survey of all team members was undertaken early in 2006 and was repeated at the end of the scheme in July 2007. A similar survey was undertaken of comparator teams.

There were two exceptions to this. One team felt that the way they worked and the local policies and procedures in their region were not duplicated elsewhere and that there were no similar teams in the area of diabetes care. For this team, a comparator from a different medical specialty was selected which was in the same local area and was similar in team and organisational development. It proved too difficult to find a suitable comparator for a second team because of the nature of their group and the strategic level at which they were working. No comparator survey was therefore undertaken for this team.

Comparators were chosen in conjunction with the award teams, who selected as comparators teams which they knew to be similar to their own on the key dimensions. All the comparators for the survey were drawn from the same general localities as the award teams in order to ensure that they were subject to similar policies and conditions. The data from the first survey showed that the comparator teams were very similar to the award teams in terms of key indices (for example employing organisation, current role, gender and ethnicity). The comparison can therefore be regarded as likely to be reliable overall.

As the numbers in each team were often small, no reliable data comparison of change over time could be made at the level of the individual team. For example, in a team where five people responded, one person changing their response can make a difference in percentage

terms of 20 per cent. This can skew the comparisons in favour of teams with small numbers of respondents. For the analysis the data have therefore been aggregated and the award teams and comparator teams are each treated as a single group. This has enabled meaningful and valid data analyses to be made.

Interviews with patients

A small number of interviews with patients were undertaken. It was not anticipated by the award teams that the award would have any direct impact on patient care during its lifetime, although they felt that in the long run a more effective team was bound to impact positively. It was not expected therefore that any immediately attributable effects of the award would be identified through patient feedback. However, it was hoped that interviews with patients might provide some illustrative material which would be relevant to the improved team working of the award teams and it was therefore felt to be worthwhile to include a collection of primary data from patients in the evaluation.

Analysis of Quality and Outcomes Framework data

Department of Health (DH) Quality and Outcomes Framework (QOF) data for diabetes care (Scottish Executive data in Scotland) have been nationally available since 2005. This has meant that progress on these standardised indices could be analysed for some of the award and comparator teams over the period of the award. Although these are large populations and any effects from the award scheme are likely to be 'swamped' by other fluctuations in the data, these are the only standardised statistics currently available and therefore were thought to be worthy of examination to see if any discernible differences did emerge.

It was not considered likely by any of the teams that any effects of the award scheme would show up in the QOF data. Just as a rising tide lifts all boats, it is known that QOF and Scottish Executive statistics for diabetes are improving everywhere and it would be very difficult to identify any changes that might be due to the award scheme. Teams also felt, as with the patient interview data, that immediate impact on individual patient health was not to be expected from this kind of leadership development work. Rather, becoming more effective as a team would have long-term and generalised effects, not necessarily visible in national or local statistics. Nevertheless, it was considered by the evaluation team and the Health Foundation that it was worth examining the QOF data to see if any relationship did appear between the figures and having had an award.

Where possible the comparator teams used for this assessment were the same as those used for the team development survey. This was the case for two teams. For a third team, it was felt that the comparator used for the survey was not sufficiently similar demographically for the comparison to be a valid one and so a different comparator was chosen for the QOF data.

For three teams, comparative QOF data were not available. With the Scottish team, the Scottish Executive data were not produced in time for this report and therefore could not be included. This team therefore had to be left out of the analysis. For two other teams, the activities undertaken during the award meant that there was no real likelihood that changes would appear in the QOF data. No QOF data have therefore been reported for these teams.

Section 3

The findings (Burgoyne and Williams)

This section summarises the evaluation findings. It is illustrated with quotations from the interviews, to give a flavour of interviewees' responses to the scheme, and some statistical information drawn from the evaluation. Further details, including statistical analysis of significance, and additional quotations can be found in Part 2 of this report.

Benefits attributable to the scheme

The award scheme provided a range of benefits. All teams reported improvements in shared leadership.

- Increased levels of activity and achievement particularly in developing, agreeing and implementing strategy:

At the back of your mind you think I ought to do this [but don't do it], but when you know you are part of a team it catalyses you to actually make changes. And the trust sits up and listens because we can say we are an award winning team. *Manager*

- Improved clinical leadership: the majority of teams reported that the team leader was more effective, and that this impacted positively on the team:

We used to be in silos. Not a lot got done. No one took ownership of progressing things. Now we are getting things done, there is delegation, we have responsibilities within the team. People come to meetings now expecting a set agenda with specific projects. Before we used to discuss things but no one did anything. *Podiatrist*

The consultant used to be standoff-ish. Now I can use his name when dealing with departments. These might seem small achievements, but they are big achievements for the team. *Manager*

- Some improvements in using the collective influence of the team to drive change:

We've gained confidence, good team working, supporting one another. In that way we can drive forward changes that will benefit patients. There's strength in numbers – we have a lot more clout. We now work as a team, not just as an individual voicing an opinion. *Dietician*

- A greater sense of team cohesiveness: team members reported that team meetings were more effective, conflict could be aired and resolved, and individuals could take on leadership roles for particular elements of service development:

It has brought the team together. We used to work separately – [we had] different agendas... It's changed the way we work. We now have a can-do mentality. *Manager*

- Some indications that teams were more sustainable because of reduced reliance on one individual, indicating that a key element of the original hypothesis was proven:

It's better than individual fellowships – most gifted leaders will do it anyway. Here you are creating a system that will work even if individuals change. It's more directly relevant to what we do – it's more cost effective than individual work. *GP*

- Broad agreement on the value of having a team leader: shared leadership emphatically did not mean that the team operated by consensus alone:

There has been no development of shared leadership. [Name] is still the leader... making decisions by committee doesn't work. You have to have someone who is ultimately responsible. But we have each developed as individual leaders. *Manager*

- Four teams reported that the intervention had resulted in improvements in cross-boundary working. One team in particular emphasised the value of the award in forging a powerful alliance between primary and secondary care which created an effective lobby group for local investment:

We maintained dialogue across primary and secondary care during a very difficult time.

- Improvements in individual leadership skills for some team members: one-to-one coaching provided alongside team development enhanced the value of the award as team members reported increased confidence and understanding of the importance of political astuteness, networking, and influencing:

I have become more pro-active [in the patient representatives group], more able to participate, to chair, and to be a member of other committees in the NHS. *Patient representative*

- A cascade effect through individual participants using their newly acquired skills in other contexts, in particular through influencing professional networks:

I've used this now in other groups, how I chair meetings. *Consultant*

- Increased status within the local health community, credibility to be listened to by senior management: teams became more adept at recognising the importance of devoting time to identifying and influencing key stakeholders who could help or hinder their cause:

This has changed how we tackle the merger... We know now where we need to influence and also that we can do things better. Now I'll say we could do this, plan what we want to achieve. I wouldn't have said anything before. *Dietician*

- Able to sustain performance at a time of turbulence in the healthcare system (English teams only – Scotland and Wales were subject to less external change in the NHS and did not report this as a benefit):

It gave us confidence in facing the merger [of PCTs]. *Consultant*

Service improvement

Attribution of service improvement to the scheme is complex. The evaluation indicates that the teams became more effective and cohesive; some developed strategies which helped them to generate credibility with senior management and with clinical colleagues; and some individuals within the teams took responsibility for distinct areas for improvement. However, the evidence that the intervention directly led to service improvements within the evaluation period is inconclusive.

The main areas of achievement in which progress was at least partly attributable to the award included:

- agreeing strategy documents
- developing new or improved patient care pathways
- improving systems for tracking and monitoring patients
- following up patients who miss appointments
- influencing board strategy for diabetes care
- more staff taking part in the Warwick Medical School Certificate in Diabetes Care
- outreach events and roadshows
- new or better patient information leaflets
- a patient satisfaction survey
- creating new clinics for different patient groups and/or in different areas
- reorganising service to ensure more patients had access to a dietician or podiatrist
- setting up a screening project with local employers
- establishing a patient education project in local community pharmacies
- moving routine care from secondary to primary care and consequently reducing the waiting list times
- improving the use of agendas and action points at meetings
- increasing the focus to discussions with more emphasis on getting things done
- achieving agreement between primary and secondary care on how diabetes services should be developed
- team cohesion in times of external change
- managing the transition to a merged primary care trust (PCT).

The two teams which had scored highest in the attributes of shared leadership at the initial site visits were able to extend their repertoire through developing education and support for non-specialist healthcare teams and extending influence. In these two instances, participation in the scheme was reported to have speeded up achievements which would have happened anyway. A typical comment was:

The award was not totally responsible but has been a factor in our achieving it. These projects were being planned anyway, but have happened more quickly with the award. We might have done them anyway. *Consultant*

Two teams experienced such a high degree of contextual upheaval that they made little significant improvement to services during the award period. However, it was broadly acknowledged that the LDC had assisted in maintaining morale at a very difficult period in the NHS, 'providing a lifeline' as one team described it.

Two teams, which had started at a relatively unsophisticated level, made considerable progress in developing the basics of team working, and by the end of the award were judged to be high-functioning teams. Of these, one has continued to build on the foundations with ambitious service improvement; the other was disbanded as a consequence of PCT reorganisation.

Informal follow-up with two teams in October 2008 indicated that service improvement has been sustained, and that the team leaders are willing to acknowledge the important role shared leadership played, suggesting that the timescale for evaluation will need to be extended if longer-term benefits are to be demonstrated conclusively.

Patient-level outcomes

There was no quantifiable improvement in patient-level outcomes. If any were to accrue, participants expected this would take longer than 18 months. There was, however,

considerable doubt as to whether any patient-level outcomes were likely to be identifiable as a direct result of this kind of development activity. Patient interviews indicated that satisfaction levels with the standard of care over the period of the award were unchanged. This can be viewed positively given the challenging external environment prevailing for the English teams.

Comparator group

The evaluation included comparator sites. Comparisons between award teams and comparator groups support the finding that the award teams developed as more effective teams as a result of the scheme. There were significant differences between the comparator and award teams on about half of the indices of teamwork development and self-reported improvements in skills and abilities. This suggests that the scheme did have real results in terms of assisting the teams to improve their teamwork and develop more effective ways of interacting during the period of the scheme delivery.

Challenges in delivering leadership development to teams

As noted, most leadership development is focused on individuals. The Health Foundation entered this field with the intention of contributing to a relatively weak evidence base of previous interventions aimed at improving team leadership. It was an important finding that team leadership development presents major logistical challenges.

Identification of who were members of the core team stretched three teams. It was an important step to ensure that the boundaries of the teams were clear, one that several teams had avoided in the past but that participation in the scheme made essential.

Changes in team personnel made significant demands on leadership development consultants (LDCs). At one extreme, the entire membership of the East Berkshire team changed during the 18 months of the award, meaning that much of the LDC's time was used to assist in identifying how to build a new team, rather than making an existing high-performing team more effective. On the other hand, changes in team membership presented opportunities, for example to offer a vacant place on the team to an individual representing an important interest group, such as PCT commissioners.

External factors did mitigate the effects of the scheme. One team, Southport and Formby, ceased to exist as an entity after PCT reorganisation (this occurred after the scheme formally ended). The timescale and scope of the evaluation, however, did not permit investigation of any residual value through individuals' translation of learning from the scheme into the new diabetes network.

The Foundation did not provide backfill costs for clinicians to take part in the scheme. The overwhelming majority of participants reported that the additional costs to the service were a worthwhile investment. However, the opportunity costs were seen by a small number of individuals to outweigh the benefits.

Achieving a balance between team-based and one-to-one coaching was left to individual LDCs to negotiate. Finding times and places to meet which minimised disruption to members' clinical schedules was important, and underlines the value of the flexible support to teams which was the hallmark of this scheme.

Factors contributing to success

The key aspects of the award which were reported to be effective were:

- the scheme was flexible allowing teams to use the resources of the LDC's time and skill to suit their context
- the award forced teams to identify core and peripheral membership
- participation in the scheme prompted teams to find time for meetings to develop strategy or service improvement
- teams learned how to run effective meetings, and to embed accountability for follow-up into routine team processes
- the scheme provided individual personal development, which for some individuals led to increased confidence and a greater understanding of self and others.

The quality of individual LDCs was not explicitly evaluated and did not emerge as a factor in the evaluation results. Their major added value was in helping teams to focus upon developing targeted actions and achievable outcomes. LDCs used a variety of personal development tools in their work with the teams, alongside one-to-one coaching with team members. The data did not indicate any discernible relationship between the tools used and the outcomes.

The best was the interventions at meetings. It wasn't the personality inventories – I've done all that before. It was at the meetings – [the LDC] was very skilled at pointing out deficiencies in a pleasant way and rapping our knuckles. It had a profound effect on our decision making. Without that, we would have been stuck. *GP*

The most useful aspect of the three shared learning events was reported as sharing experiences with the other teams; participants would have appreciated more structured opportunities to learn across teams.

Factors which were important in enabling teams to make use of the scheme were:

- Stability of team membership – rapid turnover of team members had a deleterious impact. In particular, in the absence of succession planning, loss of the team leader stalled progress.
- Agreement on who needed to be in the core team which was the focus of the intervention.
- Willingness of the team leader to embrace the theory of change underlying the intervention, and to learn from it.
- Commitment of time and energy from individual team members.
- Sufficient stability in the external context to progress interventions. The Welsh and Scottish teams enjoyed the advantage of a stable environment, while PCT restructuring in England hampered progress for all four teams.

Section 4

The award and its impact on each team (Walmsley)

This section provides an account of the scheme through the story of each team's journey. It draws on data collected through the selection process, quarterly reports from the leadership development consultants (LDCs), and the end of award report to the Health Foundation, as well as evaluation data.

Each story is constructed as follows:

- details of the team and its composition (including changes in team composition during the period of the award)
- assessment of strengths and weaknesses at the Foundation's site visit in July 2005
- the local context
- the nature of the intervention
- development of leadership
- improvements in diabetic care during the period of the award.

North Bradford

The team and its composition

The North Bradford team was one of 14 intermediate care services in Bradford providing diabetes care, led by a general practitioner (GP) with a special interest (GPwSI) in diabetes. It was based around a GP surgery serving a suburban community. The surgery, as well as offering all the usual services of a GP practice, acted as a specialised diabetes care unit and therefore also served a large number of patients who received their general medical care from other GPs.

Its achievements were recognised locally, and the GP/leader had a national reputation. Its patients reported high levels of satisfaction (as measured by patient surveys carried out by the practice). It comprised:

Organisation	Role in team
North Bradford PCT	GPwSI team leader
North Bradford PCT	Diabetes practice nurse
Bradford City PCT	Diabetes specialist nurse
Bradford City PCT	Diabetes podiatrist
Bradford Acute Hospitals Trust	Diabetes dietician
North Bradford PCT	Patient services manager
North Bradford PCT	PCT long-term conditions lead

Four team members were based in the practice: the GP, the practice nurse, the practice manager and the administrator. All had other duties and diabetes was only part of their role. The manager from the local primary care trust (PCT) was based at the PCT central office and also had additional duties other than diabetes.

The other members of the team were the diabetes specialist podiatrist, the diabetes specialist dietician and the diabetes specialist nurse (DSN). These practitioners worked solely in the field of diabetes and it was the main focus of their work. They served other specialist GP practices in the area and the dietician and podiatrist also worked at the hospital diabetes unit. Soon after the beginning of the scheme, the LDC recommended the inclusion of the appointments secretary in team meetings and this was agreed.

Assessment of strengths and weaknesses at site visit

Strengths:

- Multidisciplinary, long-established and confident team with clear leadership but not overly dominant.
- Aware of weaknesses and open to new ways of addressing them.
- Real patients who do not want to move house and risk losing the care they receive.
- A national demonstration site in self-care.
- Use of patients to critique information they distribute.

Although the PCT merger was imminent, there was a strong PCT view that this team would be protected from change because it was a leader/exemplar. 'PCT reorganisation in Bradford is not to be feared' said the PCT representative at the site visit.

Challenges:

- Communicating vision and strengths coherently.
- Possible over reliance on one clinical lead and poor links with secondary care.
- May operate on too limited a canvas to be influential.
- No team members from the South Asian community which may limit capacity for effective communication with local ethnically diverse population.
- Coping with NHS instability.
- Organic growth may mean limited infrastructure for spread. No formal governance in place to facilitate.

Team development priorities:

- Some formal work on teams and how they operate.
- Communication with others outside the immediate environment.
- Development of links with other parts of the service in Bradford to facilitate spread of good practice.
- Pro-actively address the needs of an ethnically diverse population.

Local context

North Bradford is an ethnically mixed area with high levels of deprivation. Bradford's diabetes services were unusual, being organised around intermediate 'satellite' clinics which provided specialist diabetes care, rather than the usual GP and acute care model.

The four PCTs were merging into one during the award. Despite reassurances at the site visit, this reorganisation provided a difficult backdrop for the team, particularly its ability to spread its approach to other local intermediate services.

The nature of the intervention

The intervention comprised setting, reviewing and re-measuring success criteria at team meetings, and one-to-one work with individuals. The value of setting aside meeting time was recognised to be a valuable aspect in itself. The LDC helped the team locate a PCT representative as a team member, to enhance its local profile.

There was reported to have been a struggle for individuals to create enough time between clinical commitments to attend all the sessions. Many of the clinicians belonged to larger PCT teams (podiatry, dieticians, DSNs), with commitments to many different primary care practices, and were on demanding rotas.

The intervention was compromised initially by a misunderstanding as to the nature of the award. The team had anticipated that part of the award would be cash through which they could fund data collection and analysis. The LDC asked if some of their time could be translated into cash to be used for this. The Foundation refused this request. In the latter stages of the award period, the focus shifted to finding ways to influence diabetes care in the chaos following the PCT merger.

Development of leadership

Members of the team noticeably took on leadership of certain areas of work – such as the appointments secretary whose authority on patient access systems, how patients experience those systems and some of the system's flaws, was recognised to be critical to the success of the clinic. Another member of the team took on the role of challenging 'overambitious talk' which was unlikely to be followed through and encouraged a focus on what can realistically be achieved. A third was of the opinion that communication within the team had improved. This view was not held by all respondents.

For one team member, a clinician with very little development time, the time committed to the award had been to the detriment of the possible contribution made to projects affecting the larger service.

The LDC intervention helped the team secure the services of a postgraduate student to undertake data collection and analysis on a voluntary basis. This highlighted that:

- data were not always consistently collected
- data were medical and not necessarily the data needed for analysis of efficiency or effectiveness
- some indication that the service was inefficient, for example some patients remained on its books indefinitely, because there was no protocol in place for referring back to GPs, something patients would anyway have resisted.

It was reported that the data collected through this exercise strengthened the case for the PCT to dedicate effort to auditing aspects of the satellite service. The practice audit (which took place towards the end of the scheme's life) revealed that neither in clinical effectiveness nor funding terms was it a sustainable service.

Improvements in diabetic care during the period of the award

Some localised improvements were reported, such as reorganising the appointments system after asking patients' views; this had reduced the number of 'do not attends' because patients were able to request suitable times. It was recognised that patients did not need to see the GP each visit, and this had reduced waiting times.

Participation in the scheme prompted questioning of the way the team worked: its lack of hard outcome data, its inability to influence the bigger picture, even doubts about the viability of the Bradford satellite system. However, influencing this situation was difficult due to absence of a PCT chief executive, redundancy of the PCT representative on the team, and lack of interest among other local GPs and hospital-based consultants.

Outcomes were compromised by reorganisation which inhibited any influence beyond the team's immediate environment. The nature of the service in Bradford also made it difficult to spread any achievements. It seldom met as a team, it was fragmented and, as one member noted, the team lacked the potential of others participating in the award to spread good practice. Another member felt that the limited impact was inevitable because this team operated in a satellite service that it could not influence because there was no shared leadership of the larger service – seen as no leadership of any kind – and without that it would always be difficult 'to make a difference to an unstructured service with no shared sense of what it is doing or where it is going'.

From the perspective of future schemes, this indicates that a selection criterion should be, 'Is there a functioning larger service of which this team is an active part?'.

The conclusion for the Health Foundation is that selection criteria should include potential for local sharing of good practice.

Lothian

The team and its composition

At the start of the award, the team comprised core members of the Lothian diabetes MCN, accountable to the Service Redesign Committee of Lothian Health Board. It was led by a consultant diabetologist, the lead clinician for diabetes in Lothian University Hospitals Division.

The team roles and organisational affiliations were:

Organisation	Role in team
Lothian University Hospitals Division	Lead clinician
Lothian Primary and Community Division (LPCD)	Lead GP for diabetes
West Lothian Healthcare Division	Lead GP for diabetes
Lothian Diabetes Representative Group	Patient representative
Lothian Health Board	Healthcare planner
Lothian Health Board	Public health consultant
LPCD	MCN manager

Other team members included a finance accountant, the team's executive assistant and, for a short time, the clinical lead for retinal screening.

The award team was a subgroup of the larger Lothian Diabetes Service Advisory Group (LDSAG) of 25–30 members. This had been in existence for some time and had achieved a great deal but now tended to be more of a 'talking shop' with little to show in terms of concrete achievement. This team applied for the award and used the opportunity to constitute themselves as an executive group within the LDSAG. They hoped that through working with all members of the network they would be able to influence and improve diabetes care throughout the region.

Assessment of strengths and weaknesses at site visit

The assessment was that this was a well-established team with robust leadership from the lead clinician, and effective infrastructure provided by the MCN manager. It demonstrated exceptionally clear governance structures. There was active patient involvement in the core team. It had numerous achievements to its name and a strong reputation. The team used well-developed underpinning information technology (IT) systems. It enjoyed overt and stable support from Lothian Health Board.

Challenges were identified by the site visit team as:

- too dominated by tertiary services
- a need to improve standards in primary care across the board
- cost and resource pressures on hospital services.

At the time of the site visit the team's priorities were:

- encouraging diabetes care to be delivered in primary care across a very large population and geography
- ensuring good-quality care wherever it is delivered
- improving patient engagement
- improving the effectiveness of existing structures to deliver these priorities.

Local context

Lothian is the second largest health board area in Scotland with a population of 784,840. Parts of the area are rural and others urban, including some very deprived areas. There had been a series of organisational changes, including a move from competing trusts to single system working and the formation of initially five and then four community health (and care) partnerships.

Unlike the English teams, this team enjoyed a more stable contextual environment. There were, nevertheless, some tensions arising from the need to shift services from secondary to primary care, and frequent organisational changes. Team leadership and membership remained relatively stable, including the participation of a network manager and a patient representative for the duration of the award period.

The team members commented that participation had cost more than the expenses allocated by the Foundation because money had to be found to cover clinical sessions while clinicians participated in team development events. This was, however, reported to have had sufficient benefits to be worthwhile.

The nature of the intervention

The intervention focused on:

- development and regular re-measurement of agreed success criteria: having a common cause, working with patients, leading the way, influencing and political astuteness, maintaining rigour, working collaboratively, working effectively in meetings
- an accountability framework to ensure that there was assigned responsibility for follow-up actions
- 360 degree appraisals to enable team members and other colleagues to comment anonymously on the performance of other team members
- one-to-one coaching sessions with individual team members, using data from the 360 degree appraisal process.

The LDC was explicitly praised for tailoring their interventions to suit the team's needs.

Development of leadership

The team self-assessed as having improved significantly on all seven success criteria. Improvement was reported to have been sustained 18 months after the award ended, in November 2008.

The team members reported that they were able to appreciate the 'traditional behaviour patterns' which had evolved, and to find ways of making their meetings more focused, purposeful and time efficient. In particular, they were able to use their meetings to resolve some long-standing uncertainties over the patient pathway. One team member commented: 'It certainly helped us get over the rubbish that used to take up our time and concentrate on the things that are more likely to make a difference to our priorities'.

Because team members are active in a number of contexts, it was anticipated that the benefits of an increase in individual leadership skills would positively impact other parts of the Lothian Health Board. For example, the patient representative was able to transfer his learning from the scheme to leadership of the Lothian-wide Diabetes Representative Group, and the lead clinician and MCN manager were able to implement some of the skills in their national roles.

As a follow-up to the third learning workshop, this team met with the Carmarthenshire team and two Health Foundation Leadership Fellows to explore change management techniques and to share specific experiences, such as Lothian's information system. It was not formally assessed as part of the scheme.

Improvements in diabetic care during the period of the award

The team reported some significant service improvements during the period of the award:

- revising and documenting the patient pathway to define the optimal point of care for patients, and to identify referral procedures for specialist advice, communicated by members of the team to a representative section of the diabetes community at the local professional diabetes conference
- implementing the national eye screening service to provide a centralised appointment system, with improved quality of information to patients
- improved understanding of patient perspectives, a small but perceptible shift in patient centredness
- a greater willingness of patients to become involved, attributed to the influence of the patient representative.

As with other teams, these changes cannot be attributed to the award. However, this team indicated that the scheme had accelerated improvements that were already planned, such as clear articulation of the patient pathway. They also reported that improvements in team members' individual leadership skills were scheme specific, and that this was likely to result in wider enhancement across the Lothian healthcare system.

Southport

The team and its composition

The team was based in a PCT. It was a subgroup of a larger diabetes network which had around 14–15 members. The team was led by a local GP at the site visit and later by the consultant diabetologist from the local hospital. Other members were a manager from the PCT, a DSN, a podiatrist, a dietician, a patient representative, a health improvement officer and a GP. Only the consultant and the DSN worked full time on diabetes care. For the other team members, diabetes was only a small part of their job.

Organisation	Role in team
Southport and Formby PCT	General practice clinical lead
Southport and Ormskirk NHS Trust	Consultant diabetologist
Southport and Formby PCT	Health improvement
Southport and Formby PCT	Director of clinical services, management overview of diabetes services across the whole health community
Patient	Patient representative
Southport and Formby PCT	Practice nurse – general practice
Southport and Ormskirk NHS Trust	Diabetes dietician
Southport and Formby PCT	Project manager for coronary heart disease (CHD) and diabetes for Southport and Formby PCT, and South Sefton PCT; network manager for Southport and Formby, and West Lancashire Diabetic Network

Assessment of strengths and weaknesses at site visit

At the site visit the team was led by a GP. The team was described as multidisciplinary and not medically dominated.

Strengths were:

- a very positive integration of public health and links with local health improvement initiatives
- outreach work in the community, for example 'supermarket dashes' to promote healthy eating, proactive work with care homes
- strong links with the 19 local GPs through the GP clinical lead
- patient centred with a well-established Expert Patients Programme and an influential patient team member
- knowing own weaknesses.

The team's challenges were identified as:

- a need to identify who is in the core team
- some doubt over secondary care commitment
- organisational commitment not in evidence, no formal links with trust boards
- a need to develop strategic thinking and application
- a financially challenged PCT.

Team development priorities were identified as to:

- agree on membership of core team
- work on the strategy developed at recent stakeholder event, and create and implement a non-bureaucratic action plan
- build firm links with board(s) and neighbouring PCTs/clinical teams.

Local context

Southport and Formby is a seaside area with a higher than average proportion of residents over 65, many of whom live in nursing or residential homes or are housebound. Although generally affluent, there are pockets of high deprivation particularly in areas with a high migrant population.

At the time of the award, Southport and Formby comprised one PCT. However, PCT reorganisation dominated the period of the award. Sefton PCT was established on 1 October 2006, but it took time for posts to be filled and new arrangements to stabilise – the director of public health in the new Sefton PCT publicly acknowledged in December 2006: 'I recognise that with the uncertainty in the system at present with organisational change, it can seem difficult to make progress'.

The nature of the intervention

The LDC worked with the team and individual members throughout the award. The initial phase focused on 'team basics' of leadership, listening, accountability, clarity of roles and relationships, augmented by one-to-one sessions for some participants using some standard techniques – 360 degree feedback and Myers–Briggs type indicator (MBTI).

Considerable work was done on external communication which intensified as reorganisation of the PCTs began to threaten the very existence of the team.

A change of leadership as the GP stood down stretched the team. The need for a new medical lead was linked to the impending merger of Southport and Formby and Sefton PCTs, and a diabetologist from Sefton was persuaded to join as part of a wider influencing strategy. Influencing and political astuteness were the main focus of the work in the last six months of the award, given the local situation.

Development of leadership

This relatively unsophisticated team benefited both individually and as a collective from the award. The greatest success was from the focus on implementation, ‘quick wins’ as the LDC described it. The team formed around the challenge to transfer annual check-ups from the hospital to GPs, with little support from management and no additional financial outlay. Translation of the team’s aims into definable performance goals and working on the skills needed to meet those goals provided the underlying structure for development of leadership.

The team reported that work with the LDC helped to develop more equal relationships in the team and to ensure that each voice was heard and valued. Consequently, there was closer working between primary and secondary care as well as with other PCTs.

After the award ended the team’s organisational sponsor wrote: ‘Members of the team seem to have had their individual potential “drawn out of them” in the interests of their joint endeavours, in a manner and to an extent which would have been previously inconceivable’.

The changing and unstable local context was a significant factor for this team. The complexities of the long-term challenge of amalgamation, heavy demands on time, and ingrained individualism of some senior people derailed the team on occasion. Indeed, they were expected by others to act as individuals, for example no time was allowed by the PCT’s senior leaders for a team response to requests for information. The LDC was acknowledged to have assisted the team to manage the anxiety associated with reorganisation in a positive and constructive way.

Improvements in diabetic care during the period of the award

The team was successful in improving local services, most notably the shift of annual reviews from secondary to primary care using practice-based commissioning, leading to reduced waiting times and costs. They believed that this was at least in part due to their increased effectiveness as a team.

Their work attracted the attention of national organisations and they were:

- approached by the National Diabetes Network for a case study on their 14–16-year-old clinic
- runner-up (out of 197 applications) in the 2006 Annual Guidelines in Practice award for diabetes service for the elderly, housebound and people living in residential homes
- cited in national publications, such as in the National Clinical Director for Diabetes’ *Working together for better diabetes care* (2007) as an example of the successful shift of annual check-ups from acute to primary care; in the DH’s *Diabetes and pharmacy services in England* (2006b) for successful multidisciplinary working with pharmacy; and in *Improving diabetes services: the NSF four years on – the way ahead: the local challenge* (DH 2007).

Ultimately, due to reorganisation, the Southport and Formby team ceased to exist as a formal entity. Some team members remained active in influencing the development of services in the

new Sefton PCT, and were able to sustain some of the improvements developed during the award. The team leader commented in November 2008:

It is very disappointing that the reorganisation of the PCT has led to the dissolution of the team. Attempts by the new PCT to develop a replacement team have been half-hearted and I feel that a great opportunity has been lost. On the positive side, the clinical changes that were made have continued but the impetus for further change has diminished... However those 2 years were a very positive experience for us and I believe many individuals benefited greatly on a personal level.

Carmarthenshire

The team and its composition

The team was based around the local hospital and the team leader was the consultant diabetologist. Four team members were based in the hospital (the consultant, a DSN, the podiatrist and the dietician). The team also included a local GP/associate medical director with an interest in diabetes care, a second DSN based in the community and a health promotion officer from the local health board (LHB) (PCT equivalent). A second GP was invited to join the team part way through the award. The specialist nurses worked full time on diabetes care. For the other team members, diabetes was only a part of what they do, for example the consultant also had duties in general medicine and endocrinology and spends only 50 per cent of the time in diabetes.

Organisation	Role in team
Carmarthenshire NHS Trust	Consultant diabetologist
Carmarthenshire NHS Trust	DSN
Carmarthenshire NHS Trust	Dietician
Carmarthenshire NHS Trust	Podiatrist
National Public Health Service	Health promotion officer
Carmarthenshire LHB	GP/LHB associate medical director
Carmarthenshire LHB	DSN

Local context

Carmarthenshire is a largely rural county of approximately 170,000 people, over half of whom are Welsh speaking. The NHS trust served this county, plus some patients from Ceredigion, during the period of the award. Although the context in Wales was markedly more stable than in England during the period of the award, during 2007 plans to merge the three West Wales trusts of Carmarthenshire, Ceredigion and Pembrokeshire were announced.

Assessment of strengths and weaknesses at site visit

The site visit team's assessment was that this was a well-established group of committed clinicians and others. Leadership was clear. All team members had a role in the presentations to the site visit team which was unusual.

The team was based in a hospital, with appropriate LHB and health promotion representation.

The team's commitment to health promotion and education, of other clinicians and of patients and the public, made it stand out. It had run a number of well-attended community events to

raise awareness of diabetes and its management. Its website, with the dual purpose of providing comprehensive information to people with diabetes about their condition and comprehensive guidelines to local health professionals for the management of all aspects of diabetes care, was evidence of this commitment.

Organisational support was impressive. The chief executive, the medical director and the director of nursing all attended part of the site visit day, and were well informed about the team and the award.

The team's ambitions to influence other areas in Wales to adopt their good practice in diabetes care and to influence other MCNs in long-term conditions, such as heart disease, indicated that the award could support significant spread of good practice.

The nature of the intervention

The intervention focused on development of leadership skills, at a team and an individual level. The LDC's focus was on:

- supporting members of the team on the development and implementation of strategic plans for the team as a whole and individuals for their particular areas of responsibility
- regular team development days covering strategic and team development issues
- individual meetings with each member of the core team to help them develop and prioritise their plans and activities for the next few years.

Attendance at development events was good. There was little change in team membership, although the addition of a second local influential GP with a particular interest in diabetes care proved a significant enhancement. Team leadership remained stable.

During 2007, the LDC worked with the team to ensure that it was influential as new models of care were set up as a result of the merger of the West Wales trusts. The team also took advantage of additional funding from the Health Foundation to undertake a learning exchange with Lothian, and to attend a workshop on measurement of improvement, based on the Institute for Healthcare Improvement's methodology.

Development of leadership

All members of the team reported that they had gained greater role clarity, their meetings were more effective, they had gained in confidence and they were increasingly recognised as a model for diabetes care in Wales.

Some individuals also reported wider personal benefit, and improved ability to influence their own professional networks thanks to the team development and one-to-one coaching. Individuals within the team had all increased their responsibilities. This could be attributed to natural career progression but it is also likely to have been influenced by the development provided by the award.

The podiatrist, for example, reported that the one-to-one coaching had helped to build the confidence to influence counterparts in other Welsh trusts to develop an improved approach to diabetic foot care, and attributed this to the award.

Improvements in diabetic care during the period of the award

The team reported significant improvements in patient care and overall influence at, and soon after, the end of the award.

In patient care over 200 acute hospital admissions of diabetic patients had been avoided in 2006 due to improved education of patients and health professionals and the employment of community diabetes DSNs. This was an area that was discussed regularly at team meetings, facilitated by the LDC.

In terms of influence there were several impressive achievements during the period of the award.

The structure and function of the team and diabetes network model had been cited as an example of good practice by other chronic disease management structures within the county such as CHD, and it was hoped to be replicated to achieve their NSF standards.

The model of care developed by this team is integrated care, with an emphasis on care in the community. The development of this model involves education and training of primary care staff, community DSNs, local enhanced service payments for GPs, and shared electronic diabetes records. With the formation of the Hywel Dda NHS Trust, the diabetes network will incorporate the three counties. The Carmarthenshire model is considered to be the appropriate way forward.

The Welsh Assembly Government QOF in diabetes is a version of the Carmarthenshire system. It aims to reward practices which have at least 60% of their diabetic patients receiving their diabetes care exclusively in a primary setting. This team had already reached 80%.

In July 2008 it was announced by the Welsh Assembly that Carmarthenshire was one of three national demonstrator sites to develop better care for patients living with long-term conditions. This is evidence of the high standing of this small trust in this important area.

In its end of award report to the Health Foundation, the team described the subtle interaction between the context, the team, and leadership development thus: 'Holding the Health Foundation award has given us all the confidence to develop a bold diabetes strategy which will take us above and beyond the diabetes NSF'.

The reference to confidence is critical to understanding the success of this team. The scheme helped to release the potential of individual members and of the team as a whole. Exposure to, or benchmarking against, other diabetes networks on the scheme at the shared learning events also contributed to this process.

Newham

The team and its composition

The team was based at the local community healthcare clinic. The team bidding for the award was led by a consultant physician and endocrinologist from the Newham University Hospitals Trust. The other members were a local GP with a particular interest in diabetes care, two specialist nurses, a manager from the PCT, a podiatrist and a dietician. The consultant and the two nurses were full-time specialists in diabetes care. For the other members of the team, diabetes was only a part of what they do. Newham was the only team whose overt mission was to bring primary and acute care more successfully into effective partnership working.

Assessment of strengths and weaknesses at site visit

The site visit team's assessment was that this was a group of talented and enthusiastic individuals, representing most professional leads with an interest in diabetes, inclusive and democratic, enthusiastic and committed.

Organisation	Role in team
Newham PCT	Team leader, community DSN team
Newham University Hospitals Trust	DSN
Newham PCT	GP diabetes lead
Newham PCT	Deputy lead of foot health service (acting lead)
Newham PCT	Acting commissioner for CHD and diabetes
Newham University Hospitals Trust	Head of dietetic and nutrition service
Newham University Hospitals Trust	Consultant physician and community diabetologist
Newham University Hospitals Trust	Consultant physician and endocrinologist
Newham University Hospitals Trust	Patient representative (had to withdraw at short notice)

Four GPs attended the site visit lunch and expressed their enthusiasm for the award and for the work of the team.

However, it was difficult to identify the core team, and we observed a lack of clarity as to who was in charge, with some barely concealed conflict evident.

The team lacked an explicit strategy shared by all the key players and disseminated effectively to others. Organisational structures did not appear to be designed around clinical needs, but rather had been imposed and were resented by some.

All agreed on the need for a more effective service. Problems were identified but responsibility for solving them was unclear.

Some outstandingly effective initiatives were shown, such as patient storytelling for black and minority ethnic (BME) groups, but these were very resource intensive, and there was no mechanism to disseminate to the whole population which might benefit.

Acute trust support was overt, the support of the PCT was less evident. The site visit team noted that there may be continuing and unacknowledged acute/PCT tension, and that it was unclear how well informed the organisational support was.

The site visit recommendation was that, 'This team would benefit from the award. Key task is to agree on core team, identify roles and responsibilities, and acknowledge individual leadership. Prioritise. Develop strategy'.

This view was reinforced by their LDC who commented in March 2006: 'The team does need strong direction and leadership. There is a lot of energy and commitment but needs to be challenged and channelled'.

Local context

Newham is an inner city East London borough with substantial socioeconomic deprivation and rich ethnic and cultural diversity. The white population constitutes less than half of the population and people of South Asian ethnicity form the single largest group. The total population is around 260,000 and is set to rise quite rapidly as the Thames Gateway Development gathers momentum. In 2007, there were an estimated 15,000 people with diabetes (95% with type 2 diabetes) and this figure was rising (QOF data, 2007).

2006 to 2007 was described as a challenging period locally by the Newham team due to:

- the introduction of Practice Based Commissioning (PBC) and the national Payment by Results tariff
- local and national NHS reorganisation
- a risk of fragmentation to services
- the financial climate; both PCT and Newham University Hospitals Trust (NUHT) in 'turnaround' in 2006/07
- reduced service level agreement to NUHT outpatient diabetes service.

Within the team itself:

- one core team member suffered long-term illness
- one core team member left the group
- patient representation on the group continued to be a problem
- there was a lack of formal backfill arrangements for core team members.

The nature of the intervention

The intervention focused on the development of leadership skills, at a team and an individual level. The LDC continuously brought the focus back to patient care, which was acknowledged to assist in reducing the silo mentality which people had brought to meetings. As the award progressed, the LDC was invited to assist the team in resolving some difficult issues, and with assisting them in developing their case for a local diabetes centre of excellence.

Attendance at development events was good. The LDC helped them work towards integrated care across primary and secondary sectors which, in the view of one team member, led to their greater impact.

Development of leadership

Two elements stand out:

- the members of the Newham team began to explicitly acknowledge one another's strengths and contributions
- the LDC encouraged the setting up of nine NSF task groups, each led by a different team member. This embedded the shared leadership concept in team practice.

The lead GP applied successfully for a place on the Royal College of General Practitioner's leadership scheme during the period of the award.

A key benefit of the award was that there was reported to have been a positive impact on team processes which enabled dialogue to be maintained across primary and secondary care during a very difficult time.

The benefits were identified by the team members as: personal development, better team working, co-ordination and cohesion, improved interpersonal relationships, conflict resolved in constructive manner, support given to struggling parts of service, designated leads on projects, high proportion of agreed action points followed through, and a framework for future progress agreed.

Of all the benefits identified, maintaining a common case through sustained co-operation between primary and secondary care was singled out as the most significant at a follow-up interview in October 2008.

Improvements in diabetic care during the period of the award

In June 2007, just as the award formally ended, Newham diabetes team agreed to the concept of a 'diabetes institute', described as a 'diabetes centre of excellence'. Thanks in large part to the efforts of this team, the proposal had consensus across primary and secondary care as the hub of the diabetes service, a multidisciplinary clinical facility for diabetes and CHD with the capability of a 'one stop shop' for the most complex patients, a multi-media educational facility for patients, carers and health professionals and a research and academic dimension.

In September 2007, the concept of a diabetes institute was included in Newham PCT's five-year commissioning strategy, with full support from Newham PCT and NUHT chief executives, the local member of parliament, and the director of public health for NHS London.

Senior managers from both trusts were given the remit of project lead. Informal follow-up indicates that this team has sustained its performance. Eighteen months after the formal end of the scheme, the team continues to pay for the services of their LDC. The team leader offered these headlines: 'Much has been achieved that would not have been'; 'We are still talking to each other!'; 'Outside facilitation is a crucial factor'; 'Backfill for members of core group remains a problem'.

East Berkshire

The team and its composition

The team assessed at the site visit in July 2005 was led by a community diabetologist. Its composition was:

Organisation	Role in team
Windsor, Ascot and Maidenhead PCT (WAM PCT) for East Berkshire PCTs	Community diabetologist, East Berkshire Diabetes Network chair and clinical champion (lead)
Diabetes Centre	Specialist service management representative
Bracknell Forest PCT	Bracknell Forest PCT diabetes lead and professional executive committee (PEC) representative
Patient	Patient representative
Rosemead Surgery, WAM PCT	WAM PCT GP and diabetes lead
Slough PCT	Slough PCT diabetes nurse facilitator and diabetes lead
WAM PCT	East Berkshire long-term conditions group lead
Heatherwood and Wexham Park Hospital Trust	Acute trust representative (temporary until diabetes lead appointed)

Following the retirement of the community diabetologist shortly after winning the award, the team suffered a large number of losses to its membership and nearly all the members had to be replaced. Following a hiatus, the replacement team was led by another consultant diabetologist. There was also a temporary diabetes network manager, a second consultant diabetologist, a GP, a podiatrist and a director of nursing from the hospital trust. The two consultants and the network manager all worked full time on diabetes care. The remainder had other duties and for them diabetes care was only part of their jobs.

Assessment of strengths and weaknesses at site visit

Strengths:

- The vision to raise the standard of primary care so that the consultant is a trouble shooter, to use nurses and nurse consultants as 'shock troops' of change; to reach hard-to-reach groups; to be patient focused.
- Some outstanding examples of outreach to BME groups in Slough, though not known about or used by the other PCTs (Bracknell, Windsor and Maidenhead).

Weaknesses:

- Three different PCTs, three different strategies.
- Pending PCT reorganisation.
- Acute care not represented on team.
- Imminent retirement of consultant diabetologist/team leader with no succession plan.

Team development priorities at the outset were:

- To address issue of transition as consultant diabetologist approaches retirement.
- To find ways to include acute care representatives.
- To build on excellent patient involvement in Slough to develop a Patient and Public Involvement (PPI) strategy which crosses the social and ethnic divisions in East Berkshire.
- To improve use of data to pinpoint where to focus on improvement.

Local context

East Berkshire is an area of stark contrasts. Slough has high levels of deprivation and a high percentage of BME 'hard-to-reach' groups. Bracknell, Windsor and Maidenhead are very affluent and have relatively low numbers of BME people.

East Berkshire had been in the forefront of prioritising community services, and had appointed one of the first ever community diabetologists. Slough's initiative with Dr Foster to identify local populations who presented late to services with diabetes was highly regarded and seen as an exemplar of the application of market research techniques to healthcare. Reorganisation of the PCT from three into one was prefigured at the time of assessment, but had yet to happen.

Following selection three key team members left the organisation including the team leader, and two of the DSNs. By the close of the award only one of the original team was in place. Throughout the award period, PCT reorganisation hampered progress. There was no named PCT diabetes lead even at the end of the award period, in mid-2007. A network manager was appointed in November 2006. Although this provided a focal point and continuity, the appointment lapsed at the end of the award.

The nature of the intervention

In practice, for the first year of the 18-month intervention the LDC's focus was on rebuilding the team, including replacing the medical leadership lost when the consultant diabetologist retired. The appointment of a network manager enabled the new team to begin to develop a strategy, and the LDC input was critical in helping it to gel, clarify roles and responsibilities, and engage the wider community of health professionals, including midwives and representatives from acute care.

Once the team membership stabilised, the LDC offered team members individual development sessions using tools such as MBTI and 360 degree assessment.

Taking part in the scheme was reported to have been time consuming, although on the whole worthwhile and well spent. Evaluation meetings and paperwork were the areas where the team was less keen to allocate time.

Development of leadership

This centred on the rebuilding and commitment of the new team. There was reported to be clarity in their roles and a shared vision. The development of political astuteness was seen as a major benefit, and essential at a period of major reorganisation. Engagement developed in the network steering groups and workshops; attendance improved with members reporting that their contributions were valued and that network meetings were a constructive use of their time.

Improvements in diabetic care during the period of the award

Reflecting back on the initial priority areas for the founding core team, the 2007 team identified progress in developing the 2007–10 diabetes strategy, health needs assessment and a strategy for PPI. In addition, care pathway design had become an integral part of network workshops.

The most notable achievement had been on the engagement of wider stakeholders in the network, and a stronger culture of multidisciplinary and cross-organisational working. A specialist adolescent clinic was started. This was a result of team discussions and greater clarity about direction.

Other achievements included:

- improvements to the treatment of pregnant women with diabetes: at the December 2006 network meeting, midwives and consultant obstetricians joined the diabetes consultants and nurses in developing preconception guidelines for women with diabetes. This partnership working from the outset was expected to result in seamless services for patients following implementation
- a PPI working group which held a series of roadshows during National Diabetes Awareness week in June 2007
- health needs assessment had been developed as a precursor to more detailed work on patient pathways by members of the diabetes network.

The view of team members was that without the award a similar way of working would still have occurred but that the input from the LDC had helped to increase the speed of implementation by those involved.

The network manager appointed on a temporary basis, coupled with the LDC's help in recruiting and helping a new team to gel, was seen to have been a catalyst for action to improve aspects of services.

Section 5

Discussion

(Burgoyne, Williams and Walmsley)

In this section the significance of the findings are discussed. The first part considers the theoretical implications for leadership interventions, the second discusses key lessons for the Health Foundation and other organisations sponsoring schemes to improve team functioning in healthcare, and the third discusses implications for the NHS and for the provision of healthcare.

Theoretical implications of the evaluation findings

In terms of one of our main guiding models (Figure 1) the aim of this initiative was to apply a leadership development intervention to develop leadership capability to enhance performance in diabetes care.

The form of leadership capability targeted was shared, or distributed, or (collective) team leadership. This is the area on the right-hand side of the framework laid out in Figure 2. The teams were in fact on the middle or the right-hand side, being neither top or intermediate operational teams, though they varied on this dimension, and it is reasonable to conclude that this was one of the factors affecting the extent and nature of their impact.

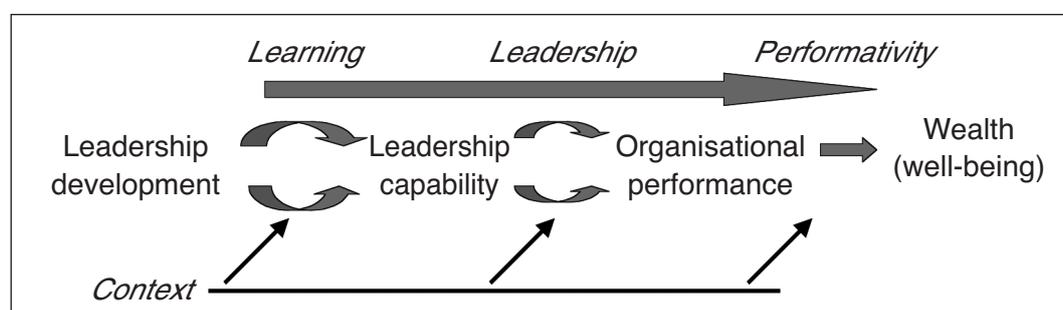


Figure 1: An organising framework

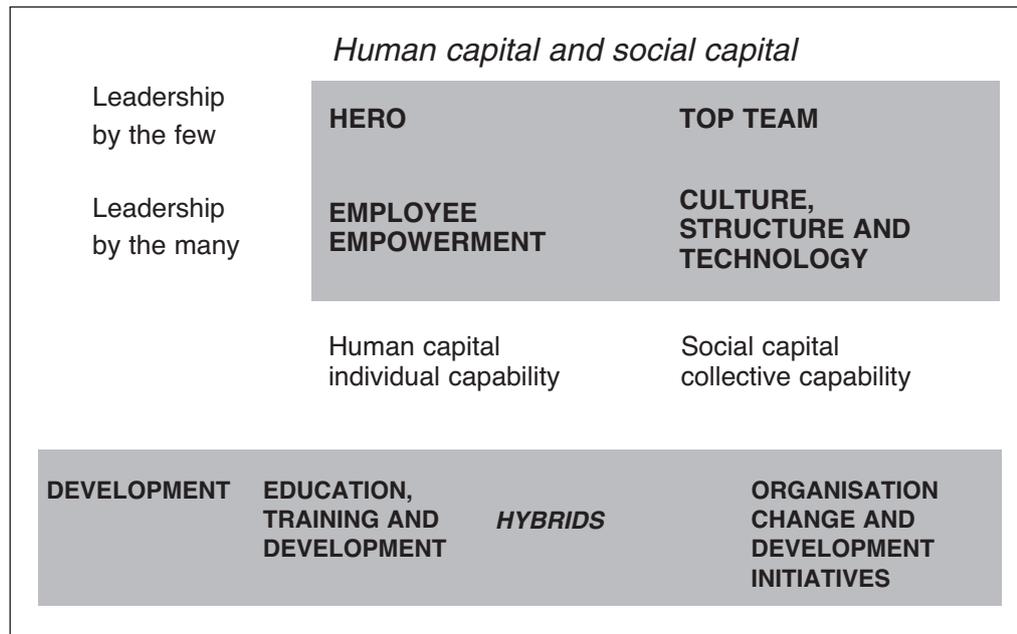


Figure 2: Where is leadership capability?

The research was carried out by comparing the six target sites with comparator sites where there was no intervention. We call them ‘comparator’ rather than ‘control’ because we are not following a strict (positivistic) science model but a critical realist one (Pawson and Tilley 1997). In this view, the world that we are dealing with is an open system with emergent properties rather than a determinist machine. The best we can do, in this view is to identify mechanisms that can work, in some contexts, to lead to certain outcomes as a result of being triggered in certain ways. These may, but cannot be guaranteed to, work in the future, but it should be possible to say something about the conditions in which this is likely. See Figure 3 for the key diagram expressing this.

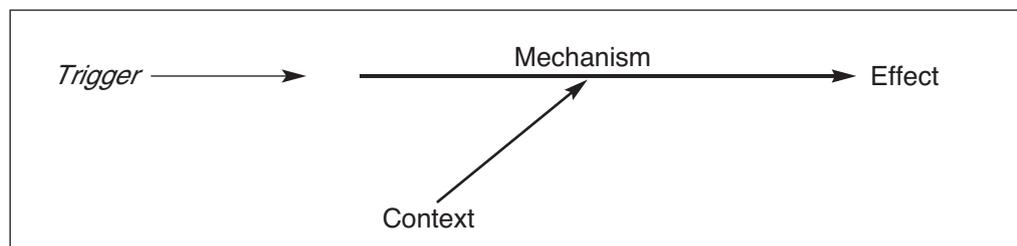


Figure 3: The Health Foundation shared leadership evaluation

The results suggest that there was an impact on terms of collective leadership capability, as judged by the self-report of team members and direct researcher observation.

However it was not possible to detect an effect in terms of performance outcome, as measured by impact on Quality and Outcomes Framework (QOF) data and the Scottish equivalent. This may have been because:

- enough time had not elapsed for the effect to work through
- the QOF data are not sensitive enough to measure it
- the effect was in a different direction to what QOF measures
- there was no effect.

It is not possible to tell, though we will suggest later that there are qualitative data to support the sensitivity argument.

We will discuss firstly the stimuli and mechanisms that may have developed the enhanced team leadership capability, secondly we will consider some of the things that may have impeded this and its translation into performance, thirdly the mechanism that might and could apply shared leadership capability to enhance actual performance, and lastly what the important contextual factors might be.

The leadership development consultants (LDCs) working with the award teams used a variety of methods and interventions, as they were encouraged to. These largely consisted of familiar team building tools – facilitating mutual understanding of personality types through Myers–Briggs, considering themselves in terms of Belbin’s team roles, 360 degree feedback, and so on. Several added one-to-one coaching to the team development activities.

Our data suggest that it did not matter very much which of these was used, what ‘worked’ was anything that encouraged them to deal with some of the real basics of teamwork. This consisted of having team meetings at all, putting some effort into organising them – having an agenda, papers and a chairing process – and finally logging action points at the end of the meeting, seeing that they were followed-up and checked at the next.

It may seem surprising that these teams of highly qualified professionals lacked basic meeting skills, but confirms other observations about the NHS in general, and is perhaps not surprising when one considers that many of the people comprising the teams consist of professionals whose training was largely technical, and who are mainly used to a mixture of autonomous working and management through one-to-one supervision. The absence of network managers with dedicated time to provide administrative support in all but two teams was also a factor.

Turning to the mechanisms through which enhanced collective team leadership capability might contribute to enhanced performance, it is our observation generally, that if leadership development programmes are thought of in terms of attempts to trigger the two link value chain as set out in Figure 1, then the majority, in their design and conception, are stronger on how the first link works than on how the second one does. In this situation it is hardly surprising if the first one works better than the second.

Team reports at the shared learning events in the scheme provided cases of specific mechanisms applied by teams. For example one set up a roadshow to raise awareness of diabetes and identify previously unknown cases. On a case study basis this was clearly successful in reaching several hundred people and identifying a dozen or so previously unknown diabetic patients. However this kind of gain, while quite real, is not going to show up as significant in QOF data that are dealing with populations of thousands.

As an analogy, if the initiative is like throwing a stone into the middle of the lake, the subsequent ripple effect will eventually reach the bank, but this is unlikely to be easily detectable if there are several ships travelling the lake creating washes of greater scale.

Pursuing this analogy, if a diabetes team is, perhaps, a dozen people costing perhaps a million pounds per annum, surrounded by various organisation change initiatives, and has an intervention consisting of a small number of consultant days, then this is like the small stone creating a ripple in the context of the wash of a number of large ships. The suggestion is that the effect may be real, but that QOF data are not sensitive enough to register it.

Another observation from the second shared learning event is that there may have been a misapprehension about the nature of shared leadership – that it means leaderless teams. To the extent that this was believed it may have got in the way of the creation of a form of leadership capability that would have been more likely to translate into a performance effect.

A more useful concept might be blended leadership, as developed by David and Margaret Collinson (Collinson 2005; Collinson and Collinson 2006). According to this evidence-based view, people like the autonomy of shared leadership but prefer someone to give a sense of direction towards which they can exercise it.

This may be the most useful concept for the NHS which attempts to work on the basis of a mixture of hierarchy and network – two of the main available forms of organisations according to Fairtlough (Fairtlough 2007), the relationship between which can be problematical as shown by Addicott and colleagues (2007) in the context of networks in the NHS very similar to those for diabetes.

Turning to the issue of the contextual variables that may affect links of the value chain (as shown in Figure 1, from leadership development initiative to leadership capability and from leadership capability to performance), it would take large-scale quantitative research, and perhaps meta-analysis (Pawson 2002), to identify them in this way and this study does not have this scale. This leaves us with qualitative data from this study and what we can glean from the literature.

From our study, the variables that have seemed important from our qualitative understanding of the processes involved have been:

- The size of the team and the size of the domain that they are seeking to influence.
- The extent to which the teams have been more strategic or more operational in their orientation. In our previous analogy this would be equivalent to being in the middle of the lake – and the subsequent effect being all around the shoreline, but with diminished effect and taking longer to get there, and being close to one particular part of the shoreline where the effect would be more local and relatively quicker to get there.
- The degree of turbulence in the environment – analogous to more big ships passing in the lake. Turbulence was greater in England than in Scotland and Wales, which affected the sustainability of some of the changes made with the teams, and indeed the membership of the teams themselves.
- The team composition – the various professions involved, technical, administrative and managerial, and the relative dominance of these.

From the literature, usefully summarised by Hackman and Wageman (2005), there are suggested to be three clusters:

- Functions:
 - whether they are teams rather than just work groups – common task and interdependence in achieving them
 - whether the teams are ‘real’ to the members, in other words, not just another task force to which they are nominally allocated
 - whether there is true interdependence – each person relies on the work of others for their contribution to add to the overall task performance
 - whether the team is a real social entity
 - whether team membership and individuals’ work within it make a real difference to the members’ sense of well-being
 - whether task achievement matters to the team leadership.
- Timing:
 - the age of the team and the stage of its development, characterised in terms of forming, storming, norming and performing as described by Tuckman (1965), and on the basis of other models proposed by those who are critical of Tuckman
 - the length of experience of teamwork of the individual members.

- Conditions:
 - the size of the team
 - the technical and organisational skills of the team members.

Unfortunately the Hackman and Wageman review (2005) is not evidence based, but it does offer a useful checklist.

Our judgement is that in this situation the stability – or lack of it – of the teams and the relatively low level of prior skills in team working are the most important factors.

We have found evidence elsewhere that leadership (and management) development works best when it is integrated as part of a bundle of activities that include the acquisition and utilisation of leadership capability as well as its development.

In the case of integration of management development and career management, this has been shown to have a direct performance effect in the private sector (Fox, McLeay et al 1990; 1992).

In this situation we conclude that the initiative would have worked better if the acquisition process in forming the teams had taken more account of the members' prior skills and experience in teamwork, and if the career management and reward systems had been organised in a way that kept the teams more together to increase the sustainability and use of the collective leadership capability that had been developed.

Key lessons for the Health Foundation, and other organisations sponsoring schemes to improve team functioning in healthcare

An important finding is that contextualised support for clinical teams improves team functioning, and has the additional benefit, unanticipated at the outset, of improving the confidence and leadership skills of individual team members. It contributes to improvement in multidisciplinary working, in understanding of different people's roles and contributions, and thus more effective use of human resources. It also acts as an important stabiliser at times of uncertainty caused by factors outside the control of clinical teams. It confirms part of the Foundation's original hypothesis, though there was widespread agreement that finding quantifiable evidence of improvements in patient-level outcomes was an over ambitious aim, and could not be realised in such a short intervention.

There are some particular challenges to aiming leadership development at teams. One of the first challenges the LDCs faced was in defining who was in the core team. The Foundation limited places at shared learning events to seven people. Although an arbitrary number, largely dictated by practical and resource considerations, it was an important discipline, and one of the most difficult tasks some teams faced, to decide on the proper composition of the group. Agreeing who was essential of the sometimes numerous competing claims was in itself a leadership challenge some teams had previously avoided.

A second challenge was to agree the balance between team development and one-to-one coaching. LDCs managed this without any undue difficulty. Nevertheless, it had not been the Foundation's expectation that one-to-one coaching would feature as prominently as it did.

A third, and probably the most difficult, challenge was changes in team membership, particularly in team leadership and where there were many changes in a short time period. It was a major task for LDCs to support these important transitions. Changes of membership and leadership could also be an opportunity – for example when the GP lead in Southport stepped down, the LDC worked with the team to identify a suitable replacement from the trust with which they were due to merge. In helping the teams to manage succession planning the LDC was modelling important leadership behaviours.

The question of attribution when discussing service improvements was a vexed one. The evaluation, largely based on self-report, consistently indicated that there was a 'speeding up' of improvements that would have happened anyway. However, there is some evidence that these developments might have taken an extremely long time without the scheme.

The external context played an important role in England. The experiences of the Southport and Formby team, which had enjoyed considerable success and public recognition, only to be merged into a larger entity, is illustrative of the risks of investment in teams. However, the combination with investment in individual team members' skills and leadership potential indicates that such a risk can be mitigated.

Improvements could be made to make the scheme more effective. These include:

- Clarity about the nature of the scheme: this was an unusual 'award', offering flexible expert support for team development rather than the more common money, material resources or defined curriculum. Some teams had not fully grasped the implications of participation, in particular opportunity costs in terms of time commitment. Future schemes need to ensure that applicants fully understand the nature of the commitment. It may be necessary to 'pump prime' the intervention with resource for backfill in the early stages of the award, to encourage participation at a time when the value of the activity is unproven in the minds of the participants.
- Clarity about the rationale for selection: the Foundation's principle of selecting the best and those 'with the potential to be the best' proved to be well founded. Those teams which were already high performing benefited in terms of increased sophistication in influencing and educating others. Those which were relatively unsophisticated at the outset but which selection panels rated as having considerable potential and to be in a situation to make a significant difference appeared to derive great benefit.
- An agreed baseline measurement so that progress can be calculated: participants struggled with the concept that the intervention might lead to improvements in services or patient care. Lack of any agreed baseline measurement at the outset made such calculations problematic. In any future intervention of this kind it will be important to agree some baseline measures.
- More structured opportunities for learning across teams: the greatest value of the shared learning events was reported to be the learning across teams. 'Expert' top-down input was on the whole not highly valued – it was regarded as either irrelevant or patronising. Future schemes need to provide more structured opportunities for cross-team learning.
- Recognition of the potential impact of external factors: reorganisation of primary care trusts (PCTs) in England during the period of the award had a major impact on several teams. Although the scheme may have mitigated the worst effects of reorganisation, there is no doubt that it was a major distraction, at the very least, for English teams. Controlling for such eventualities is not possible. It does suggest, however, that if the maximum impact is to be derived, timing is of the essence.

Lessons for the wider healthcare system

- This was a relatively simple and low-cost intervention, designed to test a hypothesis that provision of structured support to teams to improve functioning, using a model called 'shared leadership', would lead to improvements in team processes, and patient outcomes. While the latter was unproven, the former was largely substantiated.
- Managed clinical networks are an important mechanism to harness clinical leadership capability to the management of a fundamental challenge, namely responding in a cost-effective way to the growing incidence of long-term conditions, such as diabetes. The

shift of specialist care from tertiary or secondary centres to primary care is a policy that has been consistently restated, including in the (English) White Paper *Our health, our care, our say* published in January 2006 (DH 2006a), and in the (Scottish) Kerr Report (Scottish Executive 2005), during the course of the scheme delivery. The practical implications for diabetes specialists are profound role change. From being the ‘doers’ of direct care, they are expected to become the facilitators of generalists in primary care managing long-term conditions successfully, while retaining a direct care role in more complex cases. Indeed, they are expected to become ‘leaders’.

- The scheme evaluation indicates that skilled support for teams to consider how they can become more effective is an important investment. A great deal rests upon the success of these specialist teams, in particular their leadership, if high-quality care for long-term conditions is to be successfully transferred from specialist centres to primary care. Not only will it save money and improve patient convenience if it can be done successfully but lives may depend upon it.

In summary, the following are the main lessons this evaluation has to share with the wider healthcare system.

- Clinical networks have been seen as a key component of modern healthcare systems as management of long-term conditions shifts to primary care. Yet little attention is paid to training for these important and resource-intensive teams. The message from the scheme is that clinical networks require expert help in teamwork and relationship management if they are to realise their full potential.
- Attention needs to be paid to supporting senior clinicians in positions of team leadership to understand the principles of effective meetings and teamwork. Teams also benefit from some dedicated administrative support. Without this, valuable clinical time has to be devoted to clerical and administrative tasks.
- Teams can be over reliant on charismatic and passionate individual leaders. In healthcare, these are often very talented doctors. When that person moves on, the team can collapse, unless attention is paid to developing shared leadership and to succession planning.
- Structural systemic change impedes improvement. In England, the period 2005–06 was one of major structural change, with PCT reorganisation. The award helped some of the English teams to stay functioning during this period. However, it is unquestionable that two of the six teams had to devote considerable time and energy on sheer survival. The Welsh and Scottish teams, by contrast, enjoyed the advantage of a more stable environment.

The last words in Part 1 of this report should go to the participants, several of whom regarded the scheme as having a lot to offer more widely:

If you could do it for every area, it would be fantastic. If you could spread this to other priority areas. *GP*

All teams would benefit from this kind of structured input. Having an external person to look at how you function as a team and what you can do about that. *Consultant*

I really hope the Health Foundation continues to do this, working across professions. It will always make a difference if you improve the way professionals work together. I think it's great, and exciting. *Manager*

PART 2:
**DETAILS OF THE EVALUATION
METHODOLOGY AND ITS RESULTS**

Appendix 1

Findings from the results of interviews with team members (Burgoyne and Williams)

Methodology of the interviews

All award team members were interviewed half way through the scheme in 2006. The interviews were then repeated after the end of the scheme in 2007. All team members were interviewed in 2006 (100%) but three members were unavailable due to illness or personal circumstances in 2007, giving a response rate of 93% for the second set of interviews. The interviews covered team development, the main benefits of the award, working with the LDCs, the development of shared leadership in the team, the value of the large conference events, and what outcomes for patients, NHS organisations or for the local health economy had occurred.

In-depth, one-to-one interviews were undertaken with 93% of the members of the award teams in July 2007. All but one of the interviews were undertaken face to face (one had to be carried out by telephone due to incapacity). All interviews were confidential and interviewees were assured of anonymity in order to guarantee that responses would be open and frank. Three members of the award teams could not be interviewed due to illness or other unexpected circumstances. This gave a total of 41 interviews out of 44 award team members (93%).

Main benefits of the award scheme

Overall gains

Interviewees were asked what they thought had been the main benefits of taking part in the award scheme overall. Responses were similar for all teams. All the interviewees felt that the award scheme had had a worthwhile effect upon their teams and upon their behaviour and that they had gained a great deal.

The main areas where there had been gains were:

- improvements in team working

- individual personal development
- increased levels of activity and achievement for the team
- increased status for the team in their local health community
- that during periods of external change the scheme had helped the team to stay functioning (English teams only – Scotland and Wales were subject to less external change in the NHS and thus did not report this as a benefit).

Improved team working

There were several team working areas in which benefits were reported. All teams felt that there had been significant gains in:

- teams working better together
- improved ability to get things done as a team
- less conflict
- greater understanding of each other's roles
- improved techniques for running or taking part in meetings and committees
- improved understanding of where and how to influence other key stakeholders.

The following quotations illustrate this:

'It developed the team dynamic. Strengthened an already good team. We have been able to be honest with each other without people feeling it is a criticism.' *Manager*

'It helped us to think in the political and organisational context and to see that we have to set goals that are realistic in that context.' *Consultant*

Getting to know each other better

A further benefit was that teams got to know each other better and became more aware of what each other's roles entailed.

'We used to work in parallel universes and only come together with the clinic.' *Manager*

'Before the award, I wouldn't have known what health promotion does. Now I can tell patients about it. That would never have happened without the award.' *DSN*

There were thus undoubted gains for the teams but these were not necessarily having a direct effect on patient care.

'We know each other, and know who to contact now... We can talk to each other now – I used to just come in and do my bit. But there has not been much in the way of change for the patient.' *DSN*

Increased status within the NHS

Teams also reported that having received the award had improved their standing in their local organisations and given them the credibility to be listened to by senior management.

'The award has raised our profile so we can have a bit more influence than we did.' *Consultant*

'At the back of your mind you think I ought to do this [but don't do it], but when you know you are part of a team it catalyses you to actually make changes. And the trust sits up and listens because we can say we are an award winning team.' *Manager*

Responding to changes in the NHS

In addition, the English teams were subject during the period of the award to considerable external turbulence in the NHS. This included mergers of many PCTs, the introduction of Practice Based Commissioning and Payment by Results, all of which significantly altered the way in which teams had to operate, changed their relationships with each other and with the NHS organisations to which they belonged, and affected their budgets. For the English teams it was one of the great strengths of the award that it helped them to cope with these changes, to stay together as a team, and to be able to maintain a high profile for diabetes care during this turbulence. In Scotland and Wales, the situation was more stable and the teams there did not have to cope with the same upheavals and insecurities.

'It gave us confidence in facing the merger [of PCTs].' *Consultant*

'This has changed how we tackle the merger... We know now where we need to influence and also that we can do things better. Now I'll say we could do this, plan what we want to achieve. I wouldn't have said anything before.' *Dietician*

Value of working with the leadership development consultant

Value of having facilitated time out

Having facilitated time out together as a team was seen as a key benefit. Most of these teams had not previously had the opportunity to spend any time together working on wider issues such as strategy or service improvement. Having the dedicated time and also having a skilled expert to work with them were the key mechanisms by which the award scheme had been effective.

'It has given us time to reflect on how we work... Techniques for communication, planning – we were good at ideas but not at getting them into action plans.' *GP*

'It got us together and made us concentrate and think. Time out to focus and set goals. And it's all been structured, as opposed to all those other NHS meetings and committees I go to.' *Podiatrist*

'Having [the LDC] helped us structure how we work, focus on projects, who to contact, how to influence, celebrating achievements. How to put your point across at meetings, how to be heard. It was all very positive and constructive.' *DSN*

Tools and techniques

Leadership development consultants (LDCs) used a variety of standardised personal development tools in their work with the teams. The interview data suggest that it did not seem to matter which techniques the LDCs had used. Some had completed 360 degree assessments, Myers–Briggs or Belbin. Some had done all of these, some a mixture, others had done none. Either way, it did not seem to make a difference to the outcomes which of these, if any, had been used. Although individuals valued the insights which these tools gave them, and many gained a great deal personally from having one-to-one sessions with the LDC, the key benefits from the award were seen as arising from the action-based tools and techniques which the LDC helped them to develop. These included how to manage meetings, how to listen to others, having agendas for meetings, use of planning sessions and briefings, having the confidence to contribute to meetings, agreeing action points and reviewing whether they had been carried out, dealing with conflict, and knowing who to influence.

The key elements in effectiveness seem to have been:

- time out to undertake facilitated work as a team
- tools and techniques for managing meetings, setting agendas, developing action plans, and so on

- sufficient directedness from the LDC to move the team on from discussion to actual action
- personal development through one-to-one sessions with the LDC (for some people).

'The best was the interventions at meetings. It wasn't the personality inventories – I've done all that before. It was at the meetings – [the LDC] was very skilled at pointing out deficiencies in a pleasant way and rapping our knuckles. It had a profound effect on our decision making. Without that, we would have been stuck.' *GP*

'We used to spend meetings going through the minutes of the last one, and have no action points. None of us felt able to address this as an issue before the award. Now we have action lists and make sure things that were agreed are done.' *Consultant*

The LDC's main strength was seen to be in helping teams to focus upon what they needed to do and how to put their plans into action. Developing targeted actions and a focus on achievable goals and outcomes were found to be more valuable than other forms of team development. A key skill which the LDC was able to bring was being direct enough to ensure that the sessions did not degenerate into a 'talking shop' but that accountability for taking things forward was clear and that teams did actually carry things through.

'Having the space to do it. Having direction. LDC didn't actually direct us, but was a firm hand that allowed us to direct ourselves better. We had been treading water, meandering around in the dark – [name] gave us a focused direction.' *GP*

'[The LDC] gave us tools – how to look at what we are good at, what we want to stop doing. I've used that in other contexts.' *Manager*

Gains in personal development

Many individuals reported considerable gains in personal development with confidence the most frequently mentioned benefit.

'It gave me confidence, both personally and professionally. I am now sharing our best practice with other neighbouring areas.' *Podiatrist*

'It's improved my own time management... it's also made me reflect on myself as a leader. I never used to do that.' *DSN*

Transfer of the learning to other contexts

Many of the tools and techniques they had learned from the LDC were reported as being used by interviewees in other contexts, particularly in the committees or steering groups on which they sit. In this way the effects of the award can be said to have cascaded beyond diabetes care and are being transferred to the wider healthcare community.

'I'm taking on a new role through this training – I use [the LDC's] methodology to decide what we are there for and then get everybody on board. This award has given me a better understanding of how these processes work. I've had leadership development before, but not team dynamics.' *Consultant*

'I'm more clear about how to challenge people in meetings, how to keep meetings efficient, how to get things done.' *Administrator*

Outcomes and achievements as a result of the award

Increased levels of achievement

All the teams felt that they had been moved forward by the award and that working with the LDC had enabled them to achieve changes that they would not otherwise have done. All teams reported that they had previously had plenty of ideas about how to improve diabetes

care in their areas but that getting anything actually done had been a problem in the past. Working with the LDC had enabled them to translate ideas into action and all teams reported increased activity and achievement.

Areas of success

There were a number of areas in which the teams reported progress during the period of the award and which might be expected to have an impact on patient care in the long run. The main areas of achievement in which progress was at least partly attributable to the award included:

- agreeing strategy documents
- developing new or improved patient care pathways
- improving systems for tracking and monitoring patients
- following up patients who miss appointments
- influencing board strategy for diabetes care
- more staff taking part in the Warwick Medical School Certificate in Diabetes Care
- outreach events and roadshows
- new or better patient information leaflets
- a patient satisfaction survey
- creating new clinics for different patient groups and/or in different areas
- reorganising service to ensure more patients had access to a dietician or podiatrist
- setting up a screening project with local employers
- establishing a patient education project in local community pharmacies
- moving routine care from secondary to primary care and consequently reducing the waiting list times
- improving the use of agendas and action points at meetings
- increasing the focus to discussions with more emphasis on getting things done
- achieving agreement between primary and secondary care on how diabetes services should be developed
- team cohesion in times of external change
- managing the transition to a merged PCT.

As one interviewee remarked:

‘A lot of teams and committees in the NHS achieve very little. It is good to have been part of a team that has achieved something solid in a short space of time.’ *Consultant*

Attribution of achievements to the award scheme

It was generally reported by interviewees that these outcomes might have happened sooner or later, but that without the award they would not have been achieved so quickly. The award scheme had been a contributing factor in enabling teams to make progress towards their goals. A typical comment was:

‘The award was not totally responsible but has been a factor in our achieving it. These projects were being planned anyway, but have happened more quickly with the award. We might have done them anyway.’ *Consultant*

Most of the teams’ achievements were in areas where they were already working. The great benefit of having had the award was that teams began to put into practice changes that they had been thinking about for some time, often years. The award had helped them to do things more

quickly than they would otherwise have done. They did not feel that any of these changes were solely attributable to the scheme but that the award had been a contributing factor.

'We did it faster, but would have done it anyway.' *Consultant*

'The award has been a catalyst not a cause. It might have happened anyway but the award has really focused us and made us do it quicker. We have got a momentum, we've got a goal that makes us work faster. Also now if we meet a wall we try and get round it, we have greater confidence, we say, there's a lot of us in this team and this is what we are going to do.' *Dietician*

However, not everyone was convinced that the award had made much difference.

'Have we achieved more than we would without the award? Perhaps a little.' *Consultant*

'We have done things – but we would have done anyway.' *DSN*

It was not anticipated by the teams that the outcomes from their achievements would be visible objectively because they were already high-performing teams and the changes they were making were relatively minor. They did not expect marginal changes to be apparent from any measurements used, particularly against a background of ongoing and continuing change and development in diabetes care nationally.

'There is so much going on in diabetes that it is difficult to attribute any changes to the award.' *GP*

'Patients wouldn't have noticed the better team working.' *GP*

Outcomes for patients

So far, none of the teams have reported any outcomes for patients, although they all believed that patients would benefit in the long run. All the interviewees felt that a better run and managed service, with a team that was now working more effectively together, would inevitably and eventually lead to better patient care.

A different kind of scheme would of course have had different outputs but this initiative was seen as having been set up to focus mainly on team development rather than on providing measurable outcomes for improved patient care. It was seen as one of the strengths of the scheme that it was open-ended and allowed teams to use the resources of the LDC's time and skill in a way that was flexible and could be adapted to their own needs. The flexibility and open-ended nature of the award allowed teams to progress in the areas where they needed to improve, to develop their team working skills and to become more focused on activity. Teams learned to work together more effectively, to become more efficient and to understand better how to get things done. These were seen as great strengths, which the teams would carry forward into the future and would help them not only in diabetes care but in the other spheres within which they operate. In that sense, this has been a highly successful scheme.

'There will be benefits because we are working better.' *GP*

'If you concentrate on your goals and talk things through as a team, it is bound to improve patient care. It gives you a push forward, you want to achieve and be seen to achieve.' *Podiatrist*

'We are working at a strategic level that doesn't immediately have an effect on patients.' *Manager*

Shared leadership

Interviewees were asked if they felt that as a result of the award scheme there had been any development of shared leadership in their team. There were mixed responses to this question. All the interviewees felt that their team had a single leader. They also felt that this was essential in diabetes teams and that one person needed to be able to take the overall responsibility and to be the final arbiter of decisions. It will be noted that this was not contradictory to the Foundation's definition of 'shared leadership'.

However, all the teams also reported that the team dynamic had changed over the period of the award, particularly with more junior members of the team now feeling able to speak up and have a voice, and the team leader being more willing to listen to other members. In addition, it was felt that all the members of the team were now more willing to listen to each other and to value each other's ideas. Everyone's contribution was seen as important now. Non-medical staff in particular felt more able to speak up and to offer their ideas and medical staff were more willing to take these on board.

'[Name] is still the leader. It's his job to run the thing. But we do all take on responsibility to do things. Now, when we agree to do a task, it's more likely to get done than when we all used to do our own thing.' *GP*

'We all used to think [name] was God and what he said went. Now we can say I don't think you're right. We've realised he's a person. And he does listen. A person you can relate to, even though he's still the leader.' *Administrator*

In addition, the gains in confidence and understanding of oneself and others had enabled each member of the team to feel that they were now better leaders in their own sphere, whether that was medicine, podiatry, nursing, dietetics, administration, management, or as a patient representative. The effects of the award were thus able to spread beyond diabetes care into other spheres.

'I've used this now in other groups, how I chair meetings.' *Consultant*

'I'm far more exacting in other roles – asking what the task is and how we are going to measure that task... I go to a lot of meetings where I'm not sure why I'm there or what benefit anyone is deriving.' *GP*

Sustainability

All the teams hoped that the teamwork benefits would be sustained. They felt that their better understanding of each other and their new ability to work together effectively would continue, even if team composition changed in the future. Teams did not, however, anticipate being able to keep up the regular time commitment, since that had been one of the big difficulties for many of them of taking part in the scheme. It had been a real problem, particularly for those with clinical responsibilities, to give up the time for the meetings with the LDC. It had been less difficult for those in administrative or management positions to find the time to take part.

'It's taken up a huge amount of time – we all underestimated that.' *Dietician*

The teams did not therefore anticipate giving the same level of time commitment to team activities in future. Nevertheless, they hoped to have away days and/or regular meetings to refresh them, and believed that their regular scheduled meetings would be permanently improved because of what they had learned.

'The team has had enough guidance now. I hope we will continue to meet. We will miss [name] as a facilitator, but now we know how to hold the meetings, the format and everything.' *Administrator*

'We used not to communicate. Now we do phone calls and emails to support each other. We are going to continue to meet and make sure we have a voice and influence. We've acquired skills and we need to use them now.' *Podiatrist*

Large conference-style events

The award scheme involved three large conference-style shared learning events: one at the beginning of the scheme, in London; one halfway through, in Edinburgh; and one at the end of the scheme, in Cardiff. These were all enjoyed by the teams.

The format was slightly different for each one, and the view of the interviewees was that the last one (Cardiff) was the most successful in terms of format and outcomes. The earlier two

meetings were seen as too rushed. The ‘marketplace’ (London event) was not viewed as a very effective way of finding out about the other teams, whereas the presentations at the other two events were seen as by and large successful. The Cardiff presentations were seen as more effective than the Edinburgh ones, partly because there was more time allotted to them and partly because of the improved questioning technique used in Cardiff. At the Cardiff event, the teams were asked to formulate questions collectively after each presentation and this allowed time for each team to discuss the previous presentation together in their own groups. This was reported as an improvement upon individual questions.

The most useful aspect of the large events was sharing experiences with the other teams.

‘Useful to hear about best practice. It made me see that podiatry is valued, and that podiatrists are making a difference in these teams.’ *Podiatrist*

‘Useful to meet other teams. I picked up some good ideas... The idea of feeding back expected prevalence [of diabetes] to practices – I got that from [named] team.’ *GP*

Most people felt that the teams were too different in their style and approach for there to be many ‘take away’ messages, but they did feel that it was useful to see that they all shared the same problems and challenges.

‘Good to see that we all have the same problems... The questions were more useful than the presentations.’ *Consultant*

There were several comments about the format of the events. Most of the external speakers in London and Edinburgh were seen as having been largely irrelevant. The only exception was the expert patient session which was highly valued. The preponderant view was that it would be useful to have one or perhaps two presentations at the first and middle events, but these had to be carefully chosen so that they were relevant to the stage of the award. The final summing-up panel in the Cardiff event was not seen as useful.

The main criticism of the events was that there was not enough mixing between teams. It would have been valuable to have some allocated time for group exercises, or to have facilitated sessions in which the groups were mixed up randomly and had problem-solving activities to complete.

‘I would have liked more mixing of teams – we could have worked in different professional groups. We all kept to our own teams.’ *Dietician*

‘More focused activities – things to do. For example, you could have asked each team to bring a problem they were struggling with and had not yet got a solution to... I would have preferred shorter or written presentations, with questions, and then mixing up the groups.’ *Manager*

One surprising consequence of the large events was that it gave the teams the opportunity to bond. They rarely had opportunities to spend this much time together, or to meet outside work, and the time spent travelling together was for many as important as the event itself.

‘It was really useful for us as a team to be in a less formal environment. We got lots planned in the waiting room at the station.’ *Dietician*

Suggestions for improvements to future schemes

On the whole teams felt that the scheme had worked well. It had been valuable and had helped them all to develop, both as individuals and as teams. Overall it was felt that no major adjustments would be needed if the scheme were to be repeated. There were, however, some suggestions made for the future.

Understanding of the award at the outset

The main problem area was a lack of understanding at the beginning about what the award involved. Most team members had not been aware of what they were signing up to, did not necessarily want or value the intervention of an LDC at the beginning, and had not realised what the time commitment would be. Future schemes should ensure that leadership development is actually what the team wants and understands it is being offered, so that it is not seen as something thrust upon them.

Measurement of outcomes

The question of measurement of outcomes came up repeatedly in the interviews. People felt that the award had not been set up as a service improvement scheme and that there was no suggestion at the beginning that any measurable outcomes would be expected. It was felt that the Health Foundation had not been clear about what it expected at the outset. If measurable outcomes had been wanted, then interviewees felt that these should have been written into the scheme at the beginning and the scheme would have had to be set up differently. Similarly, some guidance to the LDCs about what was expected of them would have achieved more uniformity.

On the other hand, teams felt that the flexibility of the scheme and the lack of guidance about the detail was a strength and had enabled them to tailor the outputs to their own needs. Future schemes need perhaps to be more explicit about whether the award intends to 'let a thousand flowers bloom', or wants specific outcomes.

'I don't know what the Health Foundation's goal was. Was it to see projects produced, or teams functioning more efficiently, or individuals enhanced?' *Podiatrist*

Opinion was divided about whether more explicit outcomes would have been valuable at the beginning. Some people preferred setting their own goals. Others would have liked a more structured approach. The main lesson to be learned from this seems to be that the key question is clarity at the outset so that teams are fully aware of what the award involves and what will be required of them.

'The Health Foundation couldn't have set specific outcomes – setting our own made them achievable.' *Manager*

'We spent six months deciding what to do. It might have been helpful if the Health Foundation had said this is what we want you to work on.' *GP*

Other suggestions

- Those team members who had been to an optional workshop run by one of the Foundation's Quality Improvement Fellows trained in improvement methodology had found it very useful and said that it would have been helpful to have this at the beginning of the award, not the end.
- A few interviewees felt that it would have been helpful to have 'buddied' with another group and had some site visits to another team between the shared learning events.
- A handful of interviewees felt that the shared learning events had not been a good use of money and could have been done more economically.

Positive comments

Finally, there were some very positive comments.

'If you could do it for every area, it would be fantastic. If you could spread this to other priority areas.' *GP*

'All teams would benefit from this kind of structured input. Having an external person to look at how you function as a team and what you can do about that.' *Consultant*

'I really hope the Health Foundation continues to do this, working across professions. It will always make a difference if you improve the way professionals work together. I think it's great, and exciting.' *Manager*

Appendix 2

Findings from the patient interviews (Burgoyne and Williams)

Methodology of the patient interviews

Patients were interviewed at five sites. At two of the sites a focus group approach was used and the patient representatives group was taken as the forum for obtaining patient feedback. At the other three sites, individual patient interviews were undertaken. There were seven patients at one of the focus groups and fifteen at the other and fourteen individual interviews were undertaken.

Patients were selected to represent a variety of ages, type and severity of condition and ethnic background. The interviews were informal and allowed patients to describe their experiences freely. All interviews were confidential. The format was based upon the patient prompts method pioneered by the Royal College of Nursing in their research.

Site 1: Group setting

Experience of diabetes care in general

There were mixed views about the overall standard of diabetes care provided across the area. There were some positive views – ‘I feel I’m well cared for’; ‘I think we have a good standard of care here [compared to my previous area]’. Others felt it varied – ‘There’s a variation [of experience]. Some people are getting better treatment than others’; ‘The quality of the care I’ve had over the last five years has been good but that’s because I’ve been proactive’.

Experience of hospital/general practitioner visits

Again, there were mixed responses to this question with some patients feeling they had a good service at the hospital – ‘My experience at the hospital is great, they’ve attended to me very well. The consultants can be brusque but they have a lot of people to see’. Others found it below their expectations – ‘I’ve been Type 1 for twenty five years and I find the [hospital] quite

inefficient. I have to wait, for example for a blood test, and it's not very joined-up'. Another patient was dissatisfied because he only sees the consultant every 18 months, and in between times is seen by a different registrar on each visit. Hospital care was reported to be fragmented, with a variety of professionals carrying out a range of tasks and little consistency or continuity of care. It was said that there were different atmospheres in the different hospital clinics.

The experience in primary care was again thought to be variable – 'There's a vast inconsistency across the region. Some general practitioner (GP) practices are working hard, others are balking at adapting to change'. One individual was pleased with the service – 'I'm well cared for in my GP surgery'. Availability of repeat prescriptions came up as an issue, with one person claiming the service had deteriorated – 'It takes longer to get my prescription than it used to' – and another very enthusiastic about the move to email requests in their GP practice – 'They've recently gone to an email system for repeat prescriptions – it's brilliant'.

There was agreement that more resources are required in both primary and secondary care settings – 'There ought to be more diabetes nurses – there aren't enough'; 'The specialists at the hospital are overstretched – they need to train more doctors and nurses and use them more effectively'. The management of information was a major area of dissatisfaction, with most people feeling that the primary and secondary care systems do not communicate satisfactorily – 'The databases communicate with each other grudgingly and occasionally'; 'The data about me isn't correct – they have to get the data right. They weigh me and calculate my [body mass index] with my clothes on!'.

Contact with other professionals

Contact with other healthcare professionals was mostly thought to be lacking – 'I've only seen a dietician once, I've seen a podiatrist once, the clinical nurse specialists are being hived off to other tasks and I'm seeing a nursing auxiliary instead – that's a degradation of the service'; 'The problem [dieticians] have is getting referrals from GPs and consultants. They mostly see the newly diagnosed and there aren't enough resources for existing diabetics'.

Changes noticed in hospital/general practitioner/clinic visits over the last 12–18 months

There were more stories of deterioration in services than of improvements and patient education was an evident source of dissatisfaction – 'We have some contact with the retinopathy screening service. It's certainly changed [for the better]'; 'The education to patients could be improved and standardised – I haven't had any education'; 'I've learned more from being in this group than anywhere else'; 'The Managed Care Network has set up a working group to look at education but we've seen nothing yet'. There was also a remark about services to black and minority ethnic (BME) patients – 'The service for BME patients leaves a lot to be desired – they're not being reached'.

Site 2: Group setting

Experience of diabetes care in general

Members of the group were in agreement that the service they receive is of a good standard – 'We're very happy with the service we're getting'.

Concerns were expressed about the intention to transfer routine diabetes care from secondary to primary care in terms of the skills and knowledge of GPs compared to hospital clinicians.

There was a general feeling that the service on offer from GPs might be of variable standard – ‘For people treated by their GP it’s a postcode lottery. Not all GPs are up to speed’.

Experience of hospital/general practitioner/clinic visits

Those patients being seen in the acute hospital setting were very satisfied with their care – ‘Generally I think we get fairly good treatment’. Waiting times in clinic have improved greatly over the last five years and this has increased satisfaction with the service. The booking system was also praised – ‘The system is good, you can choose your own appointment’. These improved booking arrangements have been in place for two to three years, however, and are not therefore due to the award.

Patients being followed up by their GPs also had positive comments – ‘Having a set nurse’; ‘Everything is done in one place, you don’t have to go anywhere else’. This was not the entire picture however. There were concerns that not all GPs review their diabetic patients as thoroughly as the conscientious minority. Two patients who have moved to the area were extremely pleased with the treatment they receive from their GPs compared to the previous area. They felt that the overall level of service on offer was far superior – ‘I was very well looked after in the South East but I’m even happier with the way I’m looked after here’. A third patient was less happy. He felt that his previous GP was far more knowledgeable and up-to-date about diabetes than his new one. In his view, GPs competent in diabetes care were few and far between in this part of the world.

Contact with other professionals

Ophthalmology and retinal screening were seen to be working very well but chiropody/podiatry was creating some dissatisfaction – ‘People who need priority treatment get it, others get pushed back’. There was a general view that chiropody provision had deteriorated and that this deterioration had occurred over the last year or so. One person disagreed and felt that the situation had actually improved.

Changes noticed in hospital/general practitioner/clinic visits over the last 12–18 months

Group members agreed that their blood results were shared with them, and this was valued – ‘In my [GP] surgery you can read all the results on the screen with [the doctor] and get a print-out of them’. For hospital patients, record books are available for keeping a note of results – ‘You just have to ask the doctor what your results are and you can put them in the book’. These arrangements have been in place for varying lengths of time, in some cases five years, while others have implemented them more recently.

Blood pressure measurement and having blood tests taken were the other issues which arose. For hospital patients ‘a doctor used to take your BP [blood pressure] but now you go to a BP clinic to get that done. It’s the same for blood tests’. This was felt to be a retrograde step as it was less convenient for the patient. One lady felt disadvantaged by going to her GP surgery for blood tests – ‘If you go to a small surgery with no phlebotomist then you’re driving [to the hospital] when you’re not safe to drive’. This claim was hotly debated by the group and no conclusion was arrived at as to which was best – hospital or GP.

On a positive note there was consensus that ‘the retinopathy programme is superb’. It is seen as efficient and responsive, especially when it comes to recalls.

There were positive views about how current treatment compares to past treatment, particularly the method of injecting insulin – ‘The advances have been tremendous’.

There was a widely-held view that the service is stretched to the limit – ‘I think the system is getting stretched because there are more diabetics’. The perceived effects of this are appointments being pushed back and reduced chiropody services. One patient felt that there should be more patient education and this was supported by another, newly diagnosed patient – ‘I’d second that. It should be properly funded... If it was properly funded there would be less complications’.

Site 3: Community-based clinic

Experience of diabetes care in general

Without exception the patients reported a high level of satisfaction with the service received – ‘They’re very good with us. Really good. If there’s any new products or machinery coming out we get them’.

Experience of hospital/general practitioner/clinic visits

One patient used to be seen at a different diabetes clinic in another town. She felt that the standard of care offered here was far better – ‘This one provides better care. The doctors and nurses are nice, they talk to me, make me relaxed’.

Another patient used to be seen at the acute hospital. She had been happy with her treatment there but preferred attending here because it was closer to her home.

Contact with other professionals

There were no concerns about access to other health professionals. This remark was typical – ‘We see them all here. I’ve got [the] chiropodist this afternoon and I see the dietician when I need to’.

Changes noticed in hospital/general practitioner/clinic visits over the last 12–18 months

None of the patients had observed any changes. The patients seemed to feel that everything possible was being done for them – ‘These are brilliant. If you’ve got a problem all you have to do is ring them up’; ‘No criticism whatsoever, not here. I’ve never had a problem. They just look after us. I think they’re top-class’.

Site 4: Community-based clinic

Experience of diabetes care in general

All the patients were very satisfied with the treatment and care they received – ‘[It’s] useful. They help me out. I’ve been coming a lot lately’; ‘Fantastic... They’re down-to-earth, plain-speaking, informative’; ‘It’s fine, yeah, no problems – it’s easy enough to get to’.

One patient particularly valued the fact that the same staff were available on every visit – ‘We have the same girls all the time and they get to know you’.

Experience of hospital/general practitioner visits

The three patients with type 2 diabetes are managed at their GP practices. Their experiences of care in this setting differed: ‘Superb. Exactly the same as here [clinic]. Down-to-earth and no bullshit. The GP is superb and the nurse is excellent’; ‘They [the GP practice] do everything but I preferred it when I went to the hospital. I felt everything was done better at the hospital. I felt they were more interested. They did your feet there, they don’t do your feet at the surgery. You have to ring a different number and go to a different place’.

The patient with type 1 diabetes is seen in the hospital outpatients department and was satisfied with her treatment and care.

Changes noticed in hospital/general practitioner/clinic visits over the last 12–18 months

Three of the four patients had not noticed any improvement or deterioration in any aspects of their care or treatment over the last 18 months. The fourth felt that she had seen an improvement – ‘Yes. They’re more understanding, there’s more openness and there’s definitely more information available’. However, she attributed this improvement to the Freedom of Information Act 2000 rather than any changes introduced by the team.

There was only one comment comparing past and present treatment – ‘It is better. They’ve got to know more [about diabetes]. All the doctors have been fine’.

Site 5: Community-based clinic

Experience of diabetes care in general

All the patients interviewed were very satisfied with the treatment and care they received – ‘I’ve not had any problems. They seem to know more about me than I do at the clinic! The nurse is excellent. I have quarterly blood tests – she’s helping me to get my sugar levels down’; ‘It’s okay. It’s good. I’m never refused anything. The receptionists, nurse, doctors are all good’; ‘Here, the diabetes set-up is second to none. I talk to people in other places and it’s not so good’.

There was a high level of expressed satisfaction with the service, care and treatment received. One patient felt that the waiting times could be improved but was at pains to stress that this didn’t detract from the quality of the care – ‘My only complaint is the wait – it can be up to an hour – [but] I can’t complain. It’s a terrific service’.

Experience of hospital/general practitioner/clinic visits

In general, patients were less satisfied with the services received at their GP practices than at the diabetes clinic – ‘No, no. It’s worse. They’re bloody overrun with people aren’t they?’

There was a sense that GPs are used to fulfil particular functions (such as repeat prescriptions) rather than because the patients like the treatment and service they offer:

‘I get my medication through my GP. Now and then they send me notes [about blood tests and urine].’

‘My GP never calls me for any kind of tests. They care more at the diabetic clinic than what my GP used to. The GPs don’t want to see you. It’s so bad.’

‘I would rather go to the clinic than go to my GP. [Prompt: Why?] I never see the same GP twice, they’re always on the move. As soon as I get used to them they disappear. Different faces every time.’

One patient's GP is sited near the clinic and the patient reported joined-up care, with good communication between the GP and the diabetes service.

Contact with other professionals

Only two of the patients interviewed had seen a dietician, one because he had had a heart attack and was a high-risk type 1 diabetic patient. He had this to say about access to other health professionals: 'If I ask to see a dietician or chiropodist, yeah, [I can see one]. But the NHS chiropody centre is so busy that I pay for myself privately'.

Others were less fortunate. One young mother of four reported that she had been diagnosed with diabetes six years earlier while pregnant with her first child and was only now going to see a dietician because she didn't understand what she should be eating. She made the point that: 'If you knew these things were available that would help... Not just leaflets – you need to talk [to someone]'.

Another young woman had not seen a dietician, but added that she had not asked to see one. It seemed that the patients who knew what they wanted and how to ask for it had better access to additional services than those who did not know they were available or did not ask.

A man with type 2 diabetes who visits the centre every three to six months wanted to be seen more frequently as he felt this would lead to better control of his blood sugar levels. On a similar note another patient said: 'Now, you only see the specialist once a year. I would like to see the specialist twice a year. [Prompt: Why would that be better?] You can go through your medication, you would be able to know if you're making progress'.

Another patient felt strongly that there is not enough education provided. Having been diagnosed with type 1 diabetes in her 20s she said that she denied it completely and consequently put her health at serious risk. In her view: 'When you are diagnosed they should put you in a group with other diabetics to find out how they cope. They should make more of an effort to teach you... They need to teach, not tell, you about managing diabetes. And the person needs to be understanding and care about you'.

Changes noticed in hospital/general practitioner/clinic visits over the last 12–18 months

None of the patients had noticed any real changes in the service provided. When asked whether anything had changed for better or worse these were typical comments: 'Not really, no. I just can't complain'; 'I can't do better than what I'm doing right now'.

One patient had noticed an improvement to the record-keeping, saying that his records were now on the computer and as a result no longer got lost. Another said that building work had made the premises more modern.

Conclusions from the patient interviews

Overall the patients felt positive about their own clinicians and the care they regularly received, but they also reported a large number of inadequacies in the system. Healthcare teams were seen to be overloaded and to be trying to cope with constant increases in patient numbers without adequate resources to deal with them. There were significant gaps in provision and care was patchy in the extreme.

Appendix 3

Results of the surveys (Burgoyne and Williams)

Overview of findings

At the beginning of the intervention (T_1) the teams had been broadly similar on nearly all indices. By the end of the intervention (T_2), the award teams showed more team development overall than the comparator teams in nearly every area. Many of these differences were small and were not statistically significant. However, there were a range of areas in which significant differences were found between the award teams and the control teams over the period of the study. These are shown in Tables 1–20. This indicates that the intervention had experienced some success in terms of team working, confidence in one's own abilities and ability to relate to others. The results suggest that the influence of the award scheme did make a real difference to team functioning and did contribute to improvements in the ways in which the teams work.

However the results do need to be interpreted with some caution, since many of the cells were small and in addition there were a large number of non-significant findings. In total there were 20 significant and 30 non-significant findings.

Areas where significant differences were found

Both groups had increased their understanding of their shared goals as a team, but the increase was considerably larger for the award teams (from 49% to 95%) than for the comparator teams (from 49% to 65%) (Chi square 0.027). At T_1 the comparator groups had reported being more able to avoid conflicts between team members than had the award teams but by T_2 the award teams had overtaken them and were better at avoiding conflict (a rise from 45% to 83%, compared with a rise from 67% to 70% for the comparators) (Chi square 0.006).

At T_1 the comparator groups had been more positive about working well together as a team than the award teams were but by T_2 the award teams had overtaken the comparator teams on this dimension. They increased from 61% to 100% reporting that they worked well together as a team, while the comparators increased from 84% to 85% (Chi square 0.005) There were some differences in the views of leadership in the team. At T_1 the comparator teams were

more likely to say that the team had a strong leader but by T₂ that was reversed and the award teams were more likely than the comparator teams to say that they had a strong leader (Chi square 0.021).

At T₁ the comparator teams were more likely to have confidence in their ability to deliver NHS goals than the award teams but by T₂ the award teams had caught up with them and the two sets were the same with 95% reporting this (Chi square 0.042). The award teams had improved in their view of their ability to influence others (from 86% to 97%), while the comparators had dropped slightly on this (Chi square 0.042). There had been a substantial increase in the award teams (71% to 91%) in the ability to engage with those at senior levels, while the comparator teams had decreased slightly from 81% to 80% (Chi square 0.027).

The award teams had also had a large increase in their ability to work across organisational boundaries (from 71% to 91%) while the comparators had fallen from 79% to 60% (Chi square 0.006). The award teams had increased considerably in their reported ability to handle conflict (from 65% to 86%), while the comparators had remained almost the same (Chi square 0.039). The award teams had also become more able to deal with aggression and hostility (from 69% to 79%), while the comparator teams had become less able to deal with these (from 77% down to 70%) (Chi square 0.044). The award team had become more able to negotiate well (up from 80% to 91%), while the comparators had fallen slightly on this index (from 91% to 85%) (Chi square 0.039).

The award teams had increased markedly in their understanding of other people's behaviour (from 75% to 95%), while the comparator teams had fallen from 81% to 70% (Chi square 0.012). Similarly, the award teams had increased their understanding of their own behaviour from 84% to 95% and the comparator teams had dropped slightly from 86% to 80% (Chi square 0.037).

The award teams saw substantial gains in their understanding of regional/local issues in the health economy (from 53% to 79%) while the comparator teams had fallen on this index from 54% to 45% (Chi square 0.014). When it came to better communication between professional groups there was a marked difference with the award teams improving their ratings from 88% to 91% while the comparators fell from 91% to 75% (Chi square 0.034). The award teams also showed a considerable rise in their view of their contribution to the better efficiency of procedures in their organisations (from 55% to 74%), while the comparators stayed much the same at around 70% to 72% (Chi square 0.028).

The award teams showed almost no change in their feeling that they were contributing to local ways of implementing better care, remaining well over 90%, but the comparator teams lost some ground on this index, falling from 95% to 80% (Chi square 0.043). The award teams improved on how they saw their links with NHS organisations locally, rising from 73% to 81%. The comparator teams fell on this index from 74% to 60% (Chi square 0.028).

A similar pattern was seen in terms of their contribution to better links with other public bodies locally, with the number of award team members feeling that they were making a real contribution to these rising from 41% to 57% and the comparator teams falling from 56% to 45%. The award team is making a real contribution to better links with other public sector bodies locally (Chi square 0.021). The award teams saw a large rise in the numbers who felt that the team was making a real contribution to links with other organisations nationally, from 31% to 64%, while the comparator groups saw a fall, from 47% to 40% (Chi square 0.005).

The data above show the areas where significant differences were found between the comparator and award teams. However, on two thirds of the indices (30 items) no significant differences were found. These are listed below for comparison. This appendix also provides the tables on which the significances were based.

Areas where significant differences were not found

There were also a considerable number of areas where no significant differences were found.

- Those from different professional backgrounds in the team find it difficult to communicate.
- The team is making a real contribution to improved patient care.
- When conflicts arise they are easily settled.
- On the whole, team members trust each other.
- The team has a positive supportive culture.
- Team members would like there to be stronger leadership in the team.
- All team members are equal and there is no real leader.
- All act as leaders at their own level.
- Confidence in own ability to drive change forward.
- Confidence in own ability to take a leadership role.
- Confidence in own ideas.
- Confidence in dealing with people from other professional backgrounds to their own.
- Confidence in dealing with difficult people.
- Ability to show initiative.
- Ability to be innovative.
- Ability to be effective as a professional.
- Ability to introduce change.
- Ability to implement change.
- Ability to work across professional boundaries.
- Ability to work in a team or group.
- Having a good understanding of other people's feelings and attitudes.
- Having a good understanding of my own feelings and attitudes.
- Having a good understanding of the systems within which we work.
- Having a good understanding of the culture of the NHS.
- Having a good understanding of the policy agenda.
- Team is making a real contribution to improved patient satisfaction.
- Team is making a real contribution to innovation in patient care and service delivery.
- Team is making a real contribution to the performance of our organisations.
- Team is making a real contribution to improvements in the local health economy.
- Team is making a real contribution to better links with community groups.

Tables showing detailed findings (statistically significant data only)

For all tables, award team responses are shown in bold type, comparator team responses are shown in normal type.

Table 1 Shared goals

	<i>Agree/agree strongly (%)</i>	<i>Disagree/disagree strongly (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
We have a clear understanding of our shared goals as a team (T₁)	25 (49.0)	16 (31.4)	10 (19.6)	51 (100.0)
We have a clear understanding of our shared goals as a team (T₂)	40 (95.2)	1 (2.4)	1 (2.4)	42 (100.0)
We have a clear understanding of our shared goals as a team (T ₁)	21 (48.8)	13 (30.2)	9 (20.9)	43 (100.0)
We have a clear understanding of our shared goals as a team (T ₂)	13 (65.0)	5 (25.0)	2 (10.0)	20 (100.0)

Table 2 Avoiding conflict within the team

	<i>Agree/agree strongly (%)</i>	<i>Disagree/disagree strongly (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
We are able to avoid conflicts between members of the team (T₁)	23 (45.1)	20 (39.2)	8 (15.7)	51 (100.0)
We are able to avoid conflicts between members of the team (T₂)	35 (83.3)	5 (11.9)	2 (4.8)	42 (100.0)
We are able to avoid conflicts between members of the team (T ₁)	29 (67.4)	13 (30.2)	1 (2.3)	43 (100.0)
We are able to avoid conflicts between members of the team (T ₂)	14 (70.0)	6 (30.0)	–	20 (100.0)

Table 3 Working well together

	<i>Agree/agree strongly (%)</i>	<i>Disagree/disagree strongly (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
We work together well as a team (T₁)	31 (60.8)	10 (19.6)	10 (19.6)	51 (100.0)
We work together well as a team (T₂)	42 (100.0)	–	–	42 (100.0)
We work together well as a team (T ₁)	36 (83.7)	5 (11.6)	2 (4.7)	43 (100.0)
We work together well as a team (T ₂)	17 (85.0)	2 (10.0)	1 (5.0)	20 (100.0)

Table 4 Leadership in the team – having a strong leader

	<i>Agree/agree strongly (%)</i>	<i>Disagree/disagree strongly (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
The team has a strong leader (T₁)	21 (41.2)	21 (41.2)	9 (17.6)	51 (100.0)
The team has a strong leader (T₂)	29 (69.0)	9 (21.4)	4 (9.5)	42 (100.0)
The team has a strong leader (T ₁)	23 (53.5)	11 (25.6)	9 (20.9)	43 (100.0)
The team has a strong leader (T ₂)	11 (55.0)	6 (30.0)	3 (15.0)	20 (100.0)

Table 5 Confidence in ability to deliver NHS goals

<i>I feel confident in:</i>	<i>Agree/agree strongly (%)</i>	<i>Disagree/disagree strongly (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
My ability to deliver NHS goals (T₁)	41 (80.4)	9 (17.6)	1 (2.0)	51 (100.0)
My ability to deliver NHS goals (T₂)	40 (95.2)	–	2 (4.8)	42 (100.0)
My ability to deliver NHS goals (T ₁)	40 (93.0)	2 (4.7)	1 (2.3)	43 (100.0)
My ability to deliver NHS goals (T ₂)	19 (95.0)	1 (5.0)	–	20 (100.0)

Table 6 Influencing others

<i>I feel I am able to:</i>	<i>Very well/well (%)</i>	<i>Not very well/ not at all well (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
Influence others (T₁)	44 (86.3)	5 (9.8)	2 (3.9)	51 (100.0)
Influence others (T₂)	41 (97.6)	1 (2.4)	–	42 (100.0)
Influence others (T ₁)	38 (88.4)	4 (9.3)	1 (2.3)	43 (100.0)
Influence others (T ₂)	17 (85.0)	3 (15.0)	–	20 (100.0)

Table 7 Ability to engage those at a senior level

<i>I feel I am able to:</i>	<i>Very well/well (%)</i>	<i>Not very well/ not at all well (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
Engage those at a senior level in my organisation (T₁)	36 (70.6)	12 (23.5)	3 (5.9)	51 (100.0)
Engage those at a senior level in my organisation (T₂)	38 (90.5)	4 (9.5)	–	42 (100.0)
Engage those at a senior level in my organisation (T ₁)	35 (81.4)	5 (11.6)	3 (7.0)	43 (100.0)
Engage those at a senior level in my organisation (T ₂)	16 (80.0)	3 (15.0)	1 (5.0)	20 (100.0)

Table 8 Ability to work across organisational boundaries

<i>I feel I am able to:</i>	<i>Very well/well (%)</i>	<i>Not very well/ not at all well (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
Work across organisational boundaries (T₁)	36 (70.6)	13 (25.5)	2 (3.9)	51 (100.0)
Work across organisational boundaries (T₂)	38 (90.5)	3 (7.1)	1 (2.4)	42 (100.0)
Work across organisational boundaries (T ₁)	34 (79.1)	7 (16.3)	2 (4.6)	43 (100.0)
Work across organisational boundaries (T ₂)	12 (60.0)	8 (40.0)	–	20 (100.0)

Table 9 Working with others – handling conflict

<i>I feel I am able to:</i>	<i>Very well/well (%)</i>	<i>Not very well/ not at all well (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
Handle conflict (T₁)	33 (64.7)	14 (27.5)	4 (7.8)	51 (100.0)
Handle conflict (T₂)	36 (85.7)	6 (14.3)	–	42 (100.0)
Handle conflict (T ₁)	31 (72.1)	10 (23.3)	2 (4.6)	43 (100.0)
Handle conflict (T ₂)	15 (75.0)	5 (25.0)	–	20 (100.0)

Table 10 Working with others – handling aggression

<i>I feel I am able to:</i>	<i>Very well/well (%)</i>	<i>Not very well/ not at all well (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
Deal with aggression and hostility (T₁)	35 (68.6)	14 (27.5)	2 (3.9)	51 (100.0)
Deal with aggression and hostility (T₂)	33 (78.6)	8 (19.0)	1 (2.4)	42 (100.0)
Deal with aggression and hostility (T ₁)	33 (76.7)	7 (16.3)	3 (7.0)	43 (100.0)
Deal with aggression and hostility (T ₂)	14 (70.0)	6 (30.0)	–	20 (100.0)

Table 11 Ability to negotiate

<i>I feel I am able to:</i>	<i>Very well/well (%)</i>	<i>Not very well/ not at all well (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
Negotiate (T₁)	41 (80.4)	9 (17.6)	1 (2.0)	51 (100.0)
Negotiate (T₂)	38 (90.5)	3 (7.1)	1 (2.4)	42 (100.0)
Negotiate (T ₁)	39 (90.7)	2 (4.7)	2 (4.6)	43 (100.0)
Negotiate (T ₂)	17 (85.0)	3 (15.0)	–	20 (100.0)

Table 12 Understanding of other people's behaviour

<i>I feel I have a good understanding of:</i>	<i>Very good/good (%)</i>	<i>Fairly good/ not very good (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
Other people's behaviour (T₁)	38 (74.5)	13 (25.5)	–	51 (100.0)
Other people's behaviour (T₂)	40 (95.2)	2 (4.8)	–	42 (100.0)
Other people's behaviour (T ₁)	35 (81.4)	7 (16.3)	1 (2.3)	43 (100.0)
Other people's behaviour (T ₂)	14 (70.0)	5 (25.0)	1 (5.0)	20 (100.0)

Table 13 Understanding of one's own behaviour

<i>I feel I have a good understanding of:</i>	<i>Very good/good (%)</i>	<i>Fairly good/ not very good (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
My own behaviour (T₁)	43 (84.3)	8 (15.7)	–	51 (100.0)
My own behaviour (T₂)	40 (95.2)	2 (4.8)	–	42 (100.0)
My own behaviour (T ₁)	37 (86.0)	5 (11.6)	1 (2.3)	43 (100.0)
My own behaviour (T ₂)	16 (80.0)	3 (15.0)	1 (5.0)	20 (100.0)

Table 14 Understanding of regional and local issues

<i>I feel I have a good understanding of:</i>	<i>Very good/good (%)</i>	<i>Fairly good/ not very good (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
Regional/local issues in the health economy (T₁)	27 (52.9)	24 (47.1)	–	51 (100.0)
Regional/local issues in the health economy (T₂)	33 (78.6)	7 (16.7)	2 (4.8)	42 (100.0)
Regional/local issues in the health economy (T ₁)	23 (53.5)	18 (41.9)	2 (4.6)	43 (100.0)
Regional/local issues in the health economy (T ₂)	9 (45.0)	9 (45.0)	2 (10.0)	20 (100.0)

Table 15 Communication between those from different professional groupings

<i>Our team is making a real contribution to:</i>	<i>A great deal/ some (%)</i>	<i>A small amount/ none (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
Better communication between those from different professional groupings (T₁)	45 (88.2)	5 (9.8)	1 (2.0)	51 (100.0)
Better communication between those from different professional groupings (T₂)	38 (90.5)	2 (4.8)	2 (4.8)	42 (100.0)
Better communication between those from different professional groupings (T ₁)	39 (90.7)	4 (9.3)	–	43 (100.0)
Better communication between those from different professional groupings (T ₂)	15 (75.0)	5 (25.0)	–	20 (100.0)

Table 16 Improved efficiency of organisations

<i>Our team is making a real contribution to:</i>	<i>A great deal/ some (%)</i>	<i>A small amount/ none (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
Better efficiency of procedures in our organisations (T₁)	28 (54.9)	19 (37.3)	4 (7.8)	51 (100.0)
Better efficiency of procedures in our organisations (T₂)	31 (73.8)	9 (21.4)	2 (4.8)	42 (100.0)
Better efficiency of procedures in our organisations (T ₁)	31 (72.1)	11 (25.6)	1 (2.3)	43 (100.0)
Better efficiency of procedures in our organisations (T ₂)	14 (70.0)	6 (30.0)	–	20 (100.0)

Table 17 Local impact – better care

<i>Our team is making a real contribution to:</i>	<i>A great deal/ some (%)</i>	<i>A small amount/ none (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
Local ways of implementing better care (T₁)	48 (94.1)	1 (2.0)	2 (3.9)	51 (100.0)
Local ways of implementing better care (T₂)	39 (92.9)	2 (4.8)	1 (2.4)	42 (100.0)
Local ways of implementing better care (T ₁)	41 (95.3)	2 (4.7)	–	43 (100.0)
Local ways of implementing better care (T ₂)	16 (80.0)	4 (20.0)	–	20 (100.0)

Table 18 Better links between NHS organisations locally

<i>Our team is making a real contribution to:</i>	<i>A great deal/ some (%)</i>	<i>A small amount/ none (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
Better links between NHS organisations locally (T₁)	37 (72.5)	10 (19.6)	4 (7.9)	51 (100.0)
Better links between NHS organisations locally (T₂)	34 (81.0)	6 (14.3)	2 (4.8)	42 (100.0)
Better links between NHS organisations locally (T ₁)	32 (74.4)	10 (23.3)	1 (2.3)	43 (100.0)
Better links between NHS organisations locally (T ₂)	12 (60.0)	8 (40.0)	–	20 (100.0)

Table 19 Better links with other public sector bodies locally

<i>Our team is making a real contribution to:</i>	<i>A great deal/ some (%)</i>	<i>A small amount/ none (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
Better links with other public sector bodies locally (T₁)	21 (41.2)	27 (52.9)	3 (5.9)	51 (100.0)
Better links with other public sector bodies locally (T₂)	24 (57.1)	16 (38.1)	2 (4.8)	42 (100.0)
Better links with other public sector bodies locally (T ₁)	24 (55.8)	19 (44.2)	–	43 (100.0)
Better links with other public sector bodies locally (T ₂)	9 (45.0)	11 (55.0)	–	20 (100.0)

Table 20 National impact

<i>Our team is making a real contribution to:</i>	<i>A great deal/ some (%)</i>	<i>A small amount/ none (%)</i>	<i>None of these/ no response (%)</i>	<i>Total (%)</i>
Better links with other organisations nationally (T₁)	16 (31.4)	32 (62.7)	3 (5.9)	51 (100.0)
Better links with other organisations nationally (T₂)	27 (64.3)	13 (31.0)	2 (4.8)	42 (100.0)
Better links with other organisations nationally (T ₁)	20 (46.5)	21 (48.8)	2 (4.7)	43 (100.0)
Better links with other organisations nationally (T ₂)	8 (40.0)	12 (60.0)	–	20 (100.0)

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